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JOINT REPORT ON SOCIAL PROTECTION AND SOCIAL INCLUSION 2009

European Commission

Joint Report on Social Protection and Social Inclusion 2009

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Directorate-General for Employment, Social Affairs and Equal Opportunities
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2009 JOINT REPORT-KEY MESSAGES

KEY MESSAGES from Member States' new National Strategic Reports (NSR) outlining strategies to promote the EU's common social objectives:

- The EU can build on the values of solidarity that underpin its social policies and on progress in structural reforms to cushion the impact of the economic crisis and help recovery. Further strengthening the positive mutual interaction with action for growth and jobs is vital, notably by allowing social protection systems to fully play their role as automatic stabilisers. In order to address the negative impact on employment and social cohesion, long-term reforms need to be sustained while balanced with short-term measures aimed at preventing job losses and sustaining household incomes. Recent structural reforms in the field of social security have delivered results, bringing more people into employment, strengthening the incentives to work and the resilience of labour markets, prolonging working lives and enhancing economic growth. A strong coordinated EU response is needed and valuable indications are provided by the European Economic Recovery Plan.

- The European Social Fund should be used to its full potential in a flexible and timely way to alleviate the social impacts of the crisis, by supporting rapid labour market re-entry of the unemployed and focussing on the most vulnerable. Simplified implementation of Structural Funds and improved coordination with social policies will help. The Commission will issue a regular bulletin to monitor social trends. Reports from Member States could facilitate exchange of information and policy experiences in the Social Protection Committee.

- Comprehensive Active Inclusion strategies that combine and balance measures aimed at inclusive labour markets, access to quality services and adequate minimum income, need to be implemented. A boost must be given to Member States' efforts to implement comprehensive strategies against poverty and social exclusion of children, including accessible and affordable quality childcare. Sustained work is required to tackle homelessness as an extremely serious form of exclusion, to address the multiple disadvantages the Roma people are facing and their vulnerability to social exclusion and to promote the social inclusion of migrants. Vigilance is needed as new risk groups, e.g. young workers and labour market entrants, as well as new risks may emerge.

- Long term adequacy and sustainability of pension systems depend on continued efforts to reach the Lisbon target of a 50% employment rate of older workers notwithstanding the downturn. It is important to ensure full coverage and to monitor pension adequacy notably for women and low wage earners. Long-term oriented strategies and the regulatory framework have limited the impact of the crisis on private pension income for most of those retiring today, but some might face outcomes below their expectations. Funded scheme designs will need to be reviewed to boost their ability to cope with risk in the investment and pay-out phases and to improve coverage so they can fully realise their strength in coping with ageing.

- Member States strive to improve the value for money of healthcare and reduce health inequalities by increased attention to primary care, prevention, health promotion, better coordination and rational use of resources. These strategies need to be more vigorously pursued, in particular where healthcare systems are under-resourced. This also implies addressing potential staff shortages in health care by measures to recruit, train, retain and develop health care professionals at all levels.

- Member States are also striving to establish and strengthen systems for quality long-term care, to create a solid financing basis, to improve care coordination and to ensure sufficient human resources as well as support for informal carers.

- The current Social Open Method of Coordination (OMC) Cycle lasts until 2010, the target year for the Lisbon strategy. Strong commitment will be needed to achieve the agreed objectives on social protection and social inclusion and the 2010 European Year for combating poverty and social exclusion will reaffirm it. While the decision on setting national quantified targets and their definition remains a core responsibility of the Member States, the positive role of the Social OMC could be further strengthened by evidence-based national target-setting. Increased attention should be given to the quality and continuity of stakeholder involvement and to the mainstreaming of social considerations inter alia via the evaluation of social impacts as a vital part of integrated impact assessments.

1. INTRODUCTION

Between 2001 and 2007 average economic growth in EU-27 was 2.1% per year. The employment rate in 2007 had risen to 65.4%, mainly thanks to higher employment of women and older workers. New jobs helped reduce the share of jobless households from 10.2% in 2005 to 9.3% in 2007, but only marginally benefited jobless families with children. The latest data show that 16% of Europeans are still living at risk of poverty. While there is no better safeguard for avoiding poverty than a quality job, in-work poverty at 8% illustrates that not all jobs provide this assurance. At the same time, data shows that in several Member States high growth improved the absolute living standards of the poor while their relative situation improved or remained the same.
The economic outlook has changed fundamentally. While the labour market has shown resilience in most Member States, unemployment has risen substantially in some of them, and forecasts point to further job losses ahead.

Against this backdrop the contribution of social policy is crucial. Appropriate social policies will not only mitigate adverse social impact on the most vulnerable but also cushion the impact of the crisis on the economy as a whole. Social protection is a major countercyclical and automatic stabilising element in public expenditure. Well-functioning systems in a framework of continued sustainability-reinforcing reforms can help stabilise aggregate demand, underpin consumer confidence and contribute to job creation.

The most badly hit victims of the crisis will be those households where breadwinners are at a disadvantage in the labour market and in society. Hence the need for social safety nets which are tight enough to prevent people from falling through and effective enough to launch them back into active social and labour market participation.

Appropriate **flexicurity** measures will use active labour market policies to ease transitions, avoid people becoming long-term unemployed, resist using early retirement to regulate labour supply, enhance skills and secure transition periods. Comprehensive **active inclusion** measures are needed to address the situation of those furthest from the labour market.

This also implies adjusting benefits, when needed, to **safeguard appropriate support for recipients**. Member States are already acting to maintain the purchasing power of minimum benefits and basic pensions. The severe nature of the recession entails a need for **closer monitoring of social impacts.**

The bulk of pension income of people retiring today derives from statutory pensions financed by current contributions. Income from funded private pension is substantial in a few countries. As pension funds invest part of the savings they hold in shares they have been affected by the dramatic decline in financial markets. Long-term strategies, the regulatory framework and action by the authorities have limited the impact for most of those retiring today. Scheme designs will, nonetheless, have to be reviewed to ensure future adequacy and sustainability of funded schemes.

Effective **health and preventive care services** are of particular importance when the economy and the income declines and unemployment rises, but there is a significant risk that investment in health and long-term care will suffer. Postponement of plans to modernise and develop local healthcare and long-term care infrastructure can be expected. Such delays would be most unhelpful in those countries that have under-resourced health sectors which are very unevenly distributed across the national territory.

Several Member States have endeavoured to make the preparation of the renewed strategies a participatory exercise involving stakeholders and, to some extent, citizens at large. Local and regional authorities are increasingly involved but this needs to be taken further. Gender considerations feature more than in the past but could be mainstreamed more consistently. There are some examples of good practice in consultation activities, for example efforts to ensure an interactive two-way dialogue and provide feedback on results. Some countries make a general commitment to uphold stakeholder involvement at all policy stages and throughout the reporting cycle. The participatory bodies established at various levels could help monitor structural social reforms and thus promote opportunities, access and solidarity in the present crisis. Increasingly, policy priorities are underpinned with quantified targets. When based on sound analysis, properly resourced and backed by clear political commitment, this can boost delivery in specific policy areas.

2. FIGHTING POVERTY AND SOCIAL EXCLUSION

Children face a higher poverty risk, at 19% in EU-27, than the population as a whole. This has not improved since 2000. The 2007 OMC focus on **child poverty** helped deepen the common understanding of the determinants of child poverty in each country. It clarified the need for comprehensive strategies combining adequate, well-designed income support, quality job opportunities for parents and the provision of necessary services.

Most Member States who made the issue a priority in 2006 in response to the European Council's call for decisive action are now planning to reinforce their strategies and follow a more multi-dimensional and integrated approach. Many have mainstreamed child poverty in areas such as minimum income and wages, reconciliation of work and family life and family-friendly services. Sustained efforts are needed, notably to ensure accessible and affordable quality child care. Drawing on the improved evidence-base, 22 Member States have set targets in relation to child poverty, 16 of them using EU-agreed indicators. A few have also set intermediate targets for their specific challenges (jobless households, families most at risk, intensity of poverty, childcare).

Roma people face multiple disadvantages and belong to the most excluded in European societies. In the new reports Member States with a sizable Roma minority have upgraded their coverage of the issue and, in general, there is a better recognition of the challenges it entails. Action taken or announced mainly focus on desegregation, access to employment, addressing educational disadvantage and improved access to basic services such as housing and healthcare. However, in most countries a comprehensive policy framework is still lacking, also due to the non-availability of data and an insufficient knowledge-base.

The NSRs confirm the priority given to the **inclusion of migrants** in 2006. Increasingly adopting a holistic approach, Member States are focusing more on involving both migrants and the host society in the process, and several are attempting to create synergies between inclusion policies and anti-discrimination measures.

The inclusion of **disabled people** continues to be addressed, but disability mainstreaming remains limited. Employment activation, eliminating barriers to education and lifelong learning, and stricter conditionality generally dominate rather than the elimination of structural obstacles to full participation.

As in the 2006 NSRs, most Member States have **active inclusion** among their priorities. However, inclusive labour markets, access to quality services and adequate income are dealt with separately in most cases, whereas most disadvantaged people suffer from multiple disadvantages and integrated responses are essential. Several countries have taken steps to ensure that the purchasing power of minimum incomes is maintained. It remains essential to design better links between out-of-work benefits and in-work support, in order to create the right incentives, while at the same time ensuring adequate income support and prevent in-work poverty. Coordinated social and employment services are needed to tackle obstacles to full and lasting participation in society and the labour market. So more attention must be paid to optimising the interaction between the three strands and ensuring that due account is given to each.

The best safeguard against poverty and social exclusion is a quality job for those who can work. For those for whom work is not a real option, adequate income support and social participation must be ensured. Particularly relevant measures taken by many Member States

include those that support job retention or speedy re-entry into employment, and promote adaptability, by offering opportunities to acquire or upgrade skills and developing personalised action plans outlining pathways to the labour market. Attention should be paid to supporting job opportunities for the most vulnerable, including in the social economy. Most NSRs reflect the importance of access to quality services for tackling the social hurdles that hinder people's sustainable inclusion.

Homelessness is one of the most severe forms of exclusion and enhanced efforts in some Member States must be extended to include a greater supply of affordable **housing**. Comprehensive, multidimensional strategies aim to address its different manifestations specifically, while another approach focuses on measures integrated in wider policy frameworks, e.g. relating to housing, employment, and health. Supported housing combining the objective of independent living with personalised social support is receiving much attention. Several countries have set targets to reduce homelessness or strengthen support structures. Lack of reliable data still impairs efforts to define and monitor effective policies. Promoting financial inclusion is crucial to prevent homelessness, particularly in the current circumstances; appropriate support and advice must be ensured to people facing eviction or repossession.

Inequalities in health between different socio-economic groups persist and Member States tend to complement their universal approach with measures targeting the most vulnerable. Several NSRs present cross-sectoral policies, spanning both prevention and health promotion and mobilising a wide range of services including in the areas of education, housing and employment. The main policy orientations are: enhancing primary and preventive care, removing barriers to access and addressing the situation in deprived areas.

Most NSRs emphasise the importance of **education**, but only some integrate it in a comprehensive long-term strategy to prevent and tackle social exclusion. Pre-primary education is seen as fundamental both as a key element in levelling socio-economic disadvantage, and as a means to facilitate work/family life reconciliation. Efforts also focus on ensuring high quality standards in all schools, combating early school leaving, improving access to education for specific groups and introducing measures to validate prior learning.

Addressing **financial exclusion** is vital in any strategy against poverty; the crisis brings the issue even more to the fore. Some Member States report comprehensive policies, whereas one is tackling over-indebtedness as a priority. Most frequently quoted is debt advice, sometimes target group-based or focusing on early detection. Microcredit is provided in some countries to people who cannot access the mainstream credit market. Financial inclusion is a pre-condition for sustainable access to the housing market.

3. ADEQUATE AND SUSTAINABLE PENSIONS

During the last decade Member States have reformed their pension systems to better provide adequate and sustainable pensions. In the 2008 NSRs, countries report on incremental progress in providing adequate pensions without jeopardising financial sustainability and work incentives. The new economic outlook will make the fine-balancing required even more challenging.

In response to increased longevity reforms of pension systems have aimed at raising the employment rate of older workers and decreasing the economic dependency ratios, so as not to endanger the financial sustainability of public finances. Mostly this resulted in a decrease in the pension promises and in rules allowing workers to compensate for this by extending their working lives. Indeed keeping the balance between contributory lives and years spent in retirement will depend on more people working more and longer. This will entail lowering the entry age, avoiding long career breaks and postponing the effective exit age. At the same time more attention is being paid to ensuring that all employment periods are covered.

The employment rate of older workers has increased over the last decade, and 11 countries now meet the Lisbon target of 50% employment for older workers by 2010. Given the increase in life expectancy, higher employment rates will be necessary in the medium term. Normal working age has to increase, and the reports show that Member States are starting to **increase the pensionable age** in statutory schemes. **Early exit routes** are being closed and incentives to early retirement removed. These are important signals for employers and employees to improve their practises of age management and postpone retirement. The current economic downturn will test the durability of these achievements. Further efforts should be made to sustain the employment of older workers, including making full use of active labour market policies. It will be crucial to avoid that the effective retirement age begins to drop because early pathways out of the labour market are used again to deal with rising unemployment.

The present economic outlook highlights the need to ensure that workers affected by periods of unemployment are covered in appropriate ways by the pension systems. In reformed systems **career breaks can reduce adequacy significantly** and monitoring of pension outcomes is important for those who have difficulty fulfilling the new eligibility conditions, notably low wage earners and those with broken careers, among whom women are over-represented.

OMC work in 2008 has concentrated on private pension provision. A number of Member States have taken measures to ensure funded pensions, dealing with coverage and contributions, levels of charges, developing regulatory frameworks for annuities (longevity risk) and investments (financial risk). In voluntary schemes there is ample evidence of a strong socio-economic gradient in coverage and contribution levels. If private schemes are an essential source of future retirement income then coverage and contribution levels need to be set accordingly.

Current designs of the **pay-out phase** of funded schemes may give insufficient protection against longevity risk, volatility and inflation. Annuities are the most secure means of providing an income in retirement. Shifts in the portfolio structure when approaching retirement (life-styling) can provide a certain degree of protection against volatility of capital value. Well-functioning supervisory bodies and effective financial regulatory frameworks are essential. Shifts to multi-source pensions involving complex decisions require that scheme members have access to unbiased information and to some financial education.

Member States are changing their minimum income provisions for older people to increase benefits and ease access. In as much as benefits tend to be price-indexed relative incomes were likely to have fallen behind in recent years of growth. Yet, the relative erosion is mostly substantially smaller than could be expected. Most Member States have up rated minimum pensions and minimum provisions.

Member States use the following national targets in the area of pensions: employment rate of older workers (even beyond the EU objective), effective retirement age, contribution rates, theoretical replacement rates, and poverty rate of older persons. This suggests that pension modernisation follows long-term strategies in line with the agreed objectives.

4. HEALTHCARE AND LONG-TERM CARE

Virtually all of the 2008-2010 reports build on the previous 2006 national health plans. Member States argue that essential policies contributing to good health and longer working lives include effective workplace health policies, health promotion, disease prevention, curative care and rehabilitation. Moreover, greater coherence is necessary between economic, education, employment, environmental and social policy.

Inequalities persist in health status and in life expectancy between different socio-economic groups and different regions. Evidence shows a clear correlation between ill health and poverty, unemployment and low education. Many NSRs explicitly recognise that social inequalities in health hamper people's life chances. Several present cross-sectoral policies, spanning both health-promotion and disease-prevention and mobilising a wide range of services such as education, housing and employment. The main policies aim to enhance primary and preventive care, to remove financial, organisational, informational and other barriers to access and to address the situation in deprived areas.

Indeed all countries see enhancing **primary care** as the way to improve access, ensure coordination of care and contribute to sustainability and all the more so where resources are scarce. However, in many countries the shortages of general practitioners and nurses continue, and ageing may make them more acute. It is difficult to see how the ambition of enhancing primary healthcare can be achieved without a proper primary healthcare policy that includes measures to ensure a sufficient supply of motivated healthcare professionals.

Health promotion and disease prevention are universally prioritised as a way to improve health and functional capacity, thus reducing the need for treatment and improving sustainability. Member States recognise that the campaigns could be more effective and propose making them more local and targeted. But nonetheless healthcare/treatment, in particular hospital costs, consumes the largest part of the expenditure and many countries are still directing extra funds to this sector. Promotion and prevention receive a relatively small part of expenditure in relation to the goals they are supposed to achieve.

Member States continue in their efforts to improve **efficiency and effectiveness**, by rationalising costs and introducing cost-sharing mechanisms. Several countries have been going down the avenue of privatisation. Whether such reforms promote quality and efficiency depends on the incentives and notably the nature of contracts with insurance funds. At national level, success depends on the institutional capacity to monitor, regulate, ensure risk equalisation and identify what the private and what the public can do better. Private and public provision also needs to be coordinated to create synergies and avoid duplication.

The national reports show a growing awareness of **quality** issues among Member States and present different initiatives aiming at providing their citizens with good quality and safe preventive care and treatment, such as elaboration and implementation of quality standards or clinical guidelines based on evidence-based medicine or health technology assessment. However, only a few countries have made patient safety, one of the cornerstones of quality, a key priority, and set up appropriate structures and systems. Huge disparities are observed, with some Member States well advanced in the implementation of quality and safety strategies and in providing a patient-centred approach, and with others only at the beginning of the process. These disparities may be explained by the limited resources allocated to healthcare and the insufficient awareness about long-term advantages that good quality of care may bring. While a large number of countries see increased patient choice as a dimension

of patient centeredness, it is not acknowledged that free choice is related to increased costs of care.

Care coordination remains an issue. Member States have made progress on an integrated approach for the management of some chronic diseases, but there is still much to do to improve coordination between levels of government, between types of medical care, between health and social care, between public and private provision, between the public and the third sector. This is all the more so for long-term care.

The NSRs reaffirm the commitment to ensure universal access to high quality and affordable long-term care. Nonetheless, a sustainable mix of financing is yet to be found in many countries, hence the share of private sources of finance is relatively high. These can be private health insurance coverage (often supplementary or for high income groups) or private household payments (either co-payments for publicly provided care, and/or out-of-pocket payments for which very little or no reimbursement is offered).

Dependent people prefer long-term care in a residential or community setting rather than institutional care, but in many countries institutional care still accounts for more than half of public expenditure. Additionally, there is a widespread consensus on the need to address the expected workforce shortages in the long-term care sector (formal care) as well as devising ways to support family or informal carers. Adequately recruiting, (re)training, and retaining long-term care workers remains a challenge.

This analysis is developed further in the annexed country profiles and supporting document.

SUPPORTING DOCUMENT[1]

SEC(2009)141
{COM(2009) 58 final}

[1] The following text includes the corrections specified in SEC(2009) 141 CORRIGENDUM of 13.2.2009.

1. SCOPE AND OUTLINE OF THE REPORT

This supporting document prepared by the Commission services accompanies the 2009 Joint Report on Social Protection and Social Inclusion [Commission proposal: COM(2009) xx]. It provides an in-depth assessment of the renewed National Strategy Reports (NSRs) presented by EU-27 in autumn 2008[2]. The NSRs outline each Member State's policy priorities up until 2011 in the second cycle of the integrated EU process for Social Protection and Social Inclusion. The assessment draws on the material provided by Member States in their NSR, but also on analysis prepared by independent experts and on studies and research carried out in the framework of the Social Open Method of Coordination (OMC).

Section 2 contains an overview of the social situation in the Member States and of their overall strategic approach. A comprehensive analysis is published on the Commission website[3] showing where each Member State stands in relation to the common objectives[4] of the EU process for social protection and social inclusion based on the data available in 2008: The NSRs were presented at the end September 2008, and were therefore prepared before the fallout of the financial crisis on the real economy took hold. Although these developments could not be anticipated in the NSRs, Member States and the Commission agree on the reports are still relevant, and that the actions envisaged to strengthen delivery on shared social objectives have become all the more urgent. As stated in the Joint Commission/Council Report proper: "Appropriate social policies will simultaneously support the goals of mitigating adverse social impact on the most vulnerable and of containing impact of the crisis on the economy overall."

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

The annex contains an overview of the most recent statistical data on the indicators[5] developed to monitor progress towards the overarching common objectives of the Social OMC.

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

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

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

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

2. OVERVIEW OF THE SOCIAL SITUATION AND OVERALL STRATEGIC APPROACH

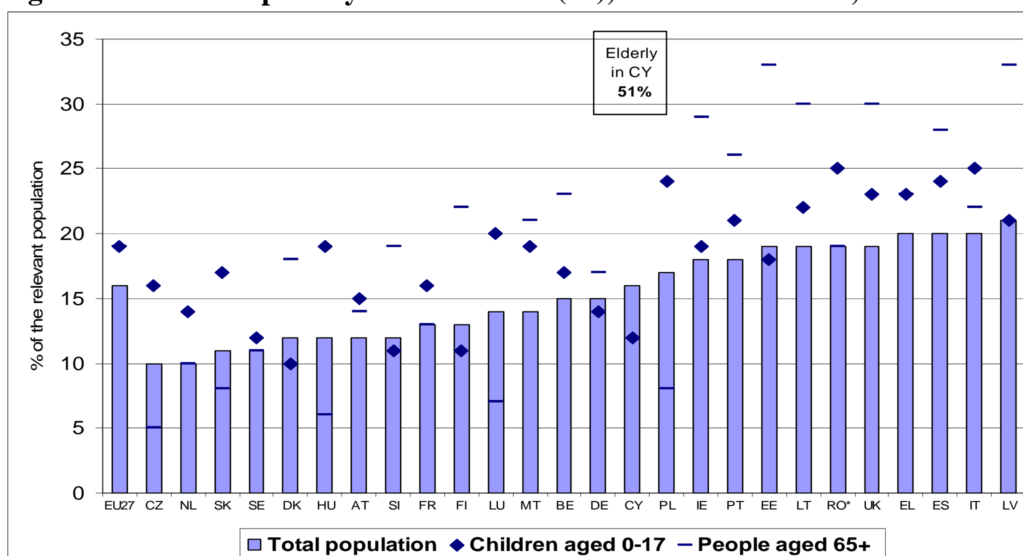
2.1 Overview of key indicators of Social Protection and Social Inclusion in Europe

- 16% of Europeans, or 79 million people, were at risk of poverty in 2007.
- Despite overall progress on the labour markets, 9.3% of working age adults and 9.4% of children live in jobless households and 8% of the employed live below the poverty threshold.
- Social transfers reduce the risk of poverty by 36% on average in the EU, but this impact varies from 17% to more than 61% across the EU.
- The employment rate of older workers reached 44.7% in 2007, against 36.9% in 2000.
- Current pension systems have generally reduced poverty among the elderly, but single elderly women face a much higher risk than single elderly men (28% as against 20%).
- In the future for the generations who have recently entered the labour market, a marked decline in pensions can be expected if the number of years worked and contribution rates remain the same.
- Life expectancy is now 82 years for women and 76 years for men. This follows a gain in longevity of 4 years for women and 5 years for men over the last 20 years.
- The gap in life expectancy between European countries is 8 years for women and 13 years for men.
- Total expenditure on health has increased throughout the EU in the last 20 years. Today it ranges from 10% of GDP or more in some countries to 6% or less in others.

2.1.1. 16% of Europeans are at risk of poverty

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

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



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

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

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

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

Table 1: Overview of poverty rates by age groups

Poverty rate/gap is ++: well below; +: below; o: around; -: above; --: well above the EU and national average[6]

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

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

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

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

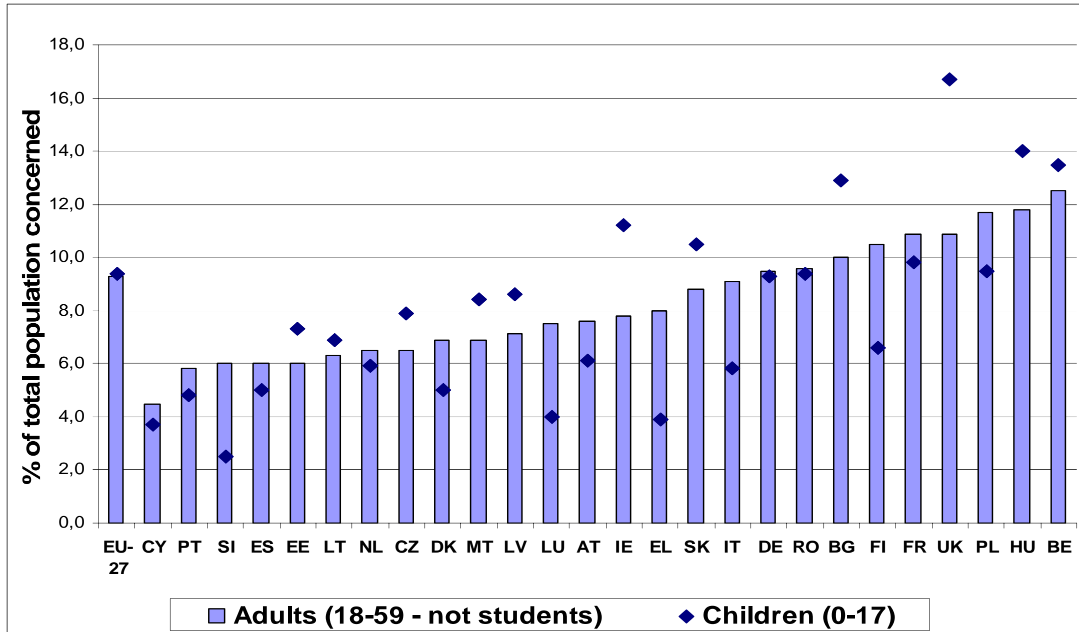
Economic growth has helped to improve overall living standards but the benefits of growth have not reached everyone at the same pace and to the same extent. In a number of countries (CZ, EE, ES, IE, CY, LV, LT, PL, SI, and SK), strong growth rates of 3% or more over several years have not left the poor behind and have helped to improve their living standards while their relative situation either improved or stayed the same. On the contrary, in EL, LU, HU and SE, growth rates over 3.5% have not had the same impact on low income households. The impact of the deepening economic crisis on living standards and inequalities will need to be closely monitored, with a specific focus on the most vulnerable[7].

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

In 2007, almost 9.3% of EU27 working age adults (aged 18-59, and not students) were living in households where no one was in paid employment. This rate ranged from 4.7% in Cyprus to 11.6% or more in Belgium, Hungary, and Poland. On average, a similar proportion of children were living in jobless households, 9.4% in the EU-27 in 2007. However, families with children are more affected by joblessness in some countries than in others. The share of children living in jobless households varies greatly across Member States, and ranges from 2.2% in Slovenia to 16.7% in the United Kingdom. Living in a household where no one works affects both children's current living conditions, and their chances to develop their full potential.

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

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

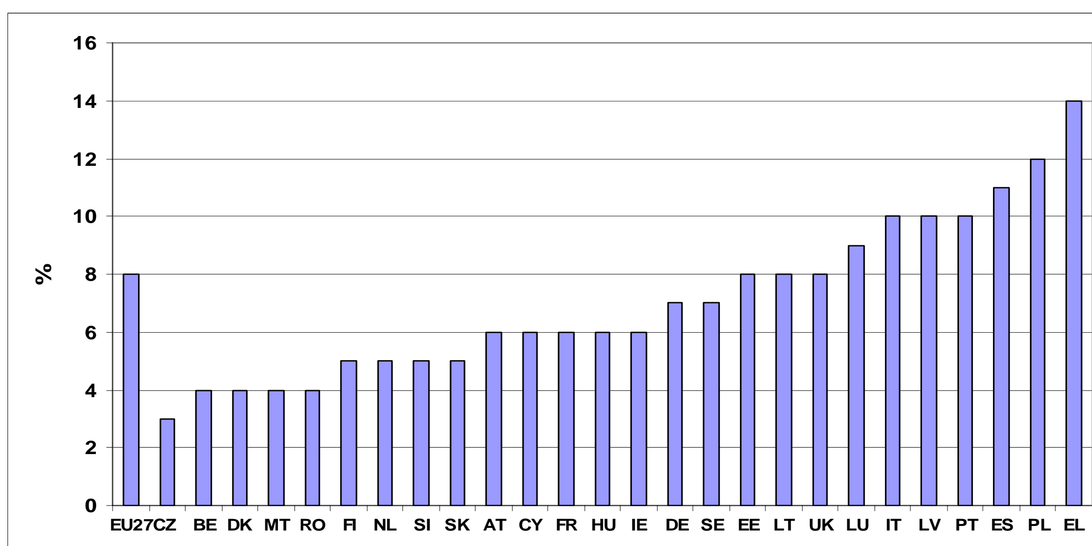


Source: Eurostat Labour Force Survey, spring results, data missing for SE

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

As indicated above, having a job does not always protect people from the risk of poverty. In 2007, 8% of EU-27 citizens in employment (aged 18 and over) lived below the poverty threshold, thereby facing difficulties in participating fully in society. This rate ranged from 4% or less in the Czech Republic, Belgium, Denmark, Malta, and Romania to 14% in Greece and 12% in Poland. In-work poverty is linked to low pay, low skills, precarious employment and often involuntary part-time working. It is also linked to the type of household in which workers live and to the economic status of other members of the household. In households with children for instance, the single-earner family model is no longer sufficient to ward off the risk of poverty

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



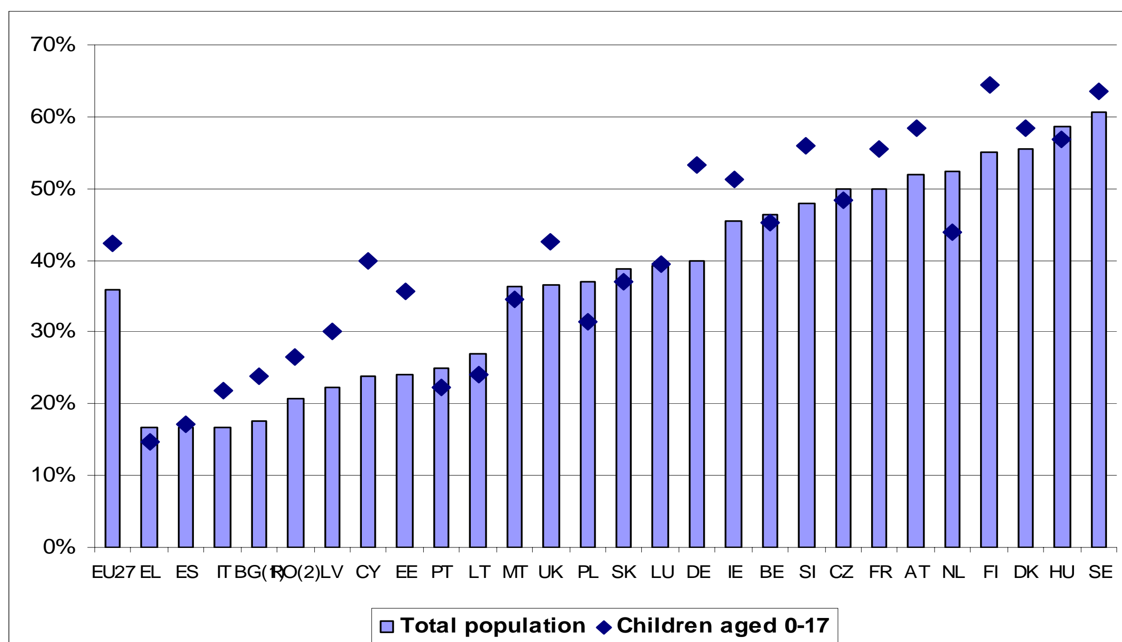
Source: EU-SILC (2007); income year 2006; except for UK (income year 2007) and for IE (moving income reference period 2006-07); RO: National Household Budget Survey 2007; data missing for BG

In 2007, the employment rate of third-country nationals/population born outside the EU was 2.6 percentage points lower than that of the host population, a similar gap to that recorded in 2006 (2.7 p.p.). This masks strong differences across the EU. In Spain, Greece, Italy and Portugal, where migration is a recent phenomenon and mainly economic, migrants have higher employment rates than the native-born population. By contrast, in Belgium, Denmark, Germany, France, the Netherlands, Poland, Austria, Finland, Sweden, and the United Kingdom, migrants have much lower employment rates than the host population, with employment gaps ranging from 5.6% in the United Kingdom to 21.7% in Poland.

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

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

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



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

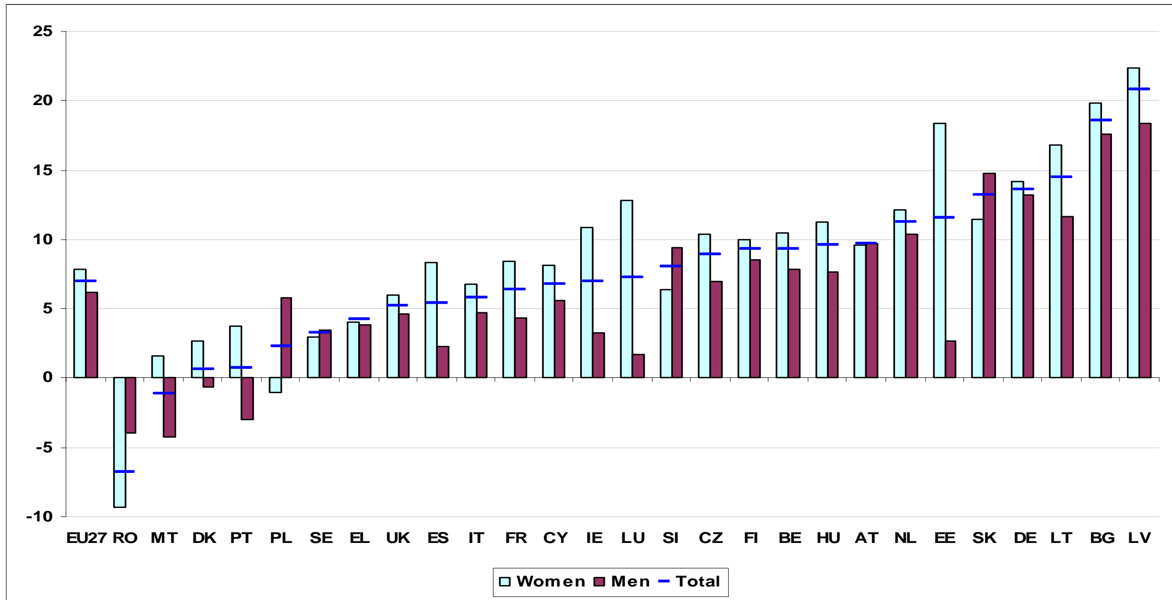
2.1.2. The adequacy and sustainability of pension systems

Ageing of the population is one of the challenges that the EU is facing. Population projections show that the share of people aged 65 years and over in the total population is predicted to increase from 17.1% to 20.1% in 2020. This means that there will be 103.1 million older persons compared to 84.6 million in 2008. The old age dependency ratios will therefore increase from the current 4 persons of working age (15-64) for every person aged 65 years to a ratio of 3 to 1.[8]

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

[8] Source: Eurostat demographic projections 2008.

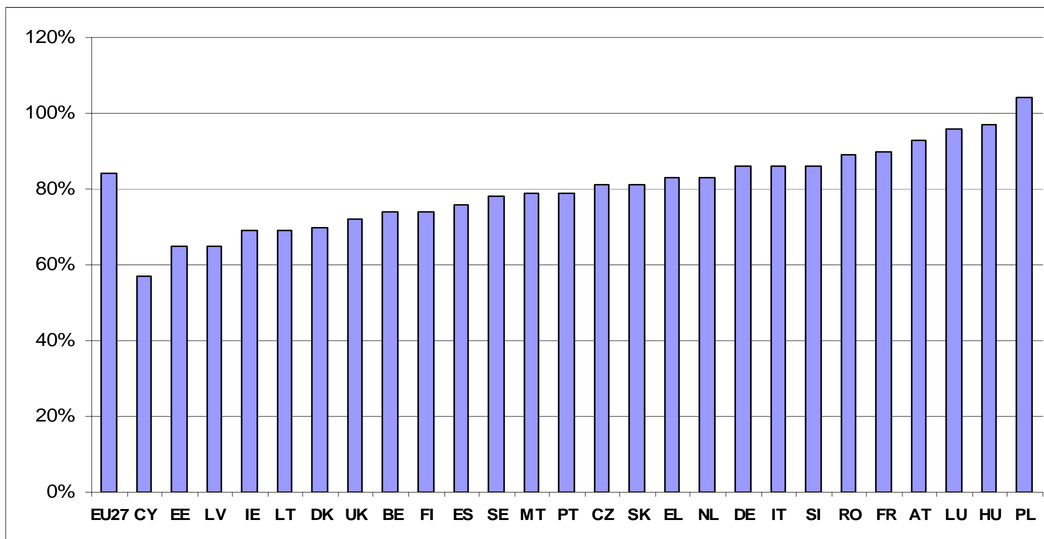
Figure 5: Change in employment rate of older workers, 55-64, 2001-2007



Source: Eurostat, Labour Force Survey, Annual averages

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

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

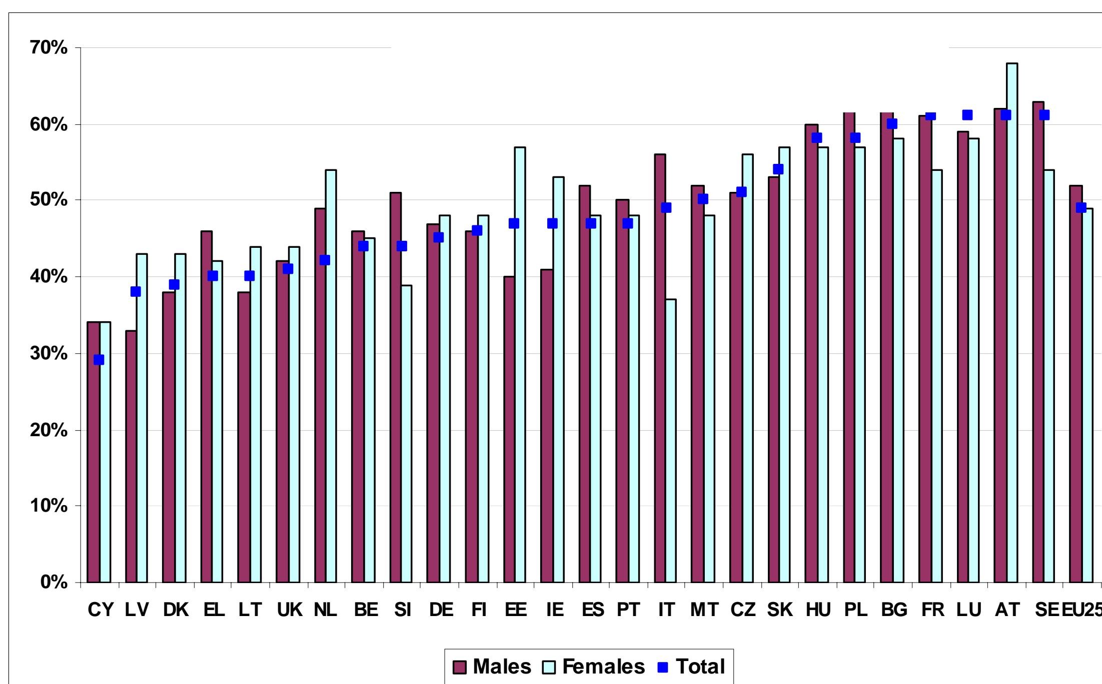


Source: SILC (2007) Income reference year 2006; except for UK (income year 2007) and for IE (moving income reference period 2006-2007). RO: National HBS 2007, income data 2007. BG: missing data.

Aggregate replacement ratios - which are based on gross individual income rather than household disposable income - however, generally show that current average pension levels can be rather low compared to current earnings. This can be due to low coverage and/or low income replacement from statutory pension schemes, but can also reflect maturing pension

systems and incomplete careers or under-declaration of earnings in the past. In this respect, it should be noted that the aggregate replacement ratio indicator is based on gross income figures, and that several factors besides aggregate replacement rates (such as differences in household composition and size and the overall design of social protection and taxation systems) can have a strong influence on the overall living standards of individuals.

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



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

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

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

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

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

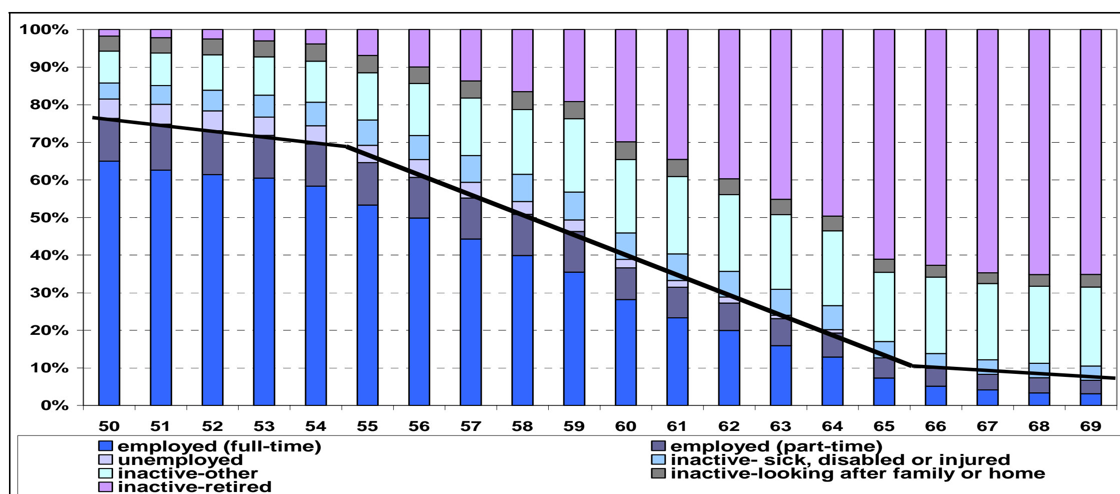
*Note: Contribution rates used for statutory schemes and also eventually occupational or private schemes included in the base case, thus giving elements on the representativeness associated with the base case. Contribution rates correspond to overall contribution rates as a share of gross wages (from employees and employers) used as assumptions for the calculation of theoretical replacement rates. Contribution rates may differ from current levels reflecting for instance projected increases in contribution rates, in particular as regards assumptions used for second pillar schemes. DK refers to contributions, to the ATP (statutory Supplementary Labour Market Pension, though it should be recalled that the financing of the first pillar mainly comes from the general budget. For CY one fourth

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

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

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

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



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

2.1.3. Health and long-term care

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

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

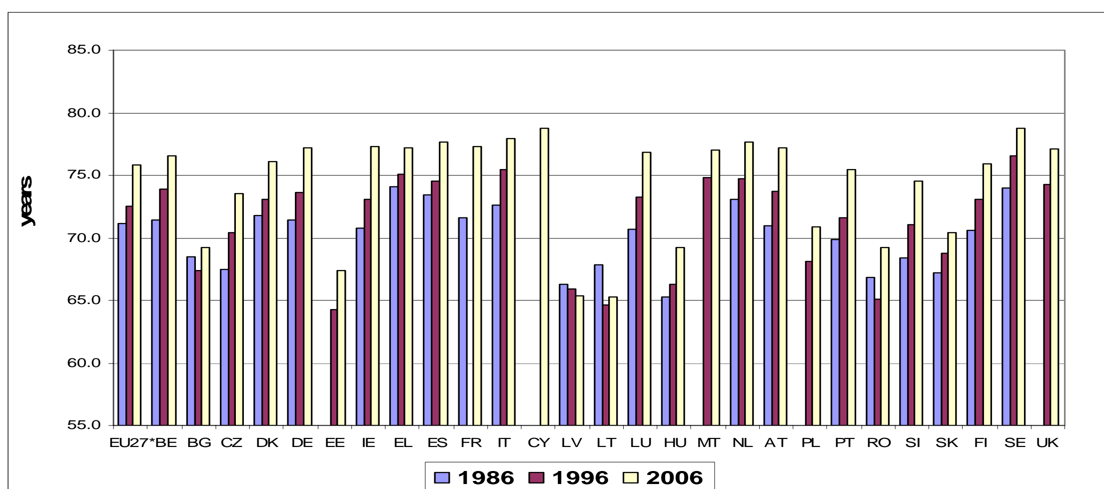
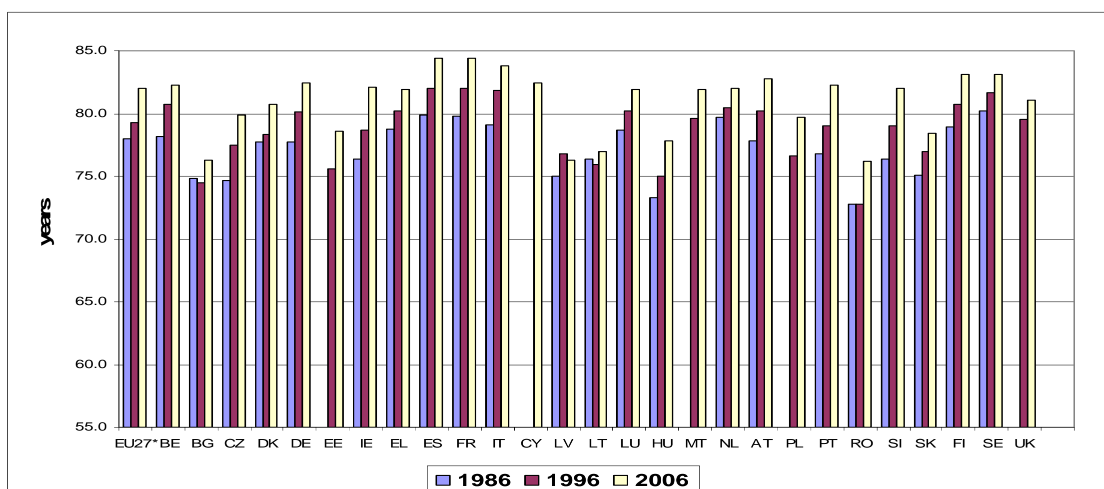


Figure 9b: Life expectancy at birth, women, 1986, 1996 and 2006



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

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

Table 3: Life Expectancy and Healthy Life Years[9], 2006

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

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

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

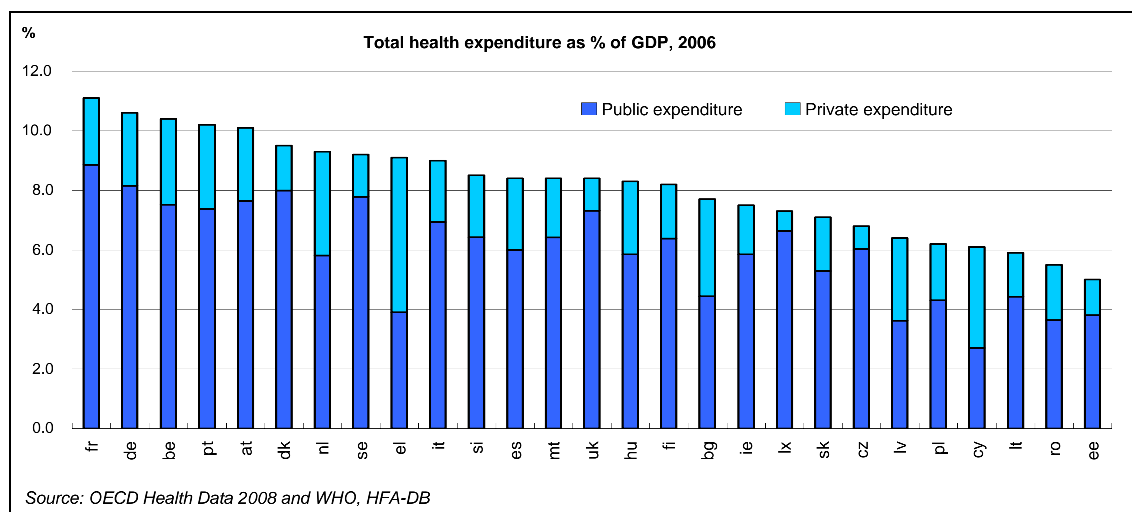
Several barriers to accessing care are identified. In the EU there remain significant gaps in health insurance coverage, i.e. non-negligible numbers of individuals are without health insurance coverage of any sort, or with limited insurance coverage (e.g. only emergency care coverage) which deters individuals from seeking necessary health, results in belated care and has significant financial consequences for patients and their families. Even where rights to access healthcare services are universal they have not necessarily translated into equal access

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

for all. Indeed, on average, 3.1% (5%) of those living in the EU, with the exception of DE, BG and RO for which there is no accurate data available, report unmet need for medical care (dental care) because they had to wait, or care was too expensive, or too far away. This percentage also varies greatly across Member States; from 0.2% (0.5%) in SI and DK to 15% (12%) in LV (EE), and across income groups in each country, with the poorest facing the greatest unmet need.

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

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



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

2.2. Progress towards the overarching objectives

The overarching objectives of the OMC for social protection and social inclusion are to promote:
(a) Social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies;
(b) Effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs and greater social cohesion, and with the EU's Sustainable Development Strategy;
(c) Good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

2.2.1 Overall Strategic Approaches

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

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

Examples of integrated approaches are found in some countries. In Luxembourg, it is clearly stated that promoting social cohesion has a key role to play for the country's future, on a par with efforts relating to the economy, monetary stability, public finance, taxation, employment and acquiring the necessary infrastructure to meet the challenges of globalisation. Under this approach, social cohesion is the target of political action. The Belgian Federal government agreement describes an action framework based on five overall priorities: a global employment strategy, policies to reduce fiscal and parafiscal pressure on labour, encouraging entrepreneurship, reinforcing the social protection system, and reinforcing environmental policy and sustainable development. Estonia sets out to exploit the synergies between the three strands by adopting the overarching message that enhanced social protection and social inclusion require an integrated approach, ensuring coherence between the policy measures taken in various fields. Within this global vision some countries stress the employment dimension (UK, NL) while others stress the social dimension (AT, PT). In this context it is important to mention that in the past decade a number of countries have carried out major pension reform where a key aim has been to encourage longer working lives.

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

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

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

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

2.2.2 Interaction between economic growth and social inclusion policies

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

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

ensure adequate pensions and healthy life years continue to increase. Many Member States suggest that the health and social sector is a large and growing employer that can be used as a tool to improve the economy in disadvantaged regions and increase labour market participation of women.

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

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

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

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

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

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

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

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

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

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

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

2.2.3. Governance

On the basis of information provided in the overarching section of the national reports it seems that in most Member States there has not been a fully integrated preparation process covering the three strands and mostly there are separate, different governance arrangements. Exceptions are AT, DK and IT. In AT, for the first time, a joint meeting was held of the various Federal Ministries and umbrella NGOs active in social and environmental affairs to discuss the challenges for the national reform programme as well as interaction between the OMC, the strategy of sustainable development and measures in these areas. A consultation on the future social model, covering overall social protection and industrial relations, has just closed in Italy.

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

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

As far as monitoring and evaluation are concerned, progress is uneven and many challenges remain. Data sources, indicators and analytical capacity need to be developed especially also with regard to the groups that are most at risk and that are seldom reached by surveys. However, examples of national target setting have been increasingly observed in the NSRs. Effective monitoring of targets requires regular monitoring. There are major differences

between Member States in the extent to which policies are systematically evaluated. Stakeholders and external expertise are often involved in evaluation at the start of the preparation of a new plan. It is good practice to start drawing up a new plan on the basis of a report on the results of the evaluation of the previous plan.

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

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

It should be noted that several European-level civil society organisations active in the social field have provided and made public their assessments of the renewed Strategic Reports, in general drawing on contributions from network members at national level. Some of them examine at the strategic reports as a whole, in most cases focussing in particular on the National Action Plan for social inclusion (NAPs). This goes notably for the comprehensive assessment carried out by the European Anti-Poverty Network which stresses as the overwhelming concern "the lack of progress on the eradication of poverty in the EU"[10] and proceeds to assessing the NSRs/NAPs overall as well as the policy responses to address specific inclusion concerns. The report presented by Caritas Europe examined in particular the "Process and Quality of Policy Design" of Member States' preparations of the NSRs and Eurodiaconia's report assessed the degree of participation in this process.[11] Depending on their specific mission others concentrate on more limited, well-defined aspects of the NSRs/NAPs within their area of concern and interest. Brief references to the latter contributions are made where appropriate in the following text.

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

The European Social Fund (ESF) is the main European financial instrument designed to support Member States in the implementation of their strategy as set out in the National Strategy Reports. In the 2007-2013 programming cycle, the European Social Fund will invest approx. €76 billion to support 117 Operational Programmes (OP) across the European Union. Together with the European Regional Development Fund (ERDF) and the European Agricultural Fund for Rural Development (EAFRD), the ESF will make a major contribution to achieving the common objectives in terms of social inclusion and social protection. The 2008 turmoil on financial markets slowed down economic growth and employment in many EU countries, thus posing an extra challenge social inclusion and social protection systems. In this context, the ESF can help to respond to emerging social challenges by supporting those

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

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

furthest from the labour market and people made redundant in the economic downturn. The current economic outlook underlines the added value of the ESF both as an expression of EU solidarity and as a tool to tailor the labour supply to a changing economic environment. Effective use of ESF funding can cushion the effects of the economic crisis in terms of unemployment and social inclusion. The role of ESF in the various policy priorities is highlighted in most NSRs, in particular with regard to the Social Inclusion strand. The Spanish report includes an annex on the contribution of the 2007-2013 strategy to social inclusion policies, focussing on the ESF-financed OP 'Fight against Discrimination'. The linkage between policy objectives and ESF is clearly visible when ESF funding is more substantial in relation to the total national expenditure on employment and social policies (e.g. BG, SK, PL, RO, HU, PT, CZ). However, the absence of references to ESF is also notable in a number of NSRs (e.g. IE, NL, FI, FR), despite the fact that in some cases the ESF allocation to social inclusion is fairly high (e.g. FR, IE).

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

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

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

3. FIGHTING POVERTY AND SOCIAL EXCLUSION

3.1 Introduction

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

The NAPs aim to translate into action at Member State level the three Common Objectives relating to social inclusion, which were adopted by the European Council in March 2006 and confirmed in March 2008: access for all to the resources, rights and services needed for

participation in society, preventing and addressing exclusion, and fighting all forms of discrimination leading to exclusion; the active social inclusion of all, both by promoting participation in the labour market and by fighting poverty and exclusion; and ensuring that social inclusion policies are well-coordinated and involve all levels of government and relevant actors, including people experiencing poverty, that they are efficient and effective and mainstreamed into all relevant public policies, including economic, budgetary, education and training policies and structural fund (notably ESF) programmes.

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

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

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

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

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

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

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

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

3.2.1. Ensuring sufficient resources for children and their families

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

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

The main concern in countries in group B (BE, CZ, DE, FR, EE, IE, BG) is to bring down the high number of children living in jobless households and help parents stay durably on the labour market. In most of these countries, further measures are envisaged to make work pay for parents while adequately supporting their income. Measures that are often part of a wider active inclusion strategy include tax rebates for low-income families (BE, CZ, EE) and activation measures targeted at parents (BE, BG, CZ). Ireland is planning to substantially increase child income support and to structure the payments to remove employment disincentives, especially for lone parents (and other low-income families) who are a specific target group of the Irish active inclusion strategy. The Irish government is also striving to increase the low take-up of in-work supplement for low-income families. In France, the newly introduced RSA (income support scheme designed to support individuals through their

[13] Eurochild's assessment to be published in February 2009: www.eurochild.org
[14] Please see footnote 12 below

transition back to work) will take account of the size and composition of the household. Belgium, Germany, Estonia, Ireland and France plan a significant increase in the availability and affordability of childcare to help parents back into work. In the Czech Republic, however, few measures are planned to increase the low provision of childcare, and the promotion of longer periods of parental leave may have an adverse impact on the relatively low labour market participation of mothers (also in EE). In the Czech Republic and Estonia, the employment rate of mothers is 16 and 14 percentage points respectively below that of women without children. Bulgaria has launched a "long-term strategy for the child" (2008-18) based on mainstreaming and specific actions aimed at families and children.

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

Countries in group D (ES, EL, IT, LT, LV, LU, PL and PT) were those in which comprehensive strategies were most needed to address high levels of in-work poverty and (apart from LU) a relatively low effectiveness of social transfers. Italy, Greece, Lithuania, Latvia, Luxembourg, Poland, and Portugal had already identified child poverty as a key priority in the 2006-08 plans and started implementing a wide range of measures to significantly increase income support to families and facilitate the labour market participation of parents, especially of the second earner. In most of these countries, the measures taken will be further reinforced. Latvia, Lithuania, Poland and Portugal in particular have enhanced income support to families through a wide range of measures including enhancing the level and coverage of family benefits. These countries also put emphasis on developing in-kind benefits (free or subsidised lunches at school, free school books, free childcare for children) and services for families, especially in the area of housing (PT). From 2009, Italy will give priority to the implementation of the newly introduced "social card" system, which allows

beneficiaries to buy essential goods such as food and utilities. Some countries enhance universal coverage by for instance extending the coverage of existing benefits further to all children (including those over 18 and still studying and living in the parental home). Latvia, Lithuania, Luxembourg Poland and Portugal also plan to enhance measures to make work pay for parents, and especially for lone parents (in-work benefits, tax credits, higher minimum wage, and childcare subsidies). Significant efforts to develop affordable childcare provision are notable in Hungary, Italy, Lithuania, Luxembourg, Poland and Portugal in order to encourage the labour market participation of the second earner. Spain does not explicitly report on overall strategies targeted at children and families.

3.2.2. Mainstreaming child poverty

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

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

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

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

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

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

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

them a particularly high proportion of childcare facilities operate on a part-time basis only (e.g. NL, UK). The availability of childcare after school hours is addressed in different ways across countries, either through prolonging the school day or through specific provision at community level.

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

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

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

3.2.3 Supporting children's development

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

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

Poor housing conditions are likely to hamper children's well-being by affecting their health, their ability to do well at school and to build social ties. According to EU-SILC data, in two-thirds of EU countries child deprivation rates in the housing dimension are higher than for the overall population. Specific housing policy measures for families include priority in accessing

social housing for lone parents and large families (most Member States), greater provision of housing accessible to low-income families (IT), increased housing benefits for large families, specific attention to the needs of families in the training of architects, urban planners and other specialists (EE), or mortgage loan guarantees issued for purchase or construction of housing for families with children (LV). See also Section 3.5.2 on housing.

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

3.2.4 Reaching the most vulnerable children

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

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

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

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

Measures to support disabled children and their families include supplementary financial support (EE, BG, LV), access to mainstream schools through adapted infrastructure and dedicated staff or additional support staff (LV, AT, BG), and specific social services (transport, housing, etc). The Czech Republic, Estonia, Latvia and Austria have adopted comprehensive sets of measures and focus on early detection and intervention to improve the situation of disabled children and their families.

3.2.5 Other children at risk

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

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

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

[17] Please see footnote 21.

3.2.6 Monitoring arrangements

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

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

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

3.3.1 Inclusion of the Roma in society and the labour market

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

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

As to the health situation of Roma people, data provided in the Romanian NSR reported 8 to 10 years lower life expectancy and a higher incidence of contagious-infectious diseases and HIV, deficient infant vaccination and poor diet and nutrition, mainly among children. In Spain, alongside the activities of the Spanish National Strategy on Equal Healthcare aimed at the Roma population (advice, training, a "Guide on assisting the Roma Community in

[18] SPC report on child poverty: http://ec.europa.eu/employment_social/spsi/child_poverty_en.htm

Healthcare Services), the first National Health Survey on the Roma was also conducted to gain knowledge of their health status, lifestyles and inequalities in healthcare access. Moreover, the health of the Roma community is being mainstreamed in relevant policies. Ireland and UK report on the All-Ireland Traveller Health Study which will include a census and an assessment of health status, mortality rates, and impact of health services currently provided.

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

In Spain several programmes, such as the ACCEDER Programme for training and access to employment aimed to Roma population and financed by the European Structural Funds, promote the employability of and jobs for the Roma. In the Czech Republic, the Agency for social inclusion in socially excluded Roma localities will implement a pilot programme in 12 localities. Hungary points to various forms of subsidised temporary employment organised at local level. Romania and Bulgaria report on specialised job fairs helping the Roma enter the labour market. However, policies presented in most NAPs stay within the limit of pilot actions or have a narrow, workfare type perspective. Member States with a significant Roma population should increasingly consider the important untapped potential which this category of citizens constitutes in view of labour force shortages and invest accordingly in education and training, including preparation for (and support of) legitimate forms of self-employment.
The 2008 NAPs are more detailed than previously on the discrimination that Roma are facing and measures taken. In Spain, the Council responsible for non-discrimination on grounds of race or ethnic origin will promote equal treatment in the areas of education, health, benefits, social services, housing, access to goods and services, as well as to employment, self-employment and to professional practice, affiliation and participation in trade union and employers' organisations, working conditions, professional promotion, vocational training and on-going training. Hungary's *Roma Anti-Discrimination Customer Service Network* which provides complainants with legal advice is extending its network. In the Czech Republic, educational seminars were held for 900 police officers in all regions on the right to equal treatment and legal aspects of social exclusion. Italy raises governance aspects, through the improvement of social inclusion and anti-discrimination policies. However, no progress is reported from Romania on the problems in getting ID papers or from Romania and Bulgaria on registering in municipalities.

3.3.2 Inclusion of migrants

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

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

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

Here are some examples from the NAPs of holistic policy measures to achieve the social inclusion of migrants:[21] Ireland focuses on three interlinked policy priorities: integration, educational supports and follow-up action arising from the 2005-2008 National Action plan against racism. In Spain, the 2007-2010 Strategic Plan for citizenship and integration provides the framework for promoting, inter alia, the social inclusion of migrants into Spanish society, while the regionally-managed Fund for the reception and integration of migrants and educational support is the main financial instrument used for this purpose. The strategy developed in Denmark provides that both refugees and citizens of migrant background must have access to the necessary resources and welfare services while making active efforts to enter the labour market and become included in the Danish society. Austria for its part adopts a mainstreaming approach for the social inclusion of migrants in its policy priorities, together with more specific measures for refugees and asylum seekers. In the Netherlands the two main points of the policy are social emancipation and social integration especially for

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

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

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

newcomers with a strong emphasis on participation which may take various forms such as voluntary work without neglecting other aspects. Germany highlights the relevance of its National Integration Plan also from a holistic social inclusion perspective.

Increasing efforts are discernible to create synergies between social inclusion policies and anti-discrimination measures. France, for example, relates its actions in favour of migrants or people with a migrant background to its policies on non-discrimination particularly as regards access to employment for women, social and professional integration of youth and access to decent housing for the Gens de voyage. The UK uses the framework of the Equality Public Service Agreement for developing its policies in respect of race, ethnic minority employment and 'Gypsies, Roma and Travellers'. Malta is developing its policy for ensuring the social inclusion of non-EU nationals as part of its priority to promote equal opportunities, with a specific focus on asylum seekers, refugees and irregular immigrants. Luxemburg adopts a similar approach, mainly through a suite on legislation on immigration policy.
Within the ESF, specific action to increase migrants' labour market participation will account for some €1.17 billion (1.5% of total ESF budget).

3.3.3 Inclusion of disabled people in society and the labour market

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

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

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

The aim to tackle the use of disability benefits as an early exit route out of the labour market is addressed by virtually all countries, some of which address it as a major policy priority (e.g. LU, RO, UK, MT, HU, NL and SI)[23]. Inadequate accessibility in society limits the opportunities and choices of people with consequently lower education levels and lower labour market participation among disabled people. Nevertheless, some Member States (AT, SI, UK, DE, LT and CZ) report slight improvements in labour market participation among disabled people**.** and the Netherlands even reports a sharp decline in the number of benefit recipients. Several reports make a link between increased labour market participation through active labour market policy and targeted measures and the need to expand and strengthen the workforce. Ireland emphasises that the main objective is to promote equal opportunities for people with disabilities in the open labour market, by means of enhanced vocational training, employment programmes and further development of support.
Several NAPs treat the removal of barriers to education and lifelong learning as key to increase labour market participation among disabled people, as well as to enhance active

[22] LFS ad hoc module on disability 2002 combined with the Eurostat population estimate for 2008.
[23] On this issue, see also section 4.2.3.6, Restricting access to disability schemes

participation in society and overall quality of life (e.g. DE, SK, UK, HU, SI, AT, CZ, LU, EE, ES, IE, CY, LT, and LV). However, disabled people's labour market skills are addressed by Member States more often in terms of special vocational rehabilitation programmes than by tackling access to lifelong learning in mainstream programmes.

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

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

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

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

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

both the entire population and groups at risk, including in the work place. In Slovenia**,** day care places are increased for mentally and physically disabled people.

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

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

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

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

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

3.3.5 Inclusion of older people in society and the labour market

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

3.3.6. Rural poverty and deprived urban areas

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

Some NAPs address the problem of disadvantaged urban areas and refer to specific regeneration programmes that tackle housing, social and economic problems in an integrated, bottom-up and participative way. The Czech Republic stresses its regional and local NAPs and a community approach for the integrated planning and provision of social services. Germany highlights the Soziale Stadt programme supporting 500 urban micro-regions complemented by ESF support to employment and training measures. In Denmark's "Our Collective Responsibility II" programme satellite offices are established in deprived areas for easy access to support from public authorities. In France urban renovation is a key priority that must reach the most disadvantaged residents and 'Mixité sociale' insists on facilitating equal access to housing for people facing multiple economic and social problems. The UK City Strategy tests an area-based partnership approach to tackling worklessness in the most disadvantaged communities. In Poland a pilot social revitalisation programme will be implemented in rural and urban local communities in the period of 2008-2010. Nonetheless, the specific urban problems or the more complex deprivation issues that are present in cities could be more adequately reflected in the NAPs[24].

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

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

3.3.7. Use of ESF to support inclusion of excluded groups

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

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

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

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

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

3.4.1. Adequate income support

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

Some Member States did in fact outline policies to better link social assistance benefits to labour market (re)integration and social support. In France, the "Revenu de solidarité active" (RSA), already mentioned in 3.2.1., is designed to create a bridge between out-of-work benefit and in-work financial support, to improve incentives to (re-)enter the labour market and fight in-work poverty. This is combined with personalised employment and social support programmes. In Spain, the "Active Income for Insertion" (RAI) aims to make it easier for unemployed workers with special economic needs and difficulty in finding work to return to the labour market, by combining income support with active labour market policies. In Portugal, the Social Integration Income (MTSS) has been combined with programmes aimed

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

at the social and professional integration of beneficiaries. Austria reported on the introduction of the means-tested guaranteed minimum income. In Germany the previous separate approaches to assistance for the integration were brought together by combining social assistance for employable people with unemployment assistance as basic social security benefits for jobseekers (ALG II). Following the "rights and duties" approach, benefit recipients are required to actively participate in schemes designed to integrate them into working life and to do all in their power to reduce or end their reliance on benefits.

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

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

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

3.4.2. Inclusive labour markets

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

Expanding and Improving Investment in Human Capital

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

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

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

Active and Preventive Labour Market Measures

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

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

Financial Incentives to Work

Active inclusion policies need to ensure a balanced interaction between tax and benefits, both providing adequate work incentives and making work pay. In many Member States entitlement to benefits has been made conditional on active job search, availability for work or participation in training (CZ, BE, BG, DE, EE, ES). Hungary mentioned that, as from 2009, those who are capable of working and receive regular social allowance will increasingly be required to participate in public employment and to cooperate with employment centres.

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

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

Non Financial Incentives to Work

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

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

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

Supporting the Demand Side

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

One issue mentioned below by the National Strategic Reports concerned *financial incentives for employers to hire disadvantaged people through subsidised employment*. (AT: subsidised employment for different vulnerable groups, increased financial aid to enterprises by granting pay subsidies and subsidies for safeguarding jobs, "Action 500" and "Disability Flexicurity"; BE: employment bonus; CY; DE: employment subsidy for recruiting long-term and older long-term unemployed and younger workers, 50 plus Initiative; EE and IT: subsidised

employment for disabled people; HU: employment policy programmes based on reduced contributions for employers employing disadvantaged employees (START programmes), LT: subsidy-based employment for people aged over 50, pregnant women, mothers, fathers, foster parents; NL: temporary wage cost subsidy to employers when they employ people in a step-up job, micro-credits for entrepreneurs starting up; PT; PL: suspending contributions to the Labour Fund and Guaranteed Employee Benefit Fund pertaining to employers employing persons returning from maternity or childcare leave; RO: employers' subsidies for lone parents and people aged 45 or more, and those who are 3 years away from reaching the legal retirement age; SI: for long-term unemployed beneficiaries; SE: subsidised employment through step-in jobs for newly arrived immigrants, new-start jobs for elderly people, job guarantee for unemployed young people).

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

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

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

The Role of the Social Economy

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

Examples of such initiatives include: increased support for placement in social enterprises of people with health-related placement handicaps (AT); establishment of an inter-departmental commission to steer investment in socially-oriented entrepreneurial initiatives (CZ); state support targeted at creating enterprises providing jobs for the disabled; (LT, see box below); pluriannual plan for reforming the governance of social enterprises; creation of a committee to investigate how labour market participation of people with an occupational disability can be encouraged (NL); increased budget assistance and easing of rules for setting up social

enterprises (PL); the “Establishment and Networking and Social Enterprises” project, intended to create favourable conditions for the development of social enterprises (SK); establishment of centres that employ a group of at least four benefit claimants who have problems other than unemployment and integrate the work in the enterprise’s normal operation (DK); and the national roll-out of the Pathways to Work service utilising mainly private and voluntary providers (UK).

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

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

3.4.3 Access to quality services for active inclusion

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

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

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

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

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

Examples of initiatives aimed at improving access to social services related to labour market access: in Cyprus the programme 'Expansion and Improvement of Care Services for Children, the Elderly, Disabled persons and other Dependants' to improve and expand social care services at the local level, and promoting programmes of open social care in order to facilitate the activation and access of inactive and unemployed women to the labour market; in the Czech Republic the government is reenergizing the vocational rehabilitation system. This initiative will facilitate effective communication between all partners involved, and attempt to broaden the system of vocational rehabilitation; in Ireland an additional 100,000 childcare places (of all types), by 2016 is a key target under the social partnership agreement Towards 2016; in Lithuania: the 'Integration of Hearing Impaired Persons into the Open Labour Market' initiative funded under EQUAL is opening up access to employment placement services for this group of people which has traditionally been reluctant to make use of PES facilities due to their handicap.

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

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

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

3.4.4. The ESF contribution to active inclusion

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

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

3.5. Access to services to enable social inclusion

3.5.1. Access to services overall

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

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

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

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

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

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

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

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

3.5.2. Access to housing and fighting homelessness

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

The first NAPs showed that homelessness was often under-researched, with a focus mainly on the most visible and severe forms of homelessness, i.e. sleeping rough. Social policies now increasingly approach homelessness in an integrated manner by looking at people who are experiencing various forms of homelessness[27], and policy priorities increasingly include access to decent and affordable housing. Housing inclusion policies are also linked to urban regeneration schemes, or other locally-based measures aimed at promoting sustainable communities.

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

Member States put forward different strategies to promote access to affordable and quality housing. These include increasing the housing supply, with specific attention to social housing (UK, AT, FI, FR, IE, IT, BE, LU, MT, PL); financial support, such as housing benefits and allowances, rent guarantees and tax rebates (UK, FI, SE, SK, EE, IE, LU, MT,

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

BE); and appropriate regulatory instruments, such as rent controls (AT, BE, MT). Several Member States have also put in place policies to promote decent housing and energy efficiency (HU, FI, DK, FR, IE). The issue of preventing eviction has received renewed attention in relation to the current financial crisis (AT, DK, FR, SE, BE).

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

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

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

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

3.5.3. Access to healthcare

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

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

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

[30] For further details see the part on Roma

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

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

The reports show that there are many sources of social inequality in health in the EU, such as income disparities, differences in living conditions, lifestyles and risky behaviour. Evidence suggests that low levels of income and education are strongly correlated with ill-health. A multifaceted strategy covering health promotion and disease prevention actions in a number of policy fields are deemed necessary by several Member States. Accordingly, reports mention the development of cross-sectoral policies. Some Member States (FI, IE, AT, SI, EE, SK and UK) use specific action plans to tackle health inequalities by encouraging health protection in other policy sectors (e.g. education, employment, working conditions, housing conditions, social work, rural development, environment). Finland has adopted an action plan against health inequalities for 2008-2011, whose objectives are 1) to impact on poverty, education, employment, working conditions and housing conditions through socio-political measures, 2) to promote a healthy lifestyle in general, and among those in a weaker social position in particular, and 3) to improve the availability and use of social and health services.

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

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

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

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

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

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

In Austria, in order to ensure actual access to a bank account, a specific account has been developed by Sparkassen, already with 2,000 recipients out of a potential target of 50,000 customers. In the UK, the Government agreed in 2004 a shared goal with the banking sector to halve the number of adults living in households without access to a bank account. 800,000 people have already been brought into banking, but 1.3 million households are still unbanked. Social credit in Belgium, and personal microcredit in France (3000 beneficiaries) help people without access to the mainstream credit market to restore a borrowing capacity that can be used for investing in mobility, home equipment, training or health. Spain and Portugal mention measures to develop microcredit as a support to active inclusion of people excluded from the labour market thanks to self-employment.

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

3.5.5. Access to Education/training

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

Pre-school education is seen as fundamental in most strategies, both to provide a firm basis for competence from the start, and to help families reconcile work and private life, especially beneficial for the most disadvantaged. As mentioned under 3.2.2., some NAPs (AT, EE, ES) address childcare facilities for 0-3 year-olds, as well as (LT) disparities in provisions between regions and rural and urban areas. Germany has decided to considerably increase the places in crèches for children under 3 (750,000 by 2013). In Belgium, enrolment in pre-school

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

education will be possible from the age of 2.5. Ireland launched a National Childcare Strategy for early childhood development and care. Hungary prioritises pre-school attendance for children with multiple disadvantages, also by providing attendance allowances. Other countries (SI, SK) are issuing allowances and subsidies to support enrolment of children from disadvantaged backgrounds. In Poland, ESF intervention will support pre-school education in rural areas. Some countries (e.g. NL) are giving priority to reducing backlog in language learning by expanding and strengthening pre-school education. Sweden has targeted support to children who do not have Swedish as their mother tongue.

Targeted resources for improving access to education and training for specific groups at risk of exclusion: Germany focuses on young people with a migrant background. The Netherlands and Belgium focus on the acquisition of basic skills and job coaching for young migrants. The French community of Belgium also intends to facilitate enrolment in schools for irregular migrants, to improve social heterogeneity in schools and re-establish teaching of language and culture of origin. Austria promotes early language support in kindergarten and provides remedial lessons in German. Denmark strengthens advisory units for bilingual pupils in vocational training programmes, through mentors, optional classes and support for parental involvement. In Ireland, English language training is offered to migrant workers. The Swedish plan includes a number of strategic initiatives for the education of migrants. In Poland the extensive measures are undertaken to support students from rural areas and help them to reach higher levels of education. In Slovakia, a new law on education prohibits all forms of discrimination and segregation in education, and is supported by financial mechanisms. Spain focuses on developing key competences and taking better account of the needs of students with an immigrant background and improving the quality and attractiveness of vocational education and training, and on grants and study allowances. Estonia, Germany, Slovakia, Lithuania and Slovenia are reviewing or extending grants and/or loans for students from financially disadvantaged families. Portugal facilitated access to higher education for older learners by making enrolment more flexible. For a complete account, please refer to the Third Annual Report on Migration and Integration (COM(2007) 512 final). The Annex provides a full description for all 27 Member States of the implementation of Common Basic Principle number *5 'Efforts in education are critical to preparing immigrants, and particularly their descendants, to be more successful and more active participants in society"*.

Combating early school leaving: While Member States' ESL rates differ considerably, the link with disadvantage is clear. According to the EU benchmark, by 2010 no more than 10% of young people on average should leave school early – but in 2007 the average EU rate for 18-24 year-olds was still 14.8%. Many Member States are implementing preventive measures. For instance, Estonia is developing career counselling and guidance; in 2006 the Netherlands established an "Offensive on drop-outs" strategy, aiming to halve the number of new school drop-outs by 2012, also focusing on smoothing transitions between school types. France is developing mentoring for pupils with difficulties and disseminating knowledge about jobs in various sectors of industry and services among young people. Austria is introducing a right to education up to the age of 18 and endeavours to offer more places in vocational schools, while new educational pathways are under discussion. Denmark established an overall goal of 95% of a youth cohort to complete qualifying education by 2015, and addresses drop-outs from VET through mentor schemes and practical training programmes. In Finland, measures to combat ESL include the increase of apprenticeships and possibilities for a flexible completion of compulsory education ('JoPo'). Ireland is investing additional resources in education support programmes. Portugal is creating alternative curricular paths and increasing the range of courses for young people. Slovakia introduced grants to access education and training from pre-primary to tertiary level. England has legislated to raise the participation age so by 2015 all young people will be in education or training until at least 18. Spain promotes measures to

ensure success at school for all students, such as PROA Plan to reduce school failure in primary and secondary education centres in social deprived areas, the Initial Vocational Qualification programmes to offer a new educational alternative for young people who have not obtained the qualification of graduate in obligatory secondary or to establish a programme of pay-grants to encourage those at risk of leaving school for financial reasons.

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

Most plans address the need to improve access at all levels for learners with disabilities and special needs. A trend can be observed toward inclusive education as opposed to special education in separate settings. Estonia will develop counselling networks to achieve early identification and treatment of special education needs, and will foster e-education programmes and flexible education opportunities. The Portuguese "Novas oportunidades" plan provides for a review of the national Special Education system, including new units specialised in multiple disabilities and autism, and an increase in the number of special education teachers in mainstream schools. Austria is planning to adopt measures to improve special pedagogical support in mainstream primary and lower secondary schools. Bulgaria hopes to induce a change in public attitude, even though issues persist in relation to institutional care for mentally disabled people. In Latvia, concrete targets have been fixed to accommodate special education needs in mainstream education. In Hungary, the number of disabled students enrolled in higher education increases year-on-year, and the state provides supplementary state subsidy for these students, though numbers still seem low. Germany refers to an ESF-funded initiative to train people with disabilities and sensitise employers.
In the area of vocational training, France plans to modernise VET and to increase its labour market relevance. The Netherlands put in place obligatory work/schooling for young people without basic qualifications, and aims to make education more relevant to the labour market. Germany is improving access to VET for people at risk, as is Portugal through the Novas Oportunidades initiative. Poland is adapting VET programmes to labour market requirements, and focusing on training and qualification standards for trainers. Both Latvia and Lithuania are modernising VET, and set ambitious national targets on participation. Ireland aims to improve the quality of training for low-skilled workers. Hungary continues to establish regional integrated training centres.

Some NAPs address the validation of prior learning as a means of facilitating inclusion through better access to employment or further learning. (Accreditation of Prior Learning processes (NL), a network of specialised centres on recognition and certification of competences (BE, PT), and initiatives for recognition of prior learning of migrants (LU, SE))
The digital divide is mentioned in only a few reports. Measures to ensure access to ICT for disadvantaged groups (PT, SK), supported access to ICT for young people (BE, Wallonia), improved school infrastructure with over 98% of schools having high-speed Internet access (BG), a network of public Internet access points, and promotion of software development for learners with special needs (SI).

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

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

3.6. Enhancing governance of social inclusion policies

3.6.1. Mobilising actors/raising awareness

Preparation process

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

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

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

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

Quality of participation

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

Some Member States ensured that high level decision-makers, e.g. ministers, participated in the seminars and conferences, thereby, highlighting the importance of these events (e.g. AT, LU). Several Member States are providing or intend to start providing capacity-building support to stakeholders so that their participation is facilitated and supported (BE subsidises organisations where people experiencing poverty can speak out, PT, LT). Participation is often more fruitful when adequate consultation documents are produced, e.g. an early draft of the plan and a report on the results of policies in the previous planning period (e.g. BG, ES, PT, HU). An important aspect of quality is the provision of feedback on the results of participation. Some of the plans refer to participation results. The Dutch plan includes an annex describing the results of consultation and the plan itself indicates how consultation has impacted on it. The Spanish plan also contains an annex that reports on the results of the consultation. For each of the main objectives of the NAP and for all target groups / policy areas, effective measures in the previous plan are highlighted, new problems and needs are identified, proposals for the new NAP are put forward, and actions developed by the stakeholders consulted are described. Luxembourg's plan indicates how the results of the consultation have been taken into account. The UK NAP includes quotations from a stakeholders' participation event.

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

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

Stakeholder involvement over the reporting and policy cycle

Because major decisions on social inclusion policy are taken in between OMC reporting deadlines and because stakeholder involvement in the implementation, monitoring and evaluation stages of the policy process can help make the policies more effective, it is important that participation in the preparation of the NAPs be embedded in a continuous process of stakeholder participation throughout the reporting and policy cycle. Although many of the plans contain a general commitment to uphold stakeholder involvement, on this subject they are often not very specific. In several Member States more or less permanent social inclusion or NAPs committees will ensure continued involvement of stakeholders throughout the policy process. The Belgian report indicates that the actions working group met ten times during 2006-2008 to follow up implementation of the report. In the UK a stakeholder working group meets regularly and a social policy task force grouping NGO's participating in the OMC process meets frequently with a social inclusion unit (ministry)).

The Swedish report indicates that there may be room for improving stakeholder participation in the preparation of the NAP, but it is considered more important that stakeholders are continuously involved in the work of state agencies and bodies like the Service Users Commission. Hungary mentions several permanent consultation councils (on Roma inclusion, elderly people, disabled, gender equality). Germany set up a "Permanent Council of Advisors on Social Integration" and organised a series of seminars ("FORTEIL"). In some Member States conferences or seminars marking the start of the implementation of the NAPIncl have been planned (e.g. UK, SK, EE).

Awareness raising

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

3.6.2. Mainstreaming social inclusion / horizontal coordination

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

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

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

Mainstreaming at the regional and local level is encouraged by the development of regional and local action plans. Some Member States mention a Progress-funded project to develop a methodology for developing these plans (CZ, ES). The challenge will be to implement the results on a permanent basis. Regional plans have been developed in Belgium. The Netherlands gives an example of social inclusion policy coordination at local level: the Groningen poverty pact. Bulgaria intends to provide methodological support to regional and local authorities for developing regional and municipal social inclusion plans (The goal is that at least half of all municipalities should have a social inclusion plan by 2010). In Portugal local social networks and supra district (regional) territorial platforms aim to take an integrated approach to social policy. In Poland a more flexible framework for cooperation between public administration and civil society, including new institutions such as public-social partnership and local initiatives, is to be implemented in 2009.

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

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

3.6.3. Involvement of regional and local authorities / vertical coordination

Despite some progress, there is still a big discrepancy between the actual role that regional and local authorities play on social inclusion and their uneven involvement in the NAPs. Indeed, the reports mention a large number of concrete achievements in which these authorities have a key role, when delivering social services on the basis of national regulations or within their own schemes, contributing to social innovations or embedding social inclusion needs into broader local development requirements. But in general, the governance

arrangements needed to ensure that they contribute and pay attention to the NAPs have yet to be developed. Many reports (e.g. CY, ES, NL, UK) emphasise that these authorities were consulted when preparing the national strategies but do not show whether it was done systematically and in a strategic manner. The various specificities of particular stakeholders are seldom emphasised. Consistency between national policy and local planning seems to remain a challenge. That is why, when national strategies come to be implemented, local action plans (PT) can help to make the objectives effective and adapt them to local specificities.

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

3.6.4. Gender mainstreaming

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

Assessing the gender impact of policies

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

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

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

34 http://www.ccre.org

Paternity Leave before their child's first birthday to allow mothers to return to work earlier if they wish.

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

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

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

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

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

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

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

3.6.5. Monitoring and evaluation

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

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

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

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

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

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

Concerning the use of indicators overall, the NSRs show how common EU indicators can be used to assess the situation in the wider EU context and in relation to all dimensions of the objectives. Most Member States draw on the EU lists of overarching and social inclusion indicators to describe the social situation, often focusing on the key indicators that are most relevant to their strategy. A number of countries also base their assessment on a full review of the overarching and social inclusion indicators agreed in the framework of the Social OMC. The EU-based indicators are often supplemented by national outcome indicators, mainly to cover populations such as specific vulnerable groups (immigrants, ethnic minorities, the disabled, people living in deprived areas, the homeless), or to reflect dimensions that are not yet covered by EU indicators (housing, persistent poverty, socio-economic gaps in life expectancy, etc).

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

Most but not all Member States have developed monitoring arrangements for each policy priority as suggested in the guidance note for the national reports. Many of them frankly acknowledge that in this respect much work still needs to be done. Although specific issues have been singled out as policy priorities, sometimes data sources and indicators still need to be developed to allow monitoring of progress. Especially when targets have been set, effective monitoring will only be possible if regular measurement and time series are available.

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

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

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

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

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

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

3.7. Annexes to Chapter 3

GOOD PRACTICE EXAMPLES OF SOCIAL INCLUSION POLICIES IN THE 2008 NAPs-INCLUSION

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

Tackling child poverty

UK: Family Nurse Partnership programme.

Target group: Single-parent families.

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

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

Monitoring and evaluation: External evaluation by Birkbeck College, London. The evaluation will focus on implementation, deliverability, take-up and costs, while looking at the short-term impact on mothers' and children's health. The evaluation is expected to report in 2009.
Outcome / result: Early signs are promising. Early learning suggests that the FNP has high take up, that it is welcomed by practitioners, and that it can lead to positive changes in behaviour, relationships and well-being.

CZ: Introducing multidisciplinary teams into Youth Court practice.

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

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

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

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

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

Active inclusion: Minimum income support

ES: The minimum income system of the autonomous communities.

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

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

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

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

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

Active inclusion: Inclusive labour markets

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

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

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

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

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

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

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

Target group: Individuals with a hearing impairment.

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

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

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

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

Active inclusion: Access to services

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

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

Objective: Deinstitutionalsze and decentralize the provision of social services.

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

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

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

Addressing social inequalities in health

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

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

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

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

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

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

Housing/homelessness

CZ: Strategy for the social inclusion of the homeless.

Target group: The homeless.

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

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

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

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

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

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

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

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

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

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

Migrants and minorities

EL: Training for Muslim children.

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

Objective: Harmonious integration of minority children in the system, acceptance of these children by the educational staff and all citizens of Thrace, provision of knowledge and suitable educational material to teachers including Turkish language courses, support for

families to encourage their children's good school performance, awareness of the education administration mechanism and representatives of local administration, awareness of all parents and the public opinion in general.

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

Monitoring and evaluation: Continuing evaluation by a scientific board.

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

AT: Basic vocational guidance in the mother tongue.

Target group: Immigrants/refugees.

Objective: Labour market integration.

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

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

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

Addressing financial exclusion and over-indebtedness

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

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

Target group: Families or lone parents facing unexpected financial difficulties

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

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

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

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

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

Target group: The over-indebted including homeless people.

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

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

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

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

Governance

IE: Technical Advisory Group and Data Matrix.

Target group: Government bodies, social partners, NGOs.

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

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

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

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

Mobilising stakeholders

LT: Webpage "Social map"

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

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

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

Monitoring and evaluation: Permanent monitoring of usage.

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

Mainstreaming

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

Target group: The socially excluded in 103 municipalities.

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

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

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

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

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

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
Austria	Credit account for people affected by poverty / persons without cash
	KomenskýFond (Komensky Fund): an initiative of the ERSTE Foundation and Caritas
	"Mummy learns German" at nurseries and schools in Vienna
	Three City of Vienna projects: 1. “Prospects“: vocational and educational counselling for persons entitled to asylum and financial support for further education; 2. “Competence Centre“: counselling to assess prior learning and further education needs ofnew migrants; 3. “Basic vocational guidance in the mother tongue” targeting newcomers
	“To your heart’s content” - -women from Favoriten live a healthy life
	“… but healthy despite everything!”
Belgium	Les experts du vécu/médiateurs de terrain
	Les fonctionnaires d’attention
	Inclusion de personnes sans-abri
	Validation des compétences
Bulgaria	Social Services Against New Employment – social support for vulnerable groups, persons and families (SANE)
	Increasing the employability of the unemployed by vocational training (German-Bulgarian Vocational Training Centres)
	Programme for targeted social protection for heating to the population with low income
Cyprus	Development of local services in social welfare services
	Project “Expansion and Improvement of Care Services for Children, the Elderly, Disabled persons and other Dependants”
Czech Republic	Three-stage permeable housing system
	Rehabilitation – Activation – Work
	Support for inclusion – Career counselling
	Introducing multidisciplinary teams into Youth Court practice
	Strategy for the social inclusion of the homeless
Denmark	Evaluation of the project Focus on the Family
	Forward - To ensure work and education for drug and alcohol misusers
	Integration of mothers and their children through the project Neighbourhood Mothers
	SPIDO (Socio-pedagogic Practice in Dementia Care)
	National Indicator Project (NIP)
Estonia	The ESF programme ‘Welfare measures to support employment 2007-2009’
	Introduction of the case management principle
Finland	Intersectoral welfare policy programme on children and youth
	Kaiku Programme to promote occupational wellbeing
	Promoting health and functional capacity

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
France	Instaurer la fluidité du parc hébergement/logement /Improving availability of housing
	Favoriser le retour à l'emploi des bénéficiaires de minima sociaux et augmenter le temps de travail des travailleurs pauvres / Return to employment of minimum benefit recipients and increased working hours for low-paid workers
	La mesure de l'atteinte de l'objectif de baisse d'un tiers de la pauvreté en 5 ans /Monitorinig target to reduce poverty by one-third in five years
	L'insertion des jeunes par la deuxième chance / Inclusion of young people by giving a second chance
Germany	The Federal Government's "Job – Jobs without Barriers" initiative
	Hesse's "Experience has a Future" programme
	The Free State of Saxony's programme "Training unemployed people without vocational qualifications to obtain recognised vocational qualifications"
	Rhineland-Palatinate "InPact" programme
Greece	Training addressed to Muslim children 2005-2008
Hungary	Micro-regional social closing-up programmes
	Subsidised housing programme for homeless people
	Senior-friendly municipality award and grant programme
Ireland	Creation of the Office of the Minister for Integration
	National Intercultural Health Strategy 2007 – 2012
	Technical Advisory Group and Data Matrix
Italy	A certificate for the Italian language: the way to know and to get known
	Prestito sull'Onore: microcredit at zero rate for unforeseen economic difficulties
	Education and training of foster families of foreign minors deprived of parental care (undocumented children)
	Fondo Autonomia Possible: Fund allowing Autonomy
Latvia	The "Complex inclusion programme"
	Creation of 'one-stop shop' for employment counselling through merging of two state agencies
Lithuania	Webpage "Social map"
	State support for the social enterprises
	EQUAL project "Integration of hearing impaired persons into the open labor market"
	Development of public internet access points network (alliance "Window to the future")
Luxemburg	Foyer scolaire "Parc Hosingen" by SISPOLO (Syndicat intercommunal pour l'éducation , l'enseignement, le sport et les loisirs) - Regional initiative of 4 neighbour communes to offer after-school quality childcare for school children aged 3-13 years, in close collaboration with pre-school and primary school professionals
	RESONORD Regional Sozialétude Norden : Projet d'étude sociale de la région LEADER+ Clervaux-Vianden en vue d'une démarche intercommunale de développement social / Project for social study of the region aimed at multi/commune action on social development

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
Malta	Integration of Asylum Seekers into Maltese Society
Malta	Equal Project - HEADSTART
Malta	National Standards of Care for Residential Childcare
Malta	Gender Mainstreaming - The Way Forward
Netherlands	Prevention Information Team (PIT) Eindhoven
Netherlands	Measures intended to strengthen debt counselling and reduce over-indebtedness
Poland	The Social Integration Program (the Post-Accession Support Program for Rural Areas – PSPRA)
Poland	Construction of multi-function sports fields generally accessible to children and young people
Poland	Social work for the benefit of social housing development
Portugal	Transnational Project LAPs & RAPs (financed by the EU)
Portugal	Entrepreneurs for Social Inclusion (EPIS)
Romania	Training modules for the technical secretariats of the County Commission for Social Inclusion
Romania	Job Fairs and Employment Caravan aimed at individuals with Roma background
Slovakia	Improving the quality of social assistance provision for citizens in the Bratislava Self-governing Region (BSK), extending and modernising social services provided and developing new types of social services relevant to the needs and the demand
Slovakia	Building a system for prevention and job placement for the long-term unemployed, persons with low qualification and other disadvantaged groups
Slovakia	Twinning project to improve resocialisation and rehabilitation of drug addicts
Slovenia	'Project Man' programme for self-help therapy and social rehabilitation of people with various forms of addiction
Slovenia	Network of maternity homes and shelters for women and children who are victims of violence
Slovenia	'Involvement of the elderly in providing home assistance to the elderly'
Spain	Programme for development of local plans for social inclusion in Cataluña
Spain	The minimum incomes system of the autonomous communities
Spain	Governance process in the 2nd regional plan for social integration (2nd PRIS) of the Regional Board of Castilla-La Mancha
Sweden	National guidelines on misuse and dependency care issued by the National Board of Health and Welfare
Sweden	Action plan against male violence against women
United Kingdom	Family Nurse Partnership programme
United Kingdom	Provider-led Pathways to Work
United Kingdom	Money Matters Financial Learning Project, Inverclyde
United Kingdom	Social Firms
United Kingdom	Off the Streets and into Work & St Mungos: improving access to training and employment for homeless people

4. ADEQUATE AND SUSTAINABLE PENSIONS

4.1. Overall strategy for Adequacy and Sustainability of Pensions

4.1.1. Introduction

Common objectives for Pensions

Member States are committed to providing adequate and sustainable pensions by ensuring:

(g) adequate retirement incomes for all and access to pensions which allow people to maintain, to a reasonable degree, their living standard after retirement, in the spirit of solidarity and fairness between and within generations;

(h) the financial sustainability of public and private pension schemes, bearing in mind pressures on public finances and the ageing of populations, and in the context of the three-pronged strategy for tackling the budgetary implications of ageing, notably by: supporting longer working lives and active ageing; by balancing contributions and benefits in an appropriate and socially fair manner; and by promoting the affordability and the security of funded and private schemes;

(i) that pension systems are transparent, well adapted to the needs and aspirations of women and men and the requirements of modern societies, demographic ageing and structural change; that people receive the information they need to plan their retirement and that reforms are conducted on the basis of the broadest possible consensus.

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

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

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

National Strategy Reports delivered in the early autumn of 2008 where Member States report on their responses to the challenges identified in the 2006 and 2007 Joint Reports form the foundation for the policy analysis in this document, which is issued in support of the Joint Report 2009.

4.1.2. Reforming pension systems to meet the demographic challenge

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

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

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

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

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

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

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

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

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

4.1.3. Prolonging working lives to address the pension challenge

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

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

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

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

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

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

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

4.1.4. The increasing role of privately managed pensions

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

A number of Member States that have introduced mandatory funded schemes recently have done so by allowing for a transfer of contributions from old pay-as-you-go systems to the funded schemes, instead of increasing the overall contribution rates (e.g. HU, LT, LV, SK). Romania has introduced a voluntary funded scheme that implies moderate extra contributions

for privately managed pension savings. In Bulgaria participation in the new funded scheme of supplementary pensions is mandatory. The interest in these schemes has often been higher than expected possibly because they were introduced in years of relatively high economic growth. The large number of people shifting part of their contribution has caused deficits in the pay-as-you-go systems. Slovakia has responded by allowing contributors who earlier chose to opt out of the pay-as-you-go system to review their choice. This has resulted in an increase of revenue in the pay-as-you-go systems and a delay in the full establishment of the mandatory funded scheme. Changing the rules within such a short timeframe though temporarily expedient may erode the legitimacy and stability of the reforms enacted and the long-term sustainability of the different tiers of the pension system.

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

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

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

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

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

Some countries report a shift towards a higher degree of earnings-linked indexing of statutory old age pensions (e.g. CZ, HU, PL, UK). To what extent this shift entails higher up-rating depends on the economic situation. In many Member States 2006-2008 has been a period with higher growth and increasing inflation. Pensions have typically been indexed to prices in order to ensure a constant purchasing power over time. Wage or GDP growth oriented indexation of pensions has been advocated as it allows the incomes of retirees to track those of the working population more closely. It is also positive from a financial sustainability point of view as the up-rating of pensions become more closely connected to economic development. The coming period 2008-2010 is likely to see very moderate economic growth and lower inflation.

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

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

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

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

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

4.1.7. Ensuring information and transparency

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

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

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

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

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

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

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

In many Member States young people are increasingly employed on temporary contracts. But membership of pension schemes is usually linked to permanent employment status, so young workers are very often exempted from mandatory pension contributions. For example Italy has made improvements allowing more people with atypical contracts to be better covered by social security and pension schemes. Member States have also made it easier to transfer entitlements between pension funds and thereby improved labour mobility.

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

4.2.2. Protecting those with non-standard careers in reforms

Typically pension reforms have extended the number of contributory years needed for a full pension and have based calculations of earnings-related benefits on income from a greater number of working years. Thus, length of career and income earned over the career have become much more important for the pension benefits accruing to individuals. In view of this development, the 2007 report advocated more in-depth analysis of the impact of these reforms on people u able to meet these conditions due to atypical career patterns. Future risk groups would include the low skilled, low waged women and men, individuals affected by long-term

unemployment or illness, people with caring duties and people excluded from pension coverage due to short term, temporary contracts or self-employed status. The 2008 national strategy reports show that the lowest pensions currently are received by those that have had the weakest link to the labour market in the past. De facto inactivity and longer spells of unemployment will impact on the future pension benefit of individuals. Past levels of long-term unemployment in many new Member States are already likely to result in lower retirement incomes in conjunction with recent reforms. Widespread future unemployment in generations where the old-age dependency ratios are already high will impact on the long-term financial sustainability of pension systems, but also affect the adequacy of pension accruals for some.

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

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

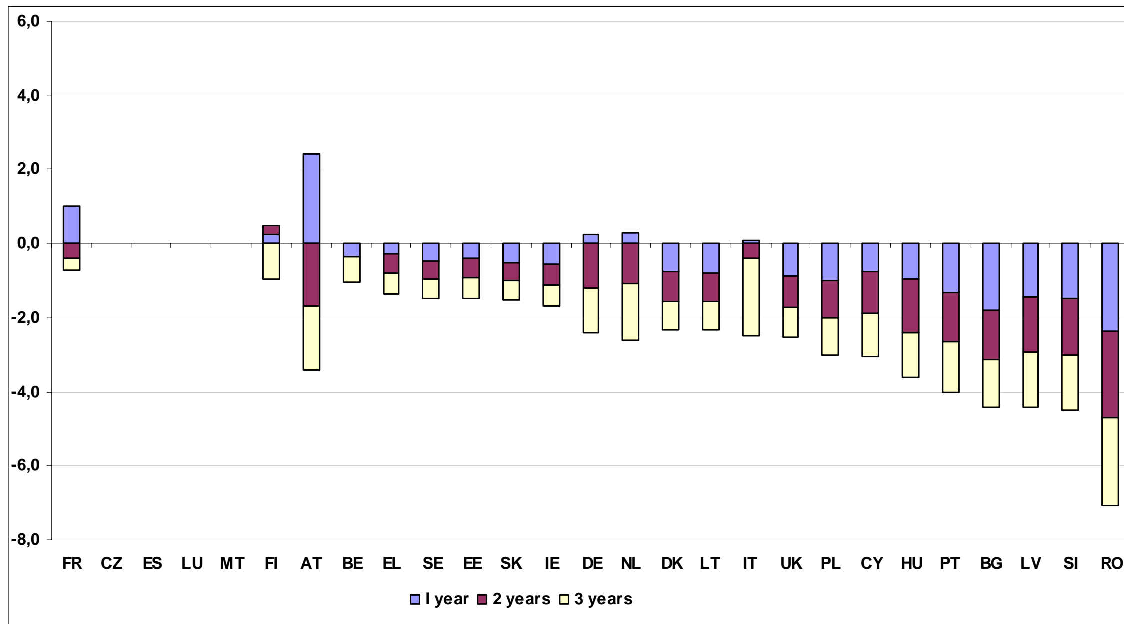
In recent years, a number of member States have also introduced care credits for other types of care than for children. These are usually linked to a general reference value rather than earnings (e.g. BE, DE, AT) or simply include care periods as a part of eligible qualifying periods (e.g. EL, IE, LT,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

Box 1: Illustrations of the result of absences from the labour market on pensions
Calculations show that in most Member States absences from the labour market due to unemployment or childcare, though partially protected, generally lead to decreases in theoretical replacement ratios.

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

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

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



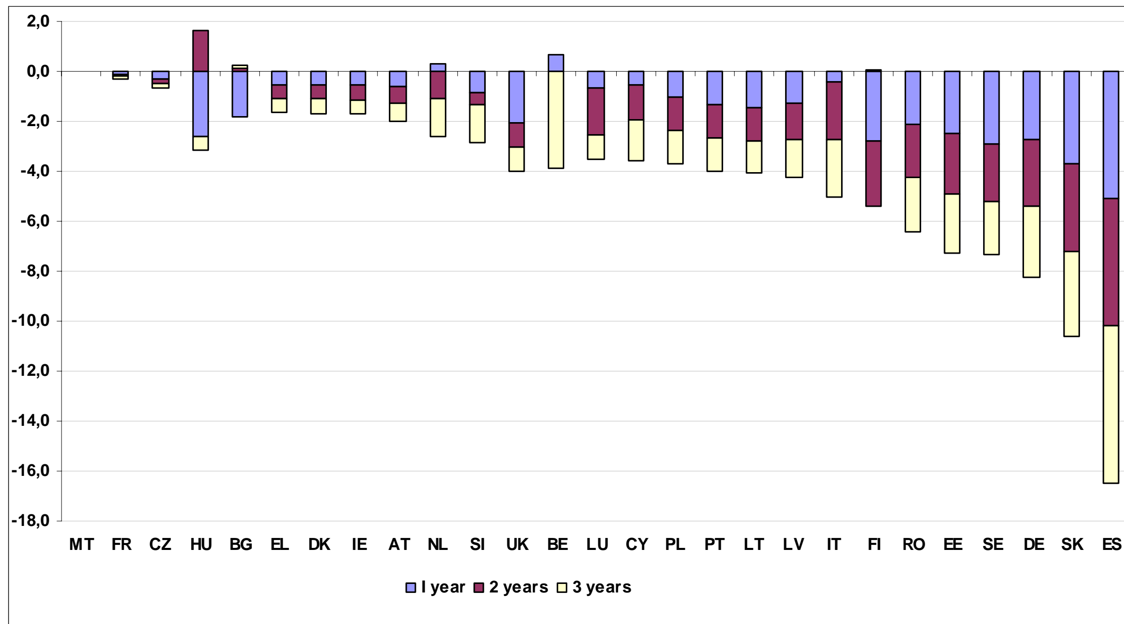
Source: ISG calculations on Theoretical replacement rates carried out in the OECD APEX model or in national models. The figures for NL are preliminary.
* The calculations assume two children are born and that the timing of the childcare years is such that full childcare benefits are received for each child. Retirement at the legislated statutory retirement age for women is calculated here

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

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

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

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



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

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

4.2.3. Improving gender equality in pension policy

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

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

4.2.4 Increasing the employment of older workers

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

4.2.4.1. Increasing the pensionable age in statutory schemes

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

4.2.4.2. Increasing the contribution period

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

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

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

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

4.2.4.3. Promoting flexible retirement options

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

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

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

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

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

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

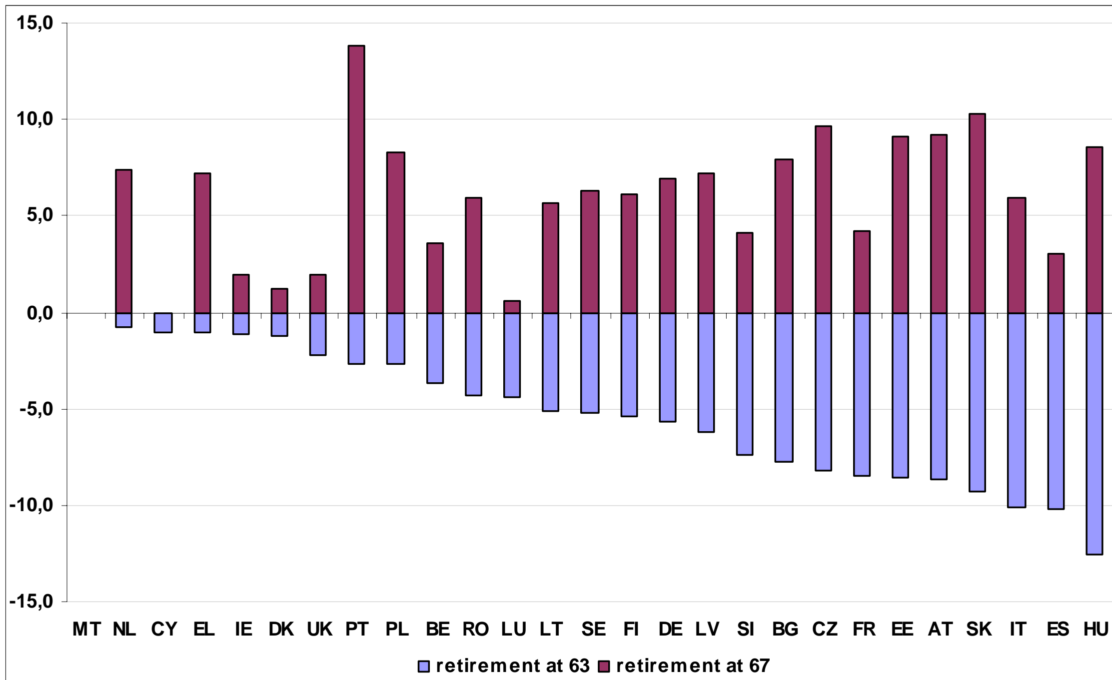
Calculations of theoretical replacement rates point to a decline in future pension levels and the subsequent replacement rates at a given pension age (please refer to Table 2, Chapter 2). This reflects the fact that reforms of statutory pensions will be lowering pensions to meet the challenges caused by increased life expectancy. Member States are planning to compensate for this decline by extending working lives and increasing supplementary pension savings.
Most countries have incorporated incentives to prolong working life into their pension systems. Many of these incentives take the form of reductions for early retirement or bonuses for later retirement. These may be carried out in an actuarial manner often based on remaining life expectancy or through bonuses and penalties fixed by legislation. Other incentives to work more and longer are generated by increasing the contributory period in pension systems and strengthening the link between pensions and contributions.

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

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

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

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



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

4.2.4.4. Restricting access to early retirement

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

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

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

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

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

4.2.4.5. Restricting access to disability schemes

In line with the challenge highlighted in the 2008 Joint Report some Member States have sought to extend working lives by curbing exits through sickness and disability schemes (e.g. CZ, DK, ES, HU, MT, NL, PL, AT, SE). Measures generally involve rehabilitation efforts in connection with stricter eligibility rules and greater cooperation between institutions involved to allow for a quicker transition back into the labour market. Restricting the use of sickness and disability schemes as pathways for early exit should however not preclude the use of such schemes for the contingencies they were meant for.

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

4.2.4.6. Improving employment opportunities for older workers

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

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

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

Member States are also using European anti-discrimination law in their promotion of better age management (e.g. DK, NL, UK). European legislation on age-based discrimination (Council Directive 2000/78/EC) states that less favourable treatment of employees on the

grounds of age needs to be objectively justified. Judgments from the European Court of Justice have recently confirmed that the provisions of the Directive also apply to the mandatory pensionable age. So the fact that a worker has reached pensionable age cannot be a sufficient reason to terminate the employment. Moreover, some Member States encourage employers, particularly in small and medium enterprises, to change ageist practices and to provide more opportunity and choice for their older workers (UK).

4.3. Supplementary funded pensions: impact on adequacy and sustainability

4.3.1. The growing importance of funded schemes

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

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

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

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

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

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

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

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

4.3.2. The double payment problem

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

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

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

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

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

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

As investment and longevity risk increasingly are shifted onto individuals they will need better financial education and information. Lifestyling/lifecycling approaches to investment

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

and flexibility around when a pension must be taken represent important ways of mitigating financial risk for individuals. The payout phase of funded schemes must be carefully designed if adequacy is to be properly ensured. Given the significant impact of administration charges on the pension ultimately accrued they must be kept as low as possible and this cannot be left to market forces alone.

4.3.4. Coverage

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

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

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

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

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

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

Another innovative approach is in Italy. The 2004 reform modified the TFR (*Trattamento di Fine Rapporto*) workers' severance pay (a portion of the worker's pay set aside by the employer formerly paid as a lump sum at the end of employment period) so that it is automatically transferred to defined contribution occupational pension schemes unless the employee actively chooses another option. With this so called 'silent-assent' mechanism if workers do not express their desire not to be members within a six month deadline, the TFR is transferred to the pension schemes set up by collective agreements between employers and trade unions at sector or local level. Employees remain free, however, to make an active choice to decide to keep the TFR with their employer, a decision that can be subsequently revoked. There has been a 43.4% increase in take up in 2007 compared to the previous year. Larger employers with good worker communication and union presence were key factors.

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

[39] ibid

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

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

4.3.5. Contributions

Contributions vary considerably between Member States and scheme type and also between occupational and voluntary pension schemes. But very broadly, DB occupational pensions tend to have the highest contributions. For instance in the UK, contributions to DB funds amount to just over 20% of the gross wage whilst they are just over 16% in the Netherlands. DC occupational schemes tend to have lower contributions, around 9% in the UK with about 10% in Ireland and 11% in Cyprus, though in Denmark they are at 12-17%. But contributions can also be quite low for occupational schemes in general for instance between 1 and 5% in Belgium.

For statutory funded schemes contribution levels are typically below the levels of DC occupational schemes and well below DB occupational scheme levels. Some levels are very low such as 1% on ATP and 1% on SP in Denmark, or the severance pay in Austria with 1.53%, or the Premium Pensions in Sweden with contributions of 2.5% of gross wages. But more typical, particularly for the new Member States, are contributions between 5% and 10% for instance Lithuania at 5.5% and Slovakia at 9% with Italy around the mid-point at 6.9%.

[40] ibid

[41] NSR for DE 2008

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

Also within this range are some Member States that have chosen to gradually increase contribution levels. For instance in Latvia they were 4% in 2007 and will rise to 10% in 2011, whilst in Romania they were 2% in 2008 and will rise to 6% by 2016.

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

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

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

4.3.6. Vulnerable groups

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

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

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

[43] ibid

4.3.7. Risk sharing

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

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

4.3.8. Decumulation – taking a pension

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

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

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

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

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

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

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

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

Some Member States which have established statutory DC pensions have yet to fully set out the payout phase rules. For example in the 2007 Report it was noted that PL needed to put in place payout phase arrangements. These arrangements are still not complete, although the issue is currently being addressed. The PL Government has introduced a bill to Parliament on the pay-out phase of the mandatory funded scheme proposing two kinds of payments, life annuities and temporary funded pension benefits (for women aged 60 – 64). EE has stipulated the basic features of the funded pension payout phase, which includes compulsory annuities as the main mode of payout, but the regulatory framework needs completing. In others such as SK where annuities are mandated, there remain questions about how viable this might be for small pension funds, although it will be some years before payouts begin.

4.3.9. Pension security and financial crisis impacts

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

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

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

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

For DC schemes, temporary falls in the value of investments of those some way from retirement should be seen as part of natural investment volatility and nothing to particularly worry about. Financial information and education needs to stress the nature of investment risk in order to encourage informed decisions and to help maintain confidence in these schemes. For those close to retirement who are taking significant investment risk with insufficient time for investments to recover, falls in DC pension investments will mean delayed or poorer retirements. Lifestyling investment approaches can mitigate this, but may not even be an option currently in some Member States with funded DC provision. Given the typically low importance of funded DC provision for those retiring today, this may not be critical. But in Member States where these funds are, or will be, an important element of overall pension provision, the mainstream investment strategy choice needs to match this role providing reasonable returns but also not being subject to unaccepTable volatility close to retirement. In HU, an optional portfolio system has been introduced in the statutory funded pension as from 2007. This creates the opportunity for long-term optimisation of investments adjusted to age and individual risk-taking ability and this system will become compulsory from 2009.

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

4.3.10. Pension policy responses to financial crisis

It is too early to see how the crisis will develop and if it will affect pension schemes, but some Member States and their pensions regulatory bodies have taken initial policy steps. For instance in DK pension rules on the composition and size of assets would have forced pension funds to sell real estate bonds due to their fall in value. Apart from the knock-on effects to the market for such bonds, this would have forced pension funds to realise the value of these assets at a low point in the market. The Danish FSA therefore changed the method of calculating solvency requirements to allow pension funds to continue to hold these bonds.
Similarly in FI the government put a Bill to Parliament on 17 October 2008 to strengthen the employment pension funds of the earnings-related pension scheme in view of the decline in the equity market. The proposal aims at ensuring the solvency requirements of the pension funds can be met without leading to forced selling of equities in a disadvantageous market situation.

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

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

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

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

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

4.4. Minimum income provision for older people (MIP)

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

Member States are using different types of provision and delivery mechanisms: (1) Minimum pensions within contributory earnings-related pension schemes for people with low income or short contribution records (e.g. in BE, BG, CZ, ES, FR, LV, LT, LU HU, PL, PT, SE, SI). (2) Basic flat-rate pensions that may be non-contributory or contributory and include years of residency in their qualifying criteria (e.g. in NL, DK, FI, IE). (3) Separate social assistance-

like, means tested benefits for older people with few or no other pension rights – often referred to as 'Social Pensions' (e.g. in SI, PT, IT, LV, CY) or as 'guaranteed minimum' for the elderly (e.g. AT, DE, BE, FR, UK). Many Member States operate parallel or combined systems of minimum pensions and means-tested guaranteed minimum income.

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

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

4.4.1. Developments and progress 2006-2008

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

A couple of Member States reformed their MIP in major ways (e.g. PT, LT). Parametric changes did also occur. Changes to up-rating and indexing mechanisms or ad-hoc increases were particularly frequent (e.g. BE, CZ, ES, FR, IE, MT, PL). Several Member States efforts were more directed at implementing earlier adopted reorganisations (e.g. UK, SK, DE, AT).
Member States where adequacy was seen as a particular challenge addressed the problems primarily through incremental upratings and smaller parametric adjustments; a couple of countries prepared major future advances

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

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

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

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

Improving the adequacy of minimum pensions and/or minimum income provision was highlighted as a key challenge for seven Member States in the 2007 Joint Report (BG, EE, IE, LT, LV, IE, UK). Assuring adequate minimum income for older people was a problem for lower GDP-per-capita Member States such as BG, RO, LV, LT, and to a lesser extent EE, but it also created problems in higher-income fast-growing Member States like CY, IE and the UK. It may be because the results of policy efforts are not captured by the common indicator data available, but it seems that most Member States facing serious challenges with minimum adequacy have made only moderate advances from 2006 to 2008. Yet in a couple of countries major new approaches which would significantly reduce at-risk-of-poverty-rates are planned or about to be presented (e.g. CY, IE). In the context of rapid wage growth and rising inflation and pressure of other priorities some may have limited themselves to alleviating poverty for the worst-off (e.g. LV, EE, RO). Others have worked at the inclusiveness of the pension system particularly in relation to women while at the same time improving their MIP systems (e.g. LT, UK, IE). The UK has reformed its basic pension so that by 2010 around 75% of women (over 90% by 2025) will receive the full amount, up from 35% at present, while lifting a large number of pensioners out of taxation and providing home visits to vulnerable pensioners. In a few Member States moderate progress reflects the amount of efforts invested. Yet, some have experienced a jump in poverty rates 65+ despite considerable efforts (e.g. UK, LV, LT). Ireland managed to lower the at-risk-of-poverty-rate for people 65+ despite rapid growth. Generally the adequacy of minimum pensions has received the bulk of attention

whereas MIPs were less in focus. But Lithuania reformed widows/survivors pensions as well as its MIP scheme and introduced regular indexing.

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

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

Various patterns emerge. In EE, LT and LV at-risk-of-poverty-rates 65+ were being reduced until 2005. While high growth and increasing inflation rates since made it difficult to maintain minimum adequacy ad hoc up-ratings together with structural improvements have allowed recipients of minimum pensions and MIP to retain purchasing power and not to fall too far behind. In Lithuania, for example, the at-risk-of-poverty-rate from 2005 to 2006 jumped from 17% to 22% as rapid wage development caused ad hoc up-rated benefits to fall behind. Likewise the median equalized income of 65+ as percentage of the one for 0-64 dropped about 6 pp. These measurements however fail to capture further up-ratings and improvements which from 2006-2007 caused the average social insurance pension to increase from 31.9% to 32.9% of the average wage. In LV and EE minimum pensions fell radically behind wages but their purchasing power was maintained. In LV a referendum on minimum pensions provoked extra up ratings even though it failed. Through regular and extra up-ratings ES has largely been able to maintain the relative income position of the elderly despite rapid growth. On the other hand the latter has prevented substantial upward adjustments from registering in the at-risk-of-poverty-rate 65+. In PT where growth has been lower the targeted implementation of the Solidarity Supplement and improvements to minimum pensions has helped reduce poverty rates. In the context of rapid growth the Special Allowance introduced in CY has had no discernable impact on poverty rates. Despite considerable growth in the period CZ, SK and PL relying on mixed price/wage indexation have managed to keep relative poverty rates at almost the same level. By contrast HU with some economic difficulties has seen an increase from 6% to 9% despite a balanced index and some extra up-rating. In Malta the national minimum pension has been pegged to poverty thresholds. Some Member States have improved the indexation of minimum income provision (e.g. BG, IT, AT). Turning to

Member States with flat-rate pensions (UK, IE, DK, NL, FI) recipients of basic pensions in the NL have retained their absolute and relative income position. In Denmark older people relying solely on the people's pension have seen moderate improvements in their situation. From a less comforTable income position pensioners dependent on flat-rate pension in Ireland have seen marked improvements. The same goes for the UK. Fast growth in FI has generated a sudden increase in the 65+ poverty rate. By contrast SE where the minimum pension also is price indexed has maintained a moderate at-risk-of-poverty-rate.

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

On average older people spend a higher share of their incomes paying for basic needs (food, housing, energy and health) than the working age population. As indicated by Table 4.2 the Member States where food costs have risen the most, are also the Member States where food costs dominate the spending of the elderly (i.e. BG, CZ, EE, LT, LV, HU, MT, RO, SI) Generally speaking, the actual increase in pensions, including ad hoc increases, have been higher than price inflation but lower than real wage increases. This has meant that pensioners have fared better than what could be expected given the indexing mechanisms in the economic situation.

Table 4.2: Structure of consumption expenditure by age in 2005 and inflation in October 2008

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

Note: in HU, MT and RO, imputed rents are unknown and supposed to be 0.

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

4.4.3. Shifting relations between pensions proper and MIPs

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

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

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

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

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

4.5. Ensuring information and transparency

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

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

4.5.1. Public consensus building and information during pension reform

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

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

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

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

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

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

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

Most Member States have information regulations requiring pension schemes of all types to provide information on the accumulation of pension rights, but the amount and character of information provided differs. Some may provide information on accumulated pension rights only if requested by individuals, while in others it is sent out automatically. This can affect how the information is absorbed and spread. Having to actively seek pension information probably limits it to certain groups, excluding the people who may need the information most. A growing number of Member States are now also providing or developing calculations of how these pensions rights may translate into a pension income, based on projections given certain economic assumptions (e.g. BE, DE, DK, IE, ES, FR, LT, FI, SE, UK). Finland and Portugal have recently introduced pension projections. In Finland these are available only for

those closest to retirement, as projections for younger cohorts are considered too hypothetical. Yet with a move towards longer contributory periods it would seem important that individuals understand the effects of shorter careers early on. As the pros and cons of different approaches are weighed, even younger cohorts might appreciate forecasting tools which provide different scenarios depending on economic assumptions, contributory years and point of retrieving the pension.

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

4.5.3. Financial education and adequate private pension provision

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

The SPC report on Privately Managed Pension Provision published in October 2008 shows that while the increased need for financial information has been widely recognised, the type and standard of financial information varies greatly between Member States. Information is regulated in a number of Member States (e.g. AT, BE, IE, IT, HU, MT, NL, UK, BG) by the supervisory authority or through self-regulation by partnership bodies. Presenting complicated financial information to people who may not have the ability or interest to take it in is difficult. Improving accessibility and absorption of information through simplification of information presented is a key concern (e.g. ES, IE, UK). Yet simplification of the information has to be strategic in order not to leave out any important information that might affect any savings decision. The number of investment choices in funded schemes varies vastly from just three or four (e.g. HU, BG, PL) to several hundred (e.g. SE, UK, IE, NL). Obviously the amount of choice will determine the depth of financial knowledge required by beneficiaries. Member States are trying various approaches. The ‘Altersvorsorge macht Schule’ (pension provision goes to school) project in DE is a government initiative together with social partners, consumer organisations and adult educational institutions, and courses focus on all relevant issues of old-age provision.

In most Member States, information is provided on current and past returns of pension funds, but there is limited information on fees and administration costs and the compounded effects of these on effective investment returns. Some countries oblige pension funds to list their administration costs (e.g. DK, S) but these may not include the effect of all investment fees. This is a vital element when comparing funds and also when considering guaranteed returns. The SPC report on privately managed pension provision shows, for example, that minimum

returns may help to support adequacy. Yet they may also entail higher direct insurance costs and indirect costs due to changes in the portfolio structure. Circumstances are not always clearly presented and this may disfavour the least knowledgeable, often including people with risk-averse investment behaviour who might have benefited from less choice.

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

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

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

4.5.4. The effectiveness of information channels

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

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

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

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

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

4.6. Conclusions

The employment rate of older people has increased markedly over the past decade, and improvements are particularly visible in a number of Member States. Nevertheless, much still needs to be done to reach the EU target of 50% employment among older workers by 2010 which, given current demographic trends, is in itself insufficient in the long run. So it is encouraging that some Member States ratchet up their targets as soon as they pass the 50% mark. Throughout Europe there is a growing willingness to act on the realisation that the age when people stop working has to increase. Member States are starting to increase the pension eligibility age in statutory schemes. Through bonus/malus rules they are also strengthening the economic incentives in pension systems to avoid premature exit and motivate people to work to higher ages. These are important signals for employers to adjust their age management practices and for employees to plan for later retirement. Member States are also trying to close early exit routes and remove unintended incentives to early retirement. Building a broad consensus for this, including the social partners, is often very difficult and in many countries there are still certain occupations for which exemptions or special regimes apply.

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

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

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

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

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

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

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

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

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

5. NATIONAL STRATEGIES ON HEALTHCARE AND LONG-TERM CARE

5.1. Introduction

Common objectives for healthcare and long-term care

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

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

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

Regarding health, countries identify a number of health risks and ill-health conditions that remain important and require attention. Risks include increasing alcohol and drugs consumption by younger people, and smoking, poor diet and lack of physical exercise in general. The main ill-health conditions in the EU are obesity, cancer, cardiovascular and respiratory diseases, mental ill-health and injuries and accidents, alongside some infectious diseases such as HIV and tuberculosis. Mental health diseases are seen to be gaining ground and appear to be related to working conditions and exclusion. These risks and ill-health conditions are deemed avoidable to a large extent, especially by those countries that report poor health status performance (HU, EE, LV, LT). This pattern of risks and diseases is determining the policy choices in the health sector (public health and healthcare services) to a large degree.

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

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

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

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

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

5.1.3. *Main priorities for 2008-2010*

This is the second full reporting exercise under the social OMC regarding the healthcare and long-term care strand. As only two years have passed since the previous NSRs, virtually all of the 2008-2010 reports (except perhaps BG, CZ, SK) build on the previous strategies and national health plans with similar priorities and policies and some additions or improvements in relation to the strategies proposed in 2006. For all Member States, universality, fairness and solidarity, accessibility, equity, equality, effectiveness, and efficiency are the guiding principles of reform. Between 2006 and 2008 a number of countries (e.g. RO, SE, UK, IE, NL) have produced inquiries/assessments of population needs and/ or health sector policies and, on that basis, have introduced/ plan to introduce additional policies (e.g. specific policy programme for health promotion in FI). Most countries have limited their reporting to a small number of policy areas, potentially those where they see more is happening or they see as priorities. Thus, the 2008-2010 NSRs are not always as detailed in relation to all the objectives as the 2006-2008 reports were.

In general the 2008-2010 NSRs in comparison to the previous 2006-2008 NSRs have seen more emphasis placed on health promotion and disease prevention to improve population health status at all ages and counteract the rise in expenditure expected as a result of ageing.

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

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

There is substantial information on the implementation of national vaccination schemes and national screening programmes for cancer, diabetes and cardiovascular diseases. There is also considerable information regarding national or group-targeted campaigns to encourage healthy life styles and develop environments that promote healthy choices, involving a variety of settings (from nurseries and schools to businesses). In 2008, more and growing interest (although still restricted to a number of countries) is placed on disease management programmes in the context of chronic disease (e.g. obesity, diabetes, heart disease, renal failure) as well as some infectious diseases such as tuberculosis and HIV.

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

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

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

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

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

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

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

5.1.4. Progress in relation to 2007 Joint Report

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

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

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

Reducing the financial barriers to access was an identified challenged in 2007. While all countries appear to have exemptions or reductions in relation to cost-sharing, some have actually increased the number of cost-sharing schemes (CZ, FR, NL with a deductible, and LV in the future and in view of the financial crisis). The reduction in care utilisation in CZ, for example, has been significant. It remains to be seen what the impacts of these schemes on more vulnerable groups are. In LV, where direct financing costs of care are more than 40% of expenditure, extra payments may translate into an extra financial burden on patients especially those more vulnerable. The financial costs of care remain high in CY and EL and no specific policies have been mentioned to address this. In IE, while the income threshold for free medical care has increased, the entitlement to free care based on age has been removed causing quite an internal uproar. Interestingly, HU and SK have withdrawn cost-sharing schemes that had been recently implemented. Following the 2007 Joint Report, BE has made substantial efforts in reducing the risk of impoverishment due to healthcare use. Some countries (e.g. PT)have since 2007 been improving system coverage for dental care for certain groups of the population (such as children, youth, and low income individuals). Just as in 2007, dental, ophthalmic and aural care remain, for the most part, outside the public basket and more countries need to make an effort to ensure their coverage for more vulnerable

groups. Moreover, informal payments still persist in several countries (SK, RO, BG, EL, HU, PL, LT, LV, IT) and it is not clear if any policies were put in place to address them and if indeed they have decreased.

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

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

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

As the biggest spenders in the EU, BE, FR, AT, DE and PT face the important challenge of ensuring long-term sustainability and obtaining greater value for money. While an array of policies have been proposed and some implemented, which translates in the fact that in recent years expenditure levels have been more sTable (as a % of GDP), more needs to be done. Amongst other measures, AT still needs to work towards more integrated funding as announced in 2007, DE still need to reap the fruits of selective contracting, FR is focusing mainly on the demand side (e.g. cost-sharing, with a possible burden on more vulnerable patients) and need to look at the supply side incentives (e.g. contracting, health technology assessment), PT needs to continue the implementation of primary care units and centres of excellence. Strict budgeting and cost-containment are measures that have allowed BE to control expenditure growth in recent times. BE is still to implement a "future fund" to build up reserves for future use. Greater use of primary care and more cost-effective use of pharmaceuticals may be of relevance to all these countries.

Still in relation to sustainability reforms, note that while NL expected to reap efficiency gains from competition in the insurance sector, 4 companies currently hold 90% of the market, fact that requires further monitoring and may question the ability for this type of competition to

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

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

5.1.5. The financial crisis and economic slowdown

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

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

On the supply side, the bases for spending on health are typically taxation and employment-based contributions. With slow economic growth and recession such revenues decrease, as a result of higher unemployment, and thus constrain the level of resources that can be spent on

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

healthcare and long-term care services. How much is then spent on care services depends on the budgetary reserves Member States have made in good times and can use in worse times, as well as budgetary rules (e.g. Can the health insurance funds run a deficit or not?) which are stricter in some countries than in others. In this context, governments may be under pressure to cut expenditure and services or, in other words, to focus on the short-term rather than on long-term agendas.

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

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

These are important especially when Member States recognise that social protection including social security and social and health services have significantly contributed to improving health and reducing the risk of poverty and exclusion including that associated with ill-health, old age or accident. Indeed, the values of universality, solidarity and equity including the protection of the most vulnerable in our societies become even more pertinent and should be emphasised as the basis for policy responses. The most relevant policies in such economic circumstances are those which protect health such as access to food and housing and those that ensure universal access to good quality care especially primary care and in particularly for children and vulnerable groups. Public health policies aimed at creating a culture of solidarity and resilience, promoting mental health and dealing with stress and at reducing risk taking behaviour such as smoking and harmful alcohol use are also very important.

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

5.2. Addressing health inequalities and inequities in access to care

Member States argue that good health and longer working lives require, amongst other things, effective health-in-the-workplace policies (notably those emphasising age management and mental health) and, importantly, that healthcare services (including health promotion, disease prevention, curative care and rehabilitation) are accessible for all. Inequalities in health status

between social groups and between different parts of Member States are seen as an important problem by about half of all Member States. Across the EU the gap in life expectancy between Member States has widened to 13 years for men and 8 years for women For the EU as a whole there is significantly more (reported) long-term illness and disability in lower income groups. Strategies to tackle health inequalities range from those which focus mainly on tackling inequities in access to healthcare to those which aim to also tackle the underlying social and economic determinants and involve policies across all areas of government. This area represents major challenges to health and social policy and is of increasing importance.

5.2.1. Health inequalities

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

In addition, within country socio-economic differences in health have remained or even increased in a large number of countries for which there is data available. For example, FI, LT, EE, AT, IE, UK, and DK all report in the 2008 NSRs that life expectancy, healthy life years, long-term illness, functional capacity, self-reported working ability, and severe mental problems are more common in the lower socio-economic groups (measured using income or education) than in the higher ones. More specifically, in AT those with higher education a) are less often smokers, b) are less frequently overweight and obese, c) have preventive health checks more often, and d) more often perceived their health to be good or very good. In EE women with higher education live on average 13 years longer than men with basic education (against the average 11-year gender gap). The UK states that parts of Wales (notably the former mining and industrial areas of south Wales) and parts of Scotland have some of the worst health indicators of Europe and certainly Western Europe. DK indicates that the most disadvantaged groups generally have poorer health and fewer healthy years to live than the rest of the population. In BE life expectancy at birth of those with low qualifications compared to those with higher education is 5.5 years less for men and 3.5 years less for women. At 45 a 5-year difference for men and women is observed. Recent EU-SILC data also indicates[53] that lower income groups feel their health to be worse than more advantaged groups and that in some countries the gap has increased.

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

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

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

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

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

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

Given the various social determinants of health above, some countries (FI, IE, AT, SI, EE, SK, UK) have encouraged health protection and the reduction of health inequalities in other sectors' policies (e.g. education, employment, housing, social work, rural development, environment). This is in line, for example, with a study looking at the links between

environment and health[54] that recommends that the policy development process be strengthened by making distributional aspects a more important part of the policy impact assessment process, and by providing guidance on methods and approaches. This would both avoid/mitigate negative distributional impacts and identify (and enhance) positive synergies between environmental and social objectives.

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

5.2.2. Access

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

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

To improve manners, more public investment is being allocated to the healthcare sector in a number of countries (FI, LT, HU, IE, RO, UK, DK) notably to improve infrastructure (facilities and beds), staff availability and technology. Additional public funding has been/ is

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

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

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

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

to be allocated to expand community and home care (LV, CZ, HU, LT, MT) and improve residential care (BE, FR, LV, HU). Many Member States wish to promote rehabilitative care (PT, BE, CZ, EL, FI, FR, DE, LT) with a view to restoring patients' skills to regain maximum self-sufficiency. Significant emphasis is being put on improving coordination between primary and secondary care and between healthcare and long-term care. However, the reading of the reports suggests that we are still at an early stage in this process.

5.2.3. Lack of insurance coverage

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

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

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

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

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

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

As highlighted in the 2007 Joint Report, while cost-sharing can have a role in the health sector in raising cost-awareness, reducing unnecessary consumption, and encouraging a preferred path of care, it is a component of healthcare that must be carefully designed so that it does not deter or delay access to necessary care by those more vulnerable (lower income, chronically ill) who may face the greatest need.[60] This is the more important in the context of high expenditure and growing demand where cost-sharing may be seen as unavoidable. Hence, it is crucial to design it so that it minimises any negative impacts and maximises efficiency gains.
All countries have reductions or exemptions of cost-sharing for certain population groups based on income, age and severity of disease (e.g. children, students, elderly, chronically ill, benefit recipients, low income, pregnant women, disabled, victims of violence). In many countries a minimum basket of care is available free of charge for all residents. For example, in BE and LV a set of preventive care (vaccination and screening) is free for all. In NL, primary, obstetric and maternity care, and dental care for those up to 22 are not included in the compulsory excess (deductible). Some (RO) plan to extend the basic care basket covered by social insurance. Several countries (BE, FR, IE) want to decrease the financial burden of care in general and for those in more vulnerable groups in particular (low income and/or chronically ill patients). In FR free care is now available for those with chronic conditions. In IE medical and GP cards entitle those in lower incomes to access free care or free primary care. IE is increasing and indexing the income threshold that qualifies for free care (though decreasing age eligibility). In BE a medical card allows full reimbursement for some individuals and for some conditions. Some countries operate expenditure ceilings to alleviate the burden of those using services (including medication) frequently (FI, BE, LV). In AT, prescription charges for those with chronic illnesses are capped at 2% of individuals' income.
Plans are put forward to increase the reimbursement of drugs (RO, PT, LV, MT for cost-effective drugs) or decrease/control the price of drugs (PT, BE, MT, BG) especially for those with special difficulties and the elderly (ES, UK), or chronic disease (MT) or children (UK).

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

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

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

Some see a greater use of generics (PT, MT) as a way to increase the affordability of drugs and ensure extra reimbursement.

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

5.2.5. Waiting times

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

Several policies are proposed on the line of more centralised and transparent waiting list management (FI, LT, HU, IE, AT, SI, EE, PT, MT), especially for non-urgent surgery. A first policy is that of implementing a national monitoring system on waiting lists and times for different healthcare facilities, whose information could be made publicly available to staff and patients, thus helping these choose the facilities with the shorter wait (FI, SI, DK, EE, ES). This is typically, though not necessary, related to the implementation of time frames/ time limits/ time guarantees that are applied to either all or some of the following: primary care, urgent treatment, non-urgent surgery, chronic and malignant disorders (FI, SI, SE, DK, UK, ES, CZ, PT, MT). The aim is not only to ensure that no one waits too long, and thus bears negative repercussions on his/her health status, but also that there are harmonised principles for all regions in an attempt to decrease geographic disparities in waiting times. When time limits are reached, other public facilities in other regions or in the private sector (FI, UK, DK, LT, SE, IE, PT) can be used, following agreements with private institutions. For example, in IE, the National Treatment Purchase Fund that manages those on the waiting list (i.e. checks if patients still require treatment), arranges treatment for those who have been waiting the longest. Interestingly, not all patients accept being treated elsewhere from originally planned (IE, PT, DK, SE) and prefer to wait longer but be treated closer to home. Further to these measures, in DK the patient ombudsman is to deal with waiting time complaints. In addition, extra funding has been put into increasing the number of public beds (IE, UK, MT) or directed at those conditions with very long waits (SI). It is expected that an increase in long-term care services also increases capacity and reduces the wait by reducing bed-blockers (MT). Moving certain healthcare services from the tertiary/secondary to the primary sector is also expected to reduce waiting times for surgery (MT). The implementation of electronic referral systems may contribute to faster evaluation of referrals to hospitals (UK). Longer hours for surgical and outpatient wards are to decrease the waiting (MT). In general, better coordination between primary and secondary care is crucial to achieve faster referrals and

treatment. Policies centralising the management of waiting lists together with time frames are becoming common around the EU and appear to have reduced waiting times for several conditions.

5.2.6. Geographic differences in services availability and quality

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

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

Measures proposed relate to improving infrastructure, resource allocation and staff support structures in needed areas. A large number of countries are focusing on building new infrastructure and modernising facilities focusing on primary, common outpatient and emergency care. The attraction of health personnel (i.e. primary care doctors) in isolated or economically disadvantaged areas is also a priority, and some (FR, RO, BE, BG) provide a related package of incentives (also for emergency staff in LV). In some countries the municipal and regional reform to broaden the population base continues (FI) and cooperation and partnerships between local authorities (FI, SI) or groups of health centres (PT) is encouraged to enhance provision. Another important aspect is to develop an adequate financial framework that guarantees a uniform supply of basic health services of standard quality by adjusting regional funding to population characteristics with annual updates (IE, AT, HU, RO, UK) or where health indicators deviate most from the average (SI). A maximum distance to hospital (BE) and mobile services in remote areas (RO, BG) are also foreseen, together with the setting up of pharmacies or outlets in disadvantaged areas (RO). SE is working with local authorities to provide more psychiatric care while DK is implementing cancer pathways throughout the country. FR is setting up regional health agencies comprising medical and social care professionals to improve the organisation of healthcare services across regions. Interestingly, in ES the ministry of health is working with the ministry of environment and rural affairs to ensure quality primary and emergency care in rural areas.

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

5.2.7. *Primary care*

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

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

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

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

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

also for chronic disease, UK for health and social care). Electronic referrals (SE) and e-prescriptions (PT, LV, ES, FI) can ensure faster patient flows in the system. Finally, ICT allows for data collection, monitoring and planning (EE).

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

5.3. Quality of healthcare

5.3.1. Introduction

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

The European Observatory on Health Systems and Policies[61] uses the definition of the American Institute of Medicine (1990) that defines quality as "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". The Council of Europe (1998) adds to this "increases (…) and diminishes the chances of undesirable results (…)". More recently the WHO (2000) defined quality of care as "the level of attainment of health systems' intrinsic goals for health improvement and responsiveness to legitimate expectations of the population". Several Member States also propose a definition of quality: for example, the UK Department of Health (1997) states that quality is "doing the right thing, at the right time, in the right way, for the right person". Such definitions cover the dimensions of effectiveness, safety, timeliness and patient centeredness. Under the social OMC we focus on all these aspects which relate directly to the common objectives and indicators that have been agreed.

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

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

5.3.2. Quality assurance systems

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

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

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

5.3.3. Effectiveness: disease prevention and chronic disease management programmes

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

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

In many Member States, preventive care has a history, especially with regard to newborn, young mothers, and children, with a free of charge follow-up in schools for example (AT, BE, SI, LV, CY, LT and PL), and notably vaccination and oral health. More punctual preventive programmes also exist and are gaining more ground concerning specific diseases (tuberculosis, AIDS, cardiovascular diseases, diabetes). Cancer prevention, notably routine screening and follow-up, have however received greater attention in the 2008 NSRs and are well documented in the majority of the reports, although the statistical data about the percentage of population screened are not always provided. Breast cancer screening is

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

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

implemented in the majority of Member States, followed by cervical cancer screening. European Guidelines on Breast Cancer Screening are/ planned to be implemented shortly in almost all Member States. Other measures include introducing (LU) or considering the introduction (IE) of vaccination programme against HPV. This is potentially related with the implementation of the Council Regulation on cancer screening, in relation to which the first report was launched. This report identifies differences in cancer diagnosis and follow-up across Member States and that the EU is only about half-way to the goal of 125 million examinations per year.[64]

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

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

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

5.3.4. Patient safety

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

Although patient safety is narrower in its definition than healthcare quality more generally, it is a key foundation of any high quality health system. Implementing effective quality and patient safety improvements is of interest to many international organisations (e.g. WHO, OECD). The European Commission has also taken specific steps in many areas to address the issue of patient safety. However, these have focused mostly on specific sources of risk such as

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

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

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

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

the safety of medicines, medical devices and resistance to antimicrobials. Building on those achievements, the Commission is currently preparing an initiative on patient safety which aims to outline an integrated approach, placing patient safety at the core of high quality healthcare systems by bringing together all factors that have an impact on the safety of patients, including a specific focus on healthcare-associated infections.

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

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

5.3.5. Patient centeredness

Although there is an overall awareness of the need to make the patient the central point of healthcare and especially long-term care systems, the level of effort and the measures undertaken by Member States to assure the patient's central role vary across Europe. This is partly due to different departing points and partly due to different systems of delivering care.
The most common way to address patient centeredness is defining the patient rights. A Charter of Patient Rights, either already in existence or under preparation, is reported as a measure being used by most EU countries. For example, CY issued, in 2008, the Charter of Citizens' Rights regarding healthcare in public medical institutions and in the NL there is ongoing work on establishing seven rights for patients, giving them a central role in the Dutch healthcare system.

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

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

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

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

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

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

5.4 Sustainability

5.4.1 Introduction

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

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

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

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

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

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

5.4.2. Progress on reforming healthcare financing and provision

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

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

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

Reinforcing and improving financing

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

The required solutions are therefore different. Measures to increase funding are taking effect in many countries that are improving the collection mechanisms of health insurance contributions (BG), imposing more control against the avoidance of contributions (HU), increasing the health insurance tax base (EE) or earmarking the revenues from some so-called “sin” taxes as tobacco and/or alcohol excise duties (RO, AT). Regarding the lack of risk-adjustment, DE has carried out an extensive reform that will centralise contributions in a new National Health Fund. On the basis of a unified contribution rate, the National Health Fund will allocate resources to each of the other funds based on a risk-adjusted capitation formula, which will be adjusted to take account of morbidity in addition to gender and age. The Social Health Insurance and the Private Health Insurance systems will be modified so that the first will become more competitive, while more social elements are introduced in the second. The German authorities will evaluate the effects of the new risk adjustment system in due time. In AT, there are some measures intended to improve financing, such as increasing health insurance contributions and increasing patient' co-payments. In HU, health insurance coverage was linked to employment and this resulted in an increase in the number of contribution payers and in the revenue of the health insurance fund and in a surplus of the Health Insurance Fund in 2007.

Making healthcare provision more rational

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

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

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

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

Containing costs

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

Some measures improve the mechanisms of payments as in BG, EE or LT. In EE, for instance, the control and optimisation of health insurance costs will be done via cost-based prices and diagnostics-related group prices Other measures are: more rational criteria for purchasing management (ES, LU, LV and MT), making costs more transparent (NL) or stronger incentives (e.g. performance based contracts) for providers to deliver high quality care whilst controlling costs (MT and UK). Cost control at macro level by the use of expenditure ceilings has been implemented in some countries, more or less successfully. In BE financial resources not used in the corresponding budget will be allocated to a "Fund for the future of healthcare", whose purpose is to constitute reserves that can be used when the ageing of the population will require greater growth of the budget of mandatory healthcare insurance.

Pharmaceutical expenditures in the EU

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

In 2007, the total size of the pharmaceutical market in the EU was €214 billion at retail price level.[71] On ex-factory price level this corresponded to € 138 billion, of which 88% was for medicines that required a prescription from a medical doctor. The remaining part of the market was non-prescription medicines, which usually can be bought freely over the counter by the consumers. For the medicines sold via pharmacies in the EU, public funding (tax-financed or by compulsory health insurance) cover on average 82% of the prices, and patients have to pay some 18% themselves.[72] This ratio varies between 60% / 40% and 99% / 1% in the EU Member States. On the demand side, the pharmaceutical sector is unusual in that for prescription medicines the ultimate consumer (the patient) is not the decision maker, but generally it is the prescribing doctor and in certain Member States the pharmacist. Nor does the ultimate consumer usually directly bear the costs, as these are generally paid for by a public health scheme. Because of this unique structure, there is usually limited price sensitivity on the part of decision makers and patients.[73]

Given the limited public financial resources available for healthcare and the constantly increasing expenditures, it is highly important for the Member States to continuously optimise the use of different pharmaceuticals and achieve the best value possible for the money spent. In doing so Member States can apply a range of various strategies, for instance: regulation of prices, reimbursement conditions for prescription medicines, optimise the use of generic products that replace more expensive original medicines. These issues were addressed by Member States, EFTA, members of the European Parliament, various stakeholders and the European Commission in the Pharmaceutical Forum[74].

The actual market conditions for, and effects of, the entry of generic medicine products into EU markets are currently being studied by the European Commission with a sector inquiry. In markets where generic medicines become available, average savings to the health system (as measured by the development of a weighted price index of originator and generic products) are almost 20% one year after the first generic entry, and about 25% after two years (EU average). Generic companies began selling generic medicines, on average, 25% lower than the price of the originator medicines. Two years after entry, generic medicine prices were on average 40% below the former originator price. The inquiry points to considerable differences, however, in the entry of generics in various EU Member States and in the effects.

However, a generic alternative product can usually only enter the market 20-25 years after the first introduction of a new, patenTable original medicine. Thus, Member States apply a range of policy measures to optimise the use of and expenditures for prescription medicines. Pharmaceutical policies are expected to attain multiple goals that reflect different

[70] Introductory Presentation: Some key features of growth and cross-country differences in health-care spending, at the conference Improving Health-system efficiency - achieving better value for money, jointly organised by the European Commission and the OECD 17 Sept. 2008 http://ec.europa.eu/social/main.jsp?catId=88&langId=en&eventsId=106&furtherEvents=yes

[71] Pharmaceutical Sector Inquiry, Preliminary report (28 Nov. 2008), European Commission, DG Competition http://ec.europa.eu/competition/sectors/pharmaceuticals/inquiry/index.html

[72] The pharmaceutical industry in figures 2008, European Federation of Pharmaceutical Industries and Associations http://www.efpia.org/content/default.asp?PageID=322

[73] Pharmaceutical Sector Inquiry, Preliminary report, European Commission, DG Competition.

[74] The Pharmaceutical Forum: http://ec.europa.eu/pharmaforum/

perspectives. So, market interventions, such as regulating prices and reimbursement conditions for pharmaceuticals, aim to limit dynamic expenditure increases while ensuring affordable access to medicines, and maintaining the incentive for pharmaceutical companies to continue with research and development on new, useful medicines.

In the National Strategy Reports 2008-2010 several member States report on actions that have been carried out to either increase citizens access to pharmaceuticals (e.g. BG), make prescription medicines more affordable to the patients (BE, DE) and/or limit the increases in public expenditures for pharmaceuticals (AT). Some Member States also report on planned actions (e.g. FI). The improved affordability for patients is often achieved by ensuring that the co-payment amounts do not grow too fast. For instance, BE states that various policies enacted to reduce the cost of medicines have reduced the average cost (all medicines prescribed for ambulatory care) for the patient by 8% from 2003 to 2007. To achieve this BE apply a whole range of measures with both detailed expenditure budgeting, use of generic alternatives and regular decreases in the price of medicines older than 12 years. However, there are also Member States that introduce (or increase) the patients' co-payment share trying to reduce the consumption of pharmaceuticals (e.g. CZ). Such measures typically also include maximum co-payment limits to ensure that more vulnerable groups can still access the medicines needed (e.g. SI).

A peer review to exchange practical experiences and ideas about pricing and reimbursement of pharmaceuticals was held in Berlin mid 2008.[75] The peer review concluded that it is essential to promote the transparency of the pharmaceutical markets in the EU, especially on the efficacy and safety of the products, the prices actually paid by consumers and insurers, as well an on the price-setting, reimbursing and other regulatory mechanisms for pharmaceuticals. Future work within the OMC could aim to contribute significantly to the needed transparency.

Improving incentive mechanisms for patients

Some countries can contain costs by reducing the overuse of resources caused by a wrong mechanism design. This is done by implementing policies to motivate people to use healthcare services in a more responsibly manner as in CZ, where the introduction of regulatory fees is giving good financial results – after the introduction of the fees, the number of specialist outpatients visits, the length of hospitalisation and the use of pharmaceuticals were reduced – or in FR where the financial participation of patients in the form of co-payments was augmented in order to moderate demand. More innovative is the coordination of care, in order to avoid duplication, and the introduction of a financial incentive to increase the use of a GP as a gatekeeper. In case the patient does not use the GP and goes directly to the specialist, the patient will face reductions in the amount paid by the social insurance and the specialist would be allowed to surpass the established tariffs. ES will establish mechanisms to promote responsible demand.

Rationalising bureaucracy

To render the system more cost-effective, another type of measures aims at rationalising and simplifying bureaucracy. Thus in BE, DK, SE and FI there are administrative simplification policies, which intend to identify and eliminate needless bureaucracy in order to get more time to core activities. Many countries like BE, EL, ES, FR, LV, LT, MT and AT, are developing e-Health systems to integrate information files about patients, organize medicine

[75] See http://www.peer-review-social-inclusion.eu/peer-reviews/2008/cost-containment-in-the-pharmaceutical-sector-innovative-approaches-to-contracting-while-ensuring-fair-access-to-drugs

prescriptions, ensure a quicker examination of patients and assessment of the results, optimise therapeutic processes and increase quality, and avoid duplication.

Health promotion policies

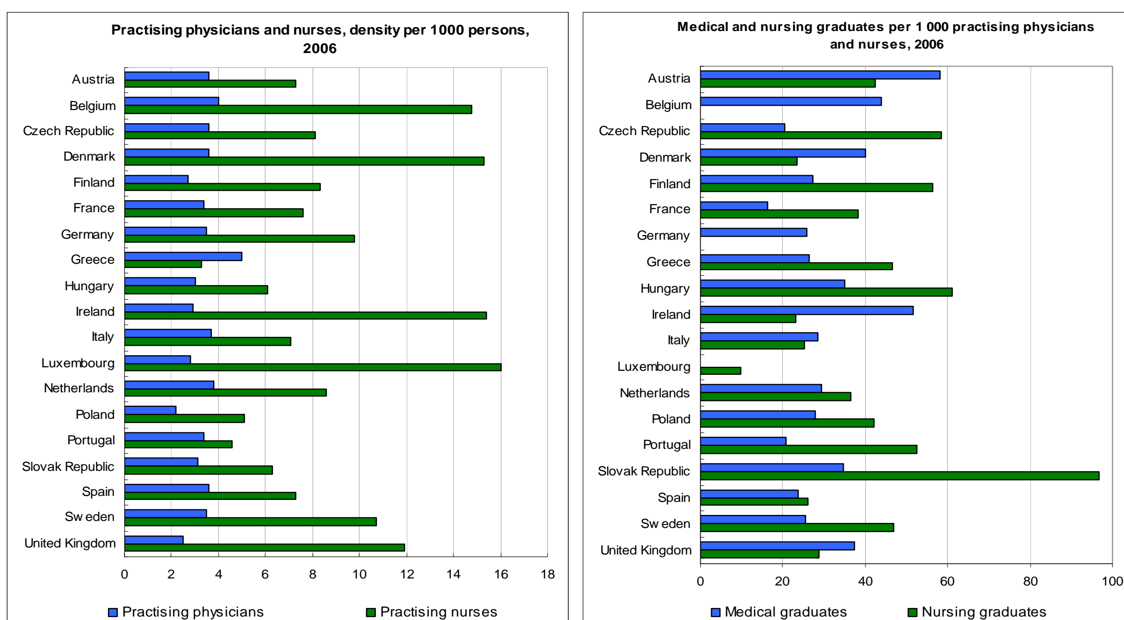
Many countries have recognised in their policies that better promotion will help to trim costs down in the future by reducing the need for healthcare services. Health promotion in early ages can result in a better health status later in life, requiring thus fewer resources from the healthcare system. Therefore, CZ, DK, DE, ES, LV, LU, MT, NL, AT, SE, and the UK will intensify the promotion of healthy lifestyles regarding better eating and exercise habits to improve the general health of the population. With the same objective, DE, EE, LV, LU, HU and the UK will pay particular attention to health promotion of children and young people and to the promotion of better food at schools and childcare institutions.

Furthermore, EE, NL, AT, RO, SE, and the UK will implement policies aimed at reducing the consumption of addictive substances, tobacco and alcohol, accompanied in some cases (AT and RO) by financial disincentives in the form of excise duties that will be assigned to health expenditure or (NL) by encouraging health insurance funds to promote healthy behaviour and reward it. Even if it may sometimes seem an exaggerated intervention of public policies in individual decisions, in general it is considered that prevention policies regarding smoking, alcohol and obesity are needed, as these lifestyle risks are increasing the number of the chronically ill. In the last years, many countries, as BE, DK, ES and the UK, have banned smoking from public spaces. Moreover, policies intended to raise awareness concerning the prevention of some specific diseases such as diabetes, obesity, cardiovascular diseases and several types of cancer are being implemented in CZ, DK, EE, IE, HU, NL and SE. DK has decidedly set up a Prevention Commission, which will study the possibilities of reducing the need for healthcare services in the future. There are also some country-specific policies: LU’s Action Plan will promote health in the area of sexual education, EE will improve the physical and psychosocial environment and the UK will implement a health improvement policy aimed to support people to make healthier lifestyle choices, particularly children and young people, adults of working age and those who are socially excluded or are "hard to reach".

Long-term sustainability of human resources

Over the next 20 years, the EU will face a serious challenge in the availability of human resources in the healthcare sector. This also casts doubts on its long-term sustainability. One reason for this development is to be found in the ageing of the population. This implies not only an increase in the needs for care in general, but also an increase in the age profile of the health workforce. A second reason is the underinvestment in education and training of professionals, which was seen in the late 80s and early 90s in some countries. The insufficient training of professionals was due to restrictions in the access to training in healthcare professions (numerus clausus). This trend is now reversed, but will not have any immediate effect. It shows both the difficulty of long-term planning the availability of human resources and the existence of trade-offs between financing more training and lacking doctors and healthcare workers. In other countries, even if training and education has been sufficient, the emigration of trained personnel has led to a serious drain of human resources. The healthcare sector in some countries also faces the dilemma that it needs people with high qualifications, but neither wages nor working conditions are especially attractive compared to other sectors. Keeping the wages of health workers low is also used to contain expenditure growth, so in some countries working conditions in the health professions do not motivate health workers to stay in the sector, but rather provoke an exodus to other sectors.

Figure 14: Medical and nursing graduates, practising physicians and nurses, 2006



Source: OECD, Health data 2008.

Hence, policies regarding human resources are articulated around a) granting more financial resources to the training of qualified doctors and nurses, b) organising work more efficiently, c) restructuring care between primary, outpatient, inpatient and long-term care, d) improving the structure of incentive mechanisms in order to motivate the health work force to stay in or to return to the profession and e) smoothing regional differences in the allocation of human resources.

CZ, IE, HU, MT, NL, FI, and the UK are granting more financial resources to the training of qualified doctors and nurses, improving the systems of training and re-training (including on-the-job training) and increasing the influx of new personnel focusing on young people, non-natives and people with low qualifications. The European Social Fund interventions in this field are targeted at developing human resources for the health sector (CZ, EL, LT, LV, PT, PL, HU, SK).

In DK, NL, SE and FI the main long-term challenge is to attract sufficient and qualified labour, so efforts aim at ensuring efficient work organisation and avoid needless bureaucracy to devote staff time mostly to core activities. They are making efforts to raise productivity introducing modern techniques, using IT more effectively and developing new care concepts, dropping inefficient and outdated administrative routines and thus reducing waiting times and costs. Also in order to attain a more effective utilisation of healthcare personnel, EE and SE are restructuring their systems by reinforcing primary care, making hospital care more efficient, e.g. by concentrating highly specialised care at national level, and modulating rehabilitation and nursing care in case of chronic illness.

Regarding incentive mechanisms, IE, ES, LT, HU, MT, NL and FI are all trying to improve the working and professional development conditions of health workers through a broad range of measures in order to restore the prestige of the professions and to get them to remain in or return to the profession. These measures involve the development of new systems for attaining and recognising qualifications in medical care (CZ and MT), better career prospects and on-the-job training that offer opportunities for learning and personal improvement, more competitive payroll systems and new salary conditions for young doctors, more decision

capacity in developing the content of work, management systems and the assignment of duties and last but not least offering the personnel more flexibility in general and, in particular, more flexible working hours.

Finally, some countries (BE, BG, FR, RO) show strong regional differences in the allocation of human resources and are trying to implement plans that will motivate young professionals to go to less attractive regions. Others, like LV and LT, face the challenge of emigration through a better planning of human resources.

5.5. Long-term care services

5.5.1 Introduction

Long-term care is often defined as a variety of health and social services provided for an ongoing or extended period to individuals who need assistance on a continuing basis due to physical or mental disability[76]. The definition of long-term care, the services and benefits provided and the population coverage vary between Member States.

Member States have continued in their quest for modernising social protection systems, particularly in light of ageing and the concerns over expanding expenditure. The growing demand for long-term care continues representing a major policy challenge for many countries as current supply is considered to be insufficient and inadequate to meet current and future long-term care needs. Recognition that there is no comprehensive system for the provision of long-term services in the EU is coupled with a firm commitment on the part of EU countries to ensure universal access to high quality and affordable long-term care.

2008 saw an impetus in the attempts to address the expanding long-term care needs of the population. The majority of Member States acknowledged that policy actions were necessary in order to secure adequate and sustainable funding structures for current and future long-term care (LTC) provision, particularly in light of demographic ageing and its consequences. The work carried out in cooperation with the Social Protection Committee within the framework of the social OMC resulted in the publication of a European Report on LTC in April 2008[77]. Following the submission of the 2006 national reports, the 2007 and 2008 Joint Reports on Social Protection and Social Inclusion identified several challenges that were assessed in the European Report. The 2008-2010 national reports are examined in relation to those challenges, focusing on four specific themes and stressing the progress since the last reporting round: the search for financial sustainability, care coordination practices, high level of quality in LTC services and the LTC workforce.

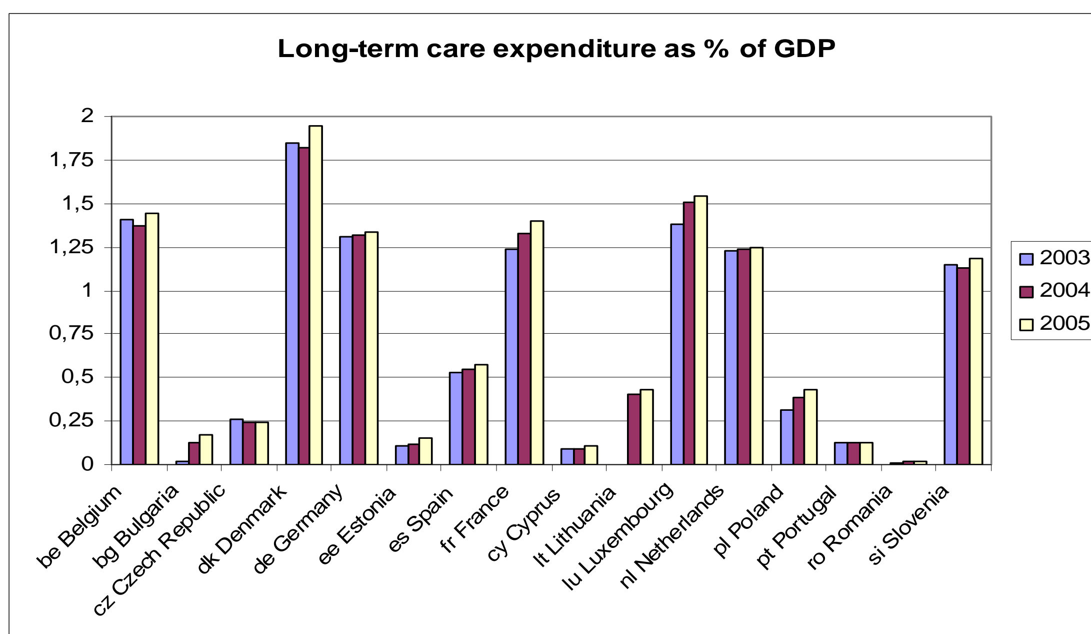
[76] OECD Observer 2007, Long-term care: a complex challenge.

[77] See http://ec.europa.eu/employment_social/spsi/docs/social_protection/ltc_final_2504_en.pdf

5.5.2. The search for financial sustainability

Long-term care funding and expenditure varies across the EU as shown in Figure 15, with an upward resource-allocation trend over time.

Figure 15: Long-term care expenditure as percentage of GDP, 2003-2005



Source: Eurostat Health expenditure data

Several Member States are concerned by the need to create a solid financing basis for long-term care and ensure the availability of devoted resources. Some established or are in the process of establishing dedicated universal social insurance schemes (DE, LU, NL, SI). Due to the important increase in expenditure spent through the LTC insurance and concerned by the future funding of the system, the NL are planning a reform that would reduce/ redefine the entitlements of the LTC insurance scheme and thus address the observed increase in spending and duplication with other policy fields such as social support and domestic care. Though improving financial sustainability, there are reports that local authorities may initially struggle with the role of buyers of services. Others address LTC via general taxation (AT, SE) or within a more restrictive social assistance framework, defining access and allocating resources through means or dependency testing (UK, CY, HU). Other countries intend to or have implemented a combination of healthcare insurance elements with tax funded social assistance mechanisms such as social care (FR).

Most Member States are concerned by the expected increases in demand for LTC services. Some intend to foster, via an increase in provision, the services provided (AT, FR, LT, BE, HU, DE) reinforcing the capacity of their systems to address the resulting multiplicity of health and social care needs. Others, wish to expand the range of provision through the establishment of new and amelioration/adaptation of existing services, responding to patients needs and reflecting their preferences in terms of locus of care (SK, LV, BG, MT, PT, LT, DE).

Independent of a country's public financial arrangements, private direct payments play an important role, with a differentiated impact on the devised systems' accessibility. Some countries envisage including the assets of dependent and elderly people in the calculation and aggregation of financial benefits with a targeting for vulnerable groups (FR, LT, SK). The 2008 National Reports point to a potential mix of public, private and third-sector provision (CY, EL). Private sources of finance refer to private health insurance coverage of LTC (often supplementary or for high income groups) and to private household payments (either co-payments for publicly provided care, and/or out-of-pocket payments for which very little or no reimbursement is offered).

High private costs impose a major financial burden on users and their relatives and act as a barrier to access, particularly for low-income groups, with private payments having a significantly regressive effect. Some countries have recourse to private health insurance in order to address the regressive incidence, with the introduction of supplementary insurance (FR). Policies to reduce the individual direct costs of care include amongst others: co-payment exemptions, means-tested co-payments capping (FR); extra financial aid/welfare benefits granted to the elderly dependent, disabled and chronically ill (FR); state coverage of LTC for low-income groups in a social assistance framework (FR, NL, CY, BE, HU, DE, SK, LV, RO); nationwide standardisation of copayments; state subsidies to use private services and coordination between the different benefits provided through the social welfare budget and the healthcare budget (FR, FI, DE).

Since demographic developments point to increasing longevity of the population, a serious challenge, or opportunity, in terms of public health is the prevention of ill-health in old age, i.e. delaying the onset of disability or dependence. Successful health promotion and disease prevention programmes can delay the onset of dependency/disability and could result in financial savings, which is a major concern for countries that aim to limit or curb long-term care expenditures (DK). Equally important is the degree of care coordination between different contingency-based social benefits, which can help in avoiding the duplication of support and care services provision, leading to a more rational use and allocation of resources.

5.5.3. Care Coordination and integrated long-term care provision

Several Member States emphasise their strategies to address often new and (re)emerging health threats such as chronic conditions (LT) and mental illnesses, with national action plans aimed at holistically addressing the needs of mentally affected patients (AT, BE, LV, LT, HU, BG, PT, MT). Equally related to the ageing of the population is the emerging health threat and necessity to address a growing number of patients affected by Alzheimer's disease, with countries proposing national plans (FR, AT, SK). Some countries focused on the provision of integrated geriatric and palliative care (LT, LU). Many Member States wish to promote rehabilitative care (PT, BE, CZ, EL, FI, FR, DE, LT) with a view to restoring patients' skills so that they regain maximum self-sufficiency in order to function in a normal or as near a normal manner as possible, also aimed at allowing, where possible, the patients' reintegration within the labour market (BE, DE).

Several countries have made significant steps towards increasing the public spending dedicated to home and/or community care (LV, CZ, HU, MT, DE) and develop homecare provision for particular target groups such as the elderly (LT, BG), patients affected by Alzheimer's disease (DE) and/or disabled persons (BG). Countries are firmly focused on enhancing tailored home and community care services (LT, HU) and moving away from institutional care, whilst allowing and/or securing institutional care access if alternatives are unsuiTable or unavailable (BE, FR, LV, HU, BG, DE, RO). Information and communication technology can enable better self-management of chronic conditions and can support carers in

their role (DK). The provision of home care services in conjunction with enhanced information and communication technology depends on resource availability (SK, LV) and the degree to which long-term care is provided in an integrated framework.

The uniform and tailored provision of long-term care services depends on the organisational features of each system and on the degree of coordination between the different services operating within these systems. Care coordination is mainly aimed at enabling a high level of quality and efficient use of resources in the provision of LTC services in an institutional or community setting (FR, DE); ensuring an adequate continuum of care irrespective of the different levels of long-term care provision and organisation (BE); and promoting a sustainable funding base streamlining the various related social benefits such as health insurance and social assistance benefits (FR, FI). Care coordination policies, particularly between different associated budgets, can help addressing differentiated provision modes and result in a more integrated financing structure clarifying entitlement rules for dependent persons and addressing the sustainability and adequacy of the provided social benefits. Equally important is the demarcated address of different contingencies that can become mutually reinforcing (disability, dependency and old-age).

Coordination problems in the interface between medical care, social services and informal care can result in negative outcomes for users and inefficient use of resources, with duplication of care provision or of financial and in-kind benefit provision. In some instances, care professionals, or dedicated teams are responsible for ensuring that patients can follow a coherent path of care with the appropriate treatment provided in the appropriate setting, with an integration of the various social benefits or insurance coverage (BE, DE, FR, FI). Long-term care is often associated with the notion of a 'care continuum' and an integrated care provision including elements of other public health policies such as preventive measures, active ageing, autonomy promotion and empowerment, social assistance, healthcare and palliative care. The care continuum approach is aimed towards the coordinated provision of a range of services (particularly homecare) on one hand and the bettered management of the transitions between services and settings. Several Member States encourage care coordination practices and integrated long-term care provision (FR, DE, MT, NL, and FI).

The uniform allocation of resources across administrative levels and loci of care can be sought on dependency profiles for example (BE, HU, NL). Since long-term care is usually provided in a devolved context and run by sub-national levels of government, national standards can ensure uniform provision and financing for all the regions of the country (ES, SE, UK, BG). Another mechanism relies on framework contracts and binding recommendations between long-term care insurers and providers (DE). The alignment of long-term care funding between health and social care components (HU, FR, BE) are also aimed at a care continuum provision. When resources are lacking, in addition to the integration between health and social care budgets, several countries are engaging with the private and voluntary sectors of the economy (HU, LV, LT, EL, CY). The integration of long-term care delivery involves creating single entry points or local assessment teams (NL, PT, UK, DK, DE) on one hand and the devolution of long-term care services at sub-national level (ES, PT, SE, UK), for a bettered management, on the other. Several countries are encountering financial complications as the sought decentralisation in the provision of services is not backed by a solid funding basis for the local, devolved or decentralised responsible level (LT, SK, BG, RO).

5.5.4. High level of quality in long-term care services

The quality of long-term care services for dependent persons varies widely both between and within countries. Many Member States have introduced or improved regulation and legislation for assessing and enhancing the quality of long-term care services. The increasingly pervasive and all-encompassing nature of long-term care services renders quality definition and measurement a complex task. Indicators of the quality of care are used in some countries to assess and evaluate the quality of the services provided in both institutional and community settings (BE). Quality regulations for long-term care are evolving from basic or minimum requirements for the structure and process of care into more comprehensive and complex quality assurance mechanisms combining procedural, structural and outcome oriented indicators such as continuous staff training requirements (BE, LT) coupled with patient rights mechanisms allowing greater patient participation and consultation (DK, HU, and MT). Inevitably, they refer to formal long-term care services rather than informal provision, which is much more difficult to measure and evaluate.

For some countries with devolved responsibility for LTC provision at municipal or local level, quality in LTC services is mainly assessed through formal regulatory and licensing mechanisms, determining the scope and accreditation processes of the services provided (SK, LT, DE, RO). Others focus on the establishment of national quality standards (CZ, ES, HU, LT, MT, RO) throughout the concerned territories. The use of outcome indicators for quality monitoring still remains in its infancy and different modes of quality assurance coexist such as internal (DE) or external quality assurance mechanisms and national inspectorates (FR, UK) with varying sanctioning capacities. Accessibility of internal and external auditing results to service users and the general public also has been taken up as an important measure of quality control (DE). Quality of care and its evaluation are increasingly viewed as encompassing other important factors such as the support given to family caregivers (DE), increasing consumer choice through the promotion of consumer-directed care (BE), ensuring the capacity of the long-term care workforce and assistive technologies. Examples of poor or inadequate care quality in both institutional and community settings include: inadequate housing (nursing homes), lack of privacy, poor social relationships and use of restraints, amongst others. One basic requirement for quality assurance, of particular relevance to long-term care, is also the active deterrence of patient maltreatment or abuse (SK, LT, RO), particularly in the institutional setting.

5.5.5. Workforce shortages

Most countries have expressed concerns with regard to expected staff shortages in the LTC sector (LT, SK, LV, NL, DK). The availability of carers and their competence and skill specialisation are inseparable concerns (SI). LTC needs have traditionally been met within the private sphere or the extended network of families. In a home or community care setting, the problem of insufficient and inadequately trained caregivers is more difficult to tackle than in institutional settings, even if formal home or community care tends to be cheaper than acute institutional care. The support of relatives (as care providers) and volunteers is and will remain an indispensable part of LTC provision. It is important to ensure that family or informal caregivers receive adequate training, guidance and support (DE, LV, RO). Supply shortages in the homecare sector cannot be viewed in isolation, but are related to the labour situation in other care settings.

Recognition that the bulk of long-term care is provided within informal settings has prompted national concerns regarding the availability and role of informal carers. While informal home care is not included in cost calculations, the lack of support of informal carers does not entail that it is a budget-neutral option for society. Informal carers are often relied upon heavily without necessarily receiving compensation, whilst foregoing employment. The expected

increase in the demand for LTC services translates into an expected increase in demand for formal LTC services since the number of working age women able to provide informal care will decrease at a time when the number of elderly dependent people is increasing; the increased labour market participation of women means less time at their disposal to devote to providing care and the changing family structures such as smaller families and an increase in the prevalence of single-parent families, mean that family members are further apart and less able to care for dependent family members in an informal, unsupported setting.

In both the institutional and home care settings, the main concern is recruiting and retaining an adequately qualified and skilled workforce. In an institutional setting, developments in medical and assistive technologies necessitate an upgrading of workforce skills and qualifications as well as measures to ensure their retention in the LTC sector, with reports of difficult working conditions and low pay levels (EL, DK). The earmarking of specific funds to upgrade working conditions and training (DK) is all the more difficult in light of existing budgetary constraints and several countries intend complementing the devoted resources with Structural Fund support (BG). The increased recourse to cost-sharing mechanisms coupled with limited financial resources dedicated to LTC and coordination problems between competing budgets, inevitably limit the possibilities for upgrading working conditions and raising pay for the staff formally employed in the sector.

Several measures are proposed in order to support informal carers. These measures depend in turn, on the organisational, administrative and funding mechanisms prevalent in each country. A overview of measures can be found in the following list: in-kind benefits (DE); financial benefits such as care allowances dedicated to paying the informal carers (HU, BG, AT, DE, RO) and to provide some additional financial support to the person in need (FR), amongst others; respite care services to allow time-off and maintenance of employment activities for informal carers (UK, MT, AT, DE); counselling and training services (MT, DE) and informal carers' needs-assessment and social security inclusion and formalisation measures for the informal carers (BG, DE).

5.6. Conclusions

As mentioned, the 2008-2010 NSRs build on the previous 2006 NSRs and national health, inclusion and/or social protection plans. They tend to focus on some more specific topics that are seen as priorities or on the most recent policies. The fact that reforms often require the approval and implementation of legislation, which are often lengthy processes, may partly explain the similarities between the 2006 and the 2008 NSRs. As in the 2007 Joint Report, the 2008 NSRs show the strong interlinks between improving access, enhancing quality and ensuring sustainability in a number of policies. Moreover, all Member States recognise that social protection including healthcare can have a significant impact in improving health and reducing poverty.

In assessing the 2008-2010 NSRs a number of issues can be raised.

While important efforts have been made to ensure universal care coverage, some gaps can still be identified in a number of Member States. In some countries private expenditure (direct payments for care) is large and in all countries some types of care (dental, aural, ophthalmic, residential care) are not covered by the public basket of health or social care. In addition, large differences in the availability and quality of healthcare and long-term care services can be observed. This suggests that barriers to access still remain that need addressing.

As said, for all countries primary care is seen as the way forward to address geographic disparities and improve access, as a vehicle for promotion and prevention, as the basis for better care coordination, and as a means to ensure a rational use of resources in the sector and obtain greater value for money. However, in many countries the shortages in GPs/ primary care doctors are structural i.e. they have been going on for a long time and appear to continue. Ageing may render them even more acute. Therefore, it is difficult to see how the ambition expressed in the reports of having primary care close to residence of all individuals and reducing regional disparities may be met without a proper primary care policy that encompasses more training and motivation of GPs (competences and remuneration related to additional competences on health promotion, disease prevention and care coordination and if are to go to deprived areas). Additionally, there is a widespread consensus of the need to address the expected workforce shortages in the long-term care sector (formal care) as well as devising ways to support family or informal carers. Adequately recruiting, (re)training, and retaining long-term care workers remains a challenge. Again, measures proposed relate to training and motivation (higher wages and better working conditions), and the formalisation, where possible, of informal carers into social security schemes. The looming/ current staff shortages may remain a challenge for years to come as even training (which is proposed by some countries in their attempt to address the ageing consequences on healthcare staff) requires time to bear fruit. Finally, several countries are currently advertising for doctors and nursing staff in nearby countries while some are experiencing massive brain-drain of care staff. This suggests that more responsibility is needed in recruiting staff and that there may be place for improved exchange of information and coordination between Member States regarding staff policies.

Another issue is technology and more specifically e-health. Virtually all countries propose a package of e-health measures to improve access, quality and sustainability. While this may be the case, they require important sums of investment (informatisation of the system, e-prescription, e-booking) and, importantly, they require that technology is compatible across all facilities in the sector, if technology is to bring about better care coordination. Moreover, despite claims that technology may improve access, some of the measures (internet-based measures) may actually create a gap, as those more vulnerable are also likely to be those more computer illiterate or have fewer means to access computers and internet.

The 2008-2010 NSRs show a growing awareness of the need to ensure healthcare and long-term care quality and present different initiatives aimed at providing their citizens with good quality and safe preventive and curative healthcare as well as long-term care services. However, quality is being addressed to varying degrees from one country to another. The 2008 NSRs reflect the lack of consensus across Europe about the definition and perimeter of quality of care. While investing in health promotion, disease prevention and primary care does not appeared to be controversial and Member States continue developing related strategies – though some more successfully than others given their available resources, existing care delivery structures and primary care attractiveness in each country –, huge disparities are observed regarding patient centeredness and patient safety.

While patient centeredness is often declared as an important issue, only a few concrete examples of action are provided. Some Member States are advanced in their efforts to ensure that the patient act as an actor in their healthcare systems, in others awareness of the issue is growing, and others are still at the beginning of their reflection process in this area. Patient safety is addressed in a very advanced way in several reports, but not even mentioned in others. Some of these disparities may be explained by the limited resources allocated to healthcare in some Member States and the need to address other more urgent issues. Patient safety strategies, for example, require a considerable initial investment, with long-term

expected results. Member States may therefore choose allocating their limited resources to other areas of healthcare which are supposed to bring immediate improvement of health indicators of the population (for example the emergency care system). Hence, enhancing quality of care and notably patient safety remains a significant challenge for healthcare, while quality of facilities, care coordination and the need for qualified carers are important issues in the context of long-term care. Growing interest is placed on prevention and management of chronic diseases, which are addressed through targeted health promotion actions, clinical guidelines and financial encouragement of doctors to provide better quality care for patients presenting chronic conditions. Finally, a number of indicators exist and are used with regard to quality of care, but available data do not, however, enable solid international comparisons about care quality in European countries. Further effort is needed to develop common terminology and gather comparable data on different aspects of quality at European level.

The NSRs also show that several Member States have been going down the avenue of privatisation and decentralisation as a way to improve access, quality and especially efficiency of the health system. However, it is important to note that these should be treated as means to an end and not a goal in itself or a decision taken on the basis of political whims. It is important to assess whether it is possible to achieve efficiency gains by privatisation and decentralisation in each national context. In general, it is necessary to consider if there is the institutional capacity to monitor and regulate private practice, to ensure risk equalisation and quality standards, to identify what the private and what the public can do better, or to induce the geographic location of private entities in order to tackle geographic disparities. Whether private entities promote quality and efficiency depends on the number of entities and the incentives they face notably the nature of contracts established in the market. The experience with decentralisation in some Member States is a mixed one, resulting in variations in supply and quality of care which have lead these countries to rethink their resource allocation mechanisms and establish nationwide norms and guidelines. Some countries that have a large private provision report duplication of care and waste of resources and thus the need to coordinate private and public provision. Hence, a number of issues must be taken into account when going down the avenue of more private insurance, private provision and decentralisation of provision.

All countries have cost-sharing schemes in place, complemented with exemptions. In some countries these have increased and have led to a reduction in care utilisation while in others they do not appear to have much effect on patient behaviour as they are covered by insurance. It is also not always clear whether there is a coherent logic behind their design i.e. are they inducing preferred pathways of care? Are they based on what is cost-effective? More monitoring is needed to ensure they achieve maximum efficiency gains while minimising the impact on necessary care utilisation by vulnerable groups.

Another interesting trade-off relates to increased patient choice. While a large number of countries see increased patient choice as a dimension of patient centeredness, it is not acknowledged how greater choice impacts on the goal of increasing system efficiency. Several countries claim they will increase patient choice but at the same time refer to the establishment of selective contracting between insurers and providers as a means to encourage efficiency. This would mean that what countries refer to as choice is additional choice within a preferred care framework. From the point of view of efficiency this is logical as evidence suggests that free choice is related to increased costs of care.

Member States are looking at various mechanisms to address the expected increase in demand for long-term care services in light of the demographic ageing and the prevalence of disability and dependency, particularly in old age. In their quest for a sound financial footing for the long-term care sector, Member States are fostering and upgrading existing services and establishing new ones, on one hand, whilst developing sound financial mechanisms to cover the multiple contingencies, on the other. Secure long-term care financing is still to be achieved in many countries and changes to financing mechanisms are required, with several countries engaging in reforms. Care coordination is seen as crucial in enabling a high level of quality and efficient use of resources in the provision of long-term care services and thus ensuring an adequate continuum of care. It also encompasses the search for coordination of budgets and thus sustainability of long-term care systems.

Ageing is seen as an important challenge as it leads to multi-morbidity and increased disability and dependence if increased life expectancy is not accompanied by healthier lives. Hence, the intensification of health promotion and disease prevention in all Member States, seen as crucial means to improve health at all ages, thus increasing quality of life while reducing the demand and costs of healthcare and long-term care. Several countries expect successful health promotion and disease prevention programmes to delay the onset of dependency/disability and eventually result in financial savings. In this context, there may be room for more effective and targeted health promotion actions. Interestingly, though, while all countries put a stronger emphasis on promotion and prevention, curative care, notably hospital care, engulfs the largest part of the expenditure and a large number of countries are still directing extra funds towards the hospital sector. Hence, the expenditure share allocated to promotion and prevention may be too small in relation to the goals they are to achieve.

Ageing is also seen as a window of opportunity to use in relation to older employees, immigrants, people with disabilities and socially disadvantaged and the young and contribute to attaining the Lisbon objectives, if these groups are provided with relevant training. On the other hand, it may mean that countries need to be more innovative and improve the use of technology and methods of work as well as working with third sector to try and reach those in more remote and disadvantaged areas or at risk groups when in the presence of staff shortages.

A final number of issues are worth mentioning. Firstly, as mentioned in the introduction, health is seen as goal in itself but also as a means to ensure employment and economic development, while the result of a set of social and economic factors. This holistic approach is translated in some countries by a broader consultation with various sectors, with NGOs on social welfare and health, and with local and regional authorities. It is, however, not necessarily clear how the consultation was taken into consideration in the report. Some of the reports were prepared in joint collaboration by more than one ministry. More multi-sector cooperation is necessary to ensure greater coherence between economic, education, employment, environment and social policy including health and housing policies if we are to ensure a high level of health protection in all policies.

Secondly, only a handful of countries report using the European Structural Funds in the field of health, even if health is a priority for the 2007-2010 funding programme. This may reflect general lack of awareness of the possibility to use structural funds for developing health promotion, address geographical gaps in infrastructure, or increased staff training. At the same time, some argue that more technical support and monitoring of the investment is needed.

Finally, some countries show a departure from previous reforms. While this may be expected in the field of healthcare due to a continuous change of treatment practices and staff qualifications, in some cases new reform choices are political in nature and their design is not necessarily thought through. Ensuring a rationale for reforms and avoid leaving health systems in a limbo is also an important responsibility of policy makers.

6. ANNEX: INDICATORS

6.1. Definition of the 14 overarching indicators

1a. At-risk-of-poverty rate: Share of persons aged 0+ with an equivalised disposable income below 60% of the national equivalised median income[78]. Source: SILC.

+ **Illustrative threshold value:** Value of the at-risk-of-poverty threshold (60% median national equivalised income) in PPS for an illustrative household type (e.g. single person household). Source: SILC.

1b. Relative median poverty risk gap: Difference between the median equivalised income of persons aged 0+ below the at-risk-of poverty threshold and the threshold itself, expressed as a percentage of the at-risk-of-poverty threshold. Source: SILC.

2. S80/S20: Ratio of total income received by the 20% of the country's population with the highest income (top quintile) to that received by the 20% of the country's population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income. Source: SILC.

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

4. Early school-leavers: Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training is 0, 1 or 2 according to the 1997 International Standard Classification of Education — ISCED 97) and have not received education or training in the four weeks preceding the survey. Source: LFS.

5. People living in jobless households: Proportion of people living in jobless households, expressed as a share of all people in the same age group[79]. This indicator should be analysed in the light of context indicator No 8: jobless households by main household types. Source: LFS.

6. Projected total public social expenditure: Age-related projections of total public social expenditure (e.g. pensions, healthcare, long-term care, education and unemployment transfers), current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-20-30-40-50).
Specific assumptions agreed in the AWG/EPC. See 'The 2005 EPC projections of age-related expenditures (2004-2050) for EU-25: underlying assumptions and projection methodologies' Source: EPC/AWG.

7a. Median relative income of elderly people: Median equivalised income of people aged 65+ as a ratio of income of people aged 0-64. Source: EU-SILC.

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78 **Equivalised median income** is defined as the household's total disposable income divided by its 'equivalent size', to take account of the size and composition of the household, and is attributed to each household member (including children). Equivalisation is on the basis of the OECD modified scale.

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

7b. Aggregate replacement ratio: Median individual pensions of 65-74 year-olds relative to median individual earnings of 50-59 year-olds, excluding other social benefits. Source: EU-SILC.

8. Self-reported unmet need for medical care: Total self-reported unmet need for medical care for the following three reasons: financial barriers + waiting times + too far to travel.

+ **Care utilisation:** To be analysed together with care utilisation defined as the number of visits to a doctor (GP or specialist) during the last 12 months. Source: EU-SILC.

9. At-risk-of-poverty rate anchored at a fixed moment in time (2005): Share of persons aged 0+ with an equivalised disposable income below the at-risk-of-poverty threshold calculated in the year 2005 (1st EU-SILC income reference year for all 25 EU countries), adjusted for inflation over the years. Source: SILC.

10. Employment rate of older workers: Persons in employment in the 55–59 and 60–64 age groups as a proportion of the total population in the same age group. Source: LFS.

11. In-work poverty risk: Individuals who are classified as employed[80] (distinguishing between 'wage and salary employment plus self-employment' and 'wage and salary employment' only) and who are at risk of poverty.

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

12. Activity rate: Share of employed and unemployed people in the total population of working age, 15-64. Source: LFS.

13. Regional disparities — coefficient of variation of employment rates: Standard deviation[81] of regional employment rates divided by the weighted national average (15-64 age group). (NUTS II). Source: LFS.

14. Total health expenditure per capita: Total health expenditure per capita in PPP. Source: EUROSTAT based on system of health accounts (SHA) data.

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[80] Individuals classified as employed according to most frequent activity status. The most frequent activity status is defined as the status that individuals declare having for more than half the number of months in the calendar year.

[81] Standard deviation measures how, on average, the situation in regions differs from the national average. As a complement to the indicator, a graph showing max/min/average per country is presented

Possible alternative measures:

Regional disparities — underperforming regions. *Source LFS*

1. Share of underperforming regions in terms of employment and unemployment (in relation to all regions and to the working age population/labour force) (NUTS II).

2. Differential between average employment/unemployment in underperforming regions and the national average for employment/unemployment (NUTS II). Thresholds to be applied: 90% and 150% of the national average rates for employment and unemployment, respectively. (An extra column with the national employment and unemployment rates would be included).

6.2. Data sources

Indicators of income and living conditions: EU-SILC

For the first time this year, EU-SILC data are available for 25 EU countries. The newly implemented reference source of statistics on income and social exclusion is the Framework Regulation (No 1177/2003) for the European Survey on Income and Living Conditions (EU-SILC). The technical aspects of this instrument are developed by Commission implementing regulations, which are published in the Official Journal. The data for Bulgaria and Romania are still based on the national household budget surveys under the transitional arrangements agreed for the European Statistical System[82].

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

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

It should also be noted that the definition currently used for income excludes non-monetary income components, which include the value of goods produced for own consumption[83] and non-cash employee income. This component will be available for all countries from the SILC (2007) exercise onwards, and will therefore be included in the indicators to be published in January 2009.

The reference year for the data is the year to which the income information refers (i.e. the 'income year'), which in most cases differs from the survey year in which the data were collected. Accordingly, 2006 data refer to the income situation of the population in 2005, even if the information was collected in 2006. EU aggregates are computed as population-weighted averages of available national values.

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

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

Note on trends

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

Limitations

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

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

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

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

Confidence intervals

Indicators are estimated values based on a sample drawn from the target population and thus are affected by sampling error. Statistical theory provides us with tools for calculating confidence intervals in which the population value lies with a high probability. The confidence intervals are centred around the estimated values reported and their length is a measure of the precision of these estimates. The precision depends on the design of the survey and can thus vary between countries. However, the EU-SILC Regulation provides for national samples to be designed so as to achieve a confidence interval of +/-1% around the estimated value of the total at-risk-of-poverty rate. Eurostat is computing these intervals for a number of indicators and exact values will be reported in EU quality reports. First computations show that the confidence intervals around the total at-risk-of-poverty rate are of the order of +/-0.8%. For the S80/S20 income quintile share ratio, the confidence intervals are of the order of +/-0.2. For the relative median at-risk-of-poverty gap, they are of the order of +/-1.7. For the Gini coefficient, they are of the order of +/-0.9. These indications of precision must be taken into account when interpreting the data.

LFS: the European Union Labour Force Survey

The European Union Labour Force Survey (LFS) is the EU's harmonised survey on labour market developments. The survey has been carried out since 1983 in the EU Members States, with some states providing quarterly results from a continuous labour force survey, and others conducting a single annual survey in the spring. From 2005, all EU Member States have conducted a quarterly survey. If not mentioned otherwise, the results based on the LFS refer to surveys conducted in the spring ('second quarter' in all countries except for France and Austria, which is 'first quarter') of each year. It also provides data for Bulgaria, Croatia and Romania.

The Annual Averages of Labour Force Data series is a harmonised, consistent series of annual averages of quarterly results on employment statistics based on the LFS, completed through estimates when quarterly data are not available. It covers all the EU-15 (for the period from 1991 to present) and all new Member States and Candidate Countries (since 1996 or later, depending on data availability) except the Former Yugoslav Republic of Macedonia. The Annual Averages of Labour Force Data consist of two series: 1) population, employment and unemployment, and 2) employment by economic activity and employment status. The first series is based mainly on the EU LFS. Data covers the population living in private households only (collective households are excluded) and refers to the place of residence (household residence concept). They are broken down by gender and aggregate age group (15–24, 25–54, 55–64 and 15–64). Unemployment data is also broken down by job search duration (less than 6 months, 6–11, 12–23, 24 months or more). The second series is based on the ESA 1995 national accounts employment data. Data covers all people employed in resident producer units (domestic concept), including people living in collective households. They are broken down by sex, working-time status (full-time/part-time) and contract status (permanent/temporary) using LFS distributions. All key employment indicators presented in this document are based on the Annual Averages of Labour Force Data series. They represent yearly averages unless stated otherwise. Where the Annual Averages of Labour Force Data series does not provide the relevant breakdowns, the original LFS data has been used for this report.

Age-related expenditure projections

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

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

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

Pension expenditure

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

Replacement rates

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

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

Healthcare expenditure — WHO Health for All database (www.who.int\nha)

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

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

6.3. Statistical tables

1a. At-risk-of-poverty rate by age and gender, 2007

		EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
Total population	Total	16ps	16p	15	14i	10	12	13p	15p	19	18	20	20	13	20	16	21	19	14	12	14	10	12	17	18	19p	12	11	13	11	19
	Men	15ps	15p	14	12i	9	11	13p	14p	17	16	20	19	12	18	14	19	17	13	12	14	10	11	18	17	18p	10	10	12	11	18
	Women	17ps	17p	16	16i	10	12	13p	16p	22	19	21	21	14	21	17	23	21	14	12	15	11	13	17	19	19p	13	11	14	11	20
Children aged 0-17	Total	19ps	19p	17	16i	16	10	12p	14p	18	19	23	24	16	25	12	21	22	20	19	19	14	15	24	21	25p	11	17	11	12	23
People aged 18-64	Total	15ps	15p	13	12i	8	11	13p	15p	16	15	19	16	12	18	10	18	16	13	12	12	9	11	17	15	17p	10	9	11	10	15
	Men	14ps	14p	12	12i	8	11	13p	14p	15	14	18	15	11	16	8	18	15	12	11	10	8	9	18	14	17p	10	9	12	11	14
	Women	15ps	15p	13	12i	9	11	13p	16p	17	16	19	17	13	19	12	19	16	13	12	14	10	12	17	16	16p	10	10	11	10	16
People aged 65+	Total	19ps	19p	23	18i	5	18	14p	17p	33	29	23	28	13	22	51	33	30	7	6	21	10	14	8	26	19p	19	8	22	11	30
	Men	16ps	17p	21	9i	2	16	12p	14p	21	24	21	26	12	18	47	21	15	7	3	24	9	10	6	24	13p	11	3	18	7	27
	Women	22ps	21p	25	24i	8	19	16p	20p	39	33	25	30	14	25	54	39	37	8	8	18	11	18	9	27	22p	25	11	24	14	32

1a. At-risk-of-poverty threshold (illustrative values), EUR and PPS, 2007

	EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
EUR '- One-person household	:	8368s	10538	:i	3251	14004	15002,73	10624p	2668	13291	6120	7203	9938	9003	9590	2010	1966	17929	2361	5475b	10924	10945	2101	4544	90p	5944b	2382	11222	11132	12572
'- Two adults with two dep. ch	:	17573s	22129	:i	6828	29409	31505,91	22310p	5603	27911	12852	15127	20870	18907	20140	4222	4128	37650	4959	11498b	22941	22985	4413	9542	140p	12482b	5003	23565	23378	26402
PPS '- One-person household	:	:	10035	:i	5348	10175	10819p	10403p	4059	10706	6946	7807	9363	8748	6298	3356	3512	17575	3979	7543b	10631	10933	3422	5360	189p	7979b	4133	9321	9581	11366
'- Two adults with two dep. ch	:	:	21075	:i	11231	21367	22720p	21846p	8524	22483	14588	16394	19661	18371	13226	7049	7376	36908	8355	15841b	22325	22960	7187	11255	295p	16756b	8678	19573	20120	23868

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); (1) BG HBS 2006, income data 2006and RO National HBS 2007, income data 2007; (2) with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

1b. Relative median at-risk-of-poverty gap by age and gender, 2007

		EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
Total population	Total	22ps	22	18	17i	18	17	18p	24p	20p	18p	26p	24	17p	22	20	25	26	19	20	17	17p	17	24	24	23p	19	19	14	20	23
	Men	23ps	23	19	18i	19	19	20p	25p	24p	18p	26p	24	17p	24	18	27	28	19	21	17	18p	19	25	24	23p	19	22	15	22	23
	Women	21ps	21	17	17i	17	16	17p	23p	19p	17p	26p	24	16p	22	21	24	23	19	19	18	17p	16	23	24	24p	20	17	14	18	23
Children aged 0-17	Total	22ps	22	18	22i	19	21	16p	21p	26p	19p	29p	25	15p	25	16	28	30	20	19	16	18p	19	26	26	26p	21	21	12	17	22
People aged 18-64	Total	24ps	24	21	18i	19	24	24p	26p	26p	20p	26p	27	17p	25	18	30	29	20	21	19	18p	21	25	27	23p	19	20	17	24	25
	Men	25ps	25	22	19i	21	24	25p	28p	29p	20p	25p	27	18p	25	17	32	30	20	21	17	22p	23	25	27	23p	20	22	18	26	26
	Women	23ps	23	20	18i	19	22	23p	24p	23p	20p	26p	27	17p	25	19	28	28	19	21	20	18p	20	24	27	23p	19	19	16	22	24
People aged 65+	Total	19ps	19	15	14i	7	9	7p	19p	14p	10p	24p	21	19p	19	23	19	15	9	13	17	10p	12	14	19	19p	20	12	10	11	20
	Men	18ps	18	17	8i	14	7	8p	19p	14p	10p	24p	21	19p	17	21	12	12	8	10	17	9p	12	15	14	17p	15	19	10	11	18
	Women	19ps	19	14	16i	7	9	7p	19p	14p	10p	24p	20	19p	20	24	19	16	12	15	16	11p	12	14	22	20p	20	11	10	12	21

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); (1) BG HBS 2007, income data 2007 and RO National HBS 2006, income data 2006; (2) with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

2. Inequality of income distribution: S80/S20 income quintile share ratio

		EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
S80/S20	Total	4.8ps	4.8p	3.9	3.5i	3.5	3.7	3.6p	5p	5.5p	4.8p	6p	5.3	3.8p	5.5	4.5	6.3	5.9	4	3.7	3.8	4p	3.8	5.3	6.5p	5.3p	3.3	3.5	3.7	3.4	5.5

Source: SILC 2007, Income data 2006; except for UK, income year 2006 and for IE moving income reference period (2005-2006); (1) BG and RO National HBS 2006, income data 2006; (2) with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

3. Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2005

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
life expectancy at birth - males	**eu27**	:	:	:	:	:	:	:	74,5	74,6	75,2	:
life expectancy at 45 - males	**eu27**	**:**	**:**	**:**	**:**	:	:	:	31,9	31,9	32,5	:
life expectancy at 65 - males	**eu27**	:	:	:	:	:	:	:	15,9	15,9	16,4	:
life expectancy at birth - females	**eu27**	:	:	:	:	:	:	:	80,9	80,8	81,5	:
life expectancy at 45 - females	**eu27**	:	:	:	:	:	:	:	37,2	37,2	37,7	:
life expectancy at 65 - females	**eu27**	:	:	:	:	:	:	:	19,5	19,4	19,9	:
life expectancy at birth - males	**eu25**	72,8	73,2	73,5	73,5	73,8	74,4	74,7	75	75,1	75,7	75,8
life expectancy at 45 - males	**eu25**	**:**	**:**	**:**	**:**	:	31,8	32,1	32,3	32,3	32,8	:
life expectancy at 65 - males	**eu25**	:	:	:	:	:	15,7	15,9	16,1	16,1	16,6	:
life expectancy at birth - females	**eu25**	79,7	79,9	80,2	80,2	80,4	80,8	81,1	81,3	81,2	81,9	81,9
life expectancy at 45 - females	**eu25**	:	:	:	:	:	37,2	37,4	37,6	37,5	38,1	:
life expectancy at 65 - females	**eu25**	:	:	:	:	:	19,4	19,6	19,7	19,6	20,2	:
life expectancy at birth - males	**eu15**	73,9	74,2	74,6	74,6	74,9	75,4	75,7	75,9	76	76,8	:
life expectancy at 45 - males	**eu15**	31,5	31,7	32	:	:	32,6	32,9	33	33,1	33,7	:
life expectancy at 65 - males	**eu15**	15,3	15,4	15,6	:	:	16,1	16,3	16,4	16,4	17,1	:
Disability free life expectancy at birth - males	**eu15**	:	:	:	:	63.2 e	63.5 e	63.6 e	64.3 e	64.5 e	:	:
life expectancy at birth - females	**eu15**	80,4	80,6	80,9	80,9	81,1	81,4	81,7	81,7	81,7	82,8	:
life expectancy at 45 - females	**eu15**	36,9	37,1	37,3	:	:	37,7	37,9	38	38	38,9	:
life expectancy at 65 - females	**eu15**	19,1	19,2	19,4	:	:	19,7	20	20	20	20,8	:
Disability free life expectancy at birth - females	**eu15**	:	:	:	:	63.9 e	64.4 e	65.0 e	65.8 e	66.0 e	:	:

Source: Eurostat - Demography; e: estimate

Disability free Life expectancy (+ Life expectancy at 0, 45, 65) 1995-2006

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**BE**	73,5	73,9	74,2	74,4	74,4	74,6	75	75,1	75,3	76	76,2	76,6
Life expectancy at 45 - males	**BE**	31,1	31,4	31,6	31,7	31,8	32	32,3	32,3	32,5	33	33,1	33,6
Life expectancy at 65 - males	**BE**	14,8	15	15,2	15,3	15,5	15,6	15,9	15,8	15,9	16,4	16,6	17
Healthy Life Years at birth - males	**BE**	63,3	64,1	66,5	63,3	66	65,7	66,6	66.9 (e)	67.4 (e)	58.4 (b)	61,7	62,8
Life expectancy at birth - females	**BE**	80,4	80,7	80,7	80,7	81	81	81,2	81,2	81,1	81,8	81,9	82,3
Life expectancy at 45 - females	**BE**	37	37,2	37,2	37,2	37,4	37,5	37,7	37,5	37,3	38	38	38,5
Life expectancy at 65 - females	**BE**	19,3	19,4	19,5	19,6	19,6	19,7	19,9	19,7	19,6	20,2	20,2	20,6
Healthy Life Years at birth - females	**BE**	66,4	68.5 (e)	68,3	65.4 (e)	68,4	69,1	68,8	69.0 (e)	69.2 (e)	58.1 (b)	61,9	62,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**BG**	67,4	67,4	67	67,4	68,2	68,4	68,6	68,8	68,9	68,9	69	69,2
Life expectancy at 45 - males	**BG**	26,6	26,6	26,3	26,4	27,2	27	27,2	27,3	27,3	27,3	27,2	27,3
Life expectancy at 65 - males	**BG**	12,7	12,5	12,3	12,5	12,9	12,7	13	13	13	13	13,1	13,2
Healthy Life Years at birth - males	**BG**	:	:	:	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**BG**	74,9	74,5	73,8	74,6	75	75	75,4	75,5	75,9	75,8	76,2	76,3
Life expectancy at 45 - females	**BG**	32,4	32,2	31,7	32,2	32,5	32,4	32,8	32,9	33,1	33	33,3	33,5
Life expectancy at 65 - females	**BG**	15,3	15	14,7	15	15,4	15,3	15,6	15,7	15,8	15,8	16,1	16,3
Healthy Life Years at birth - females	**BG**	:	:	:	:	:	:	:	:	:	:	:	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**CZ**	69,7	70,4	70,5	71,2	71,5	71,7	72,1	72,1	72	72,6	72,9	73,5
Life expectancy at 45 - males	**CZ**	27,6	27,9	28,1	28,6	28,8	29	29,3	29,3	29,2	29,7	29,9	30,4
Life expectancy at 65 - males	**CZ**	12,7	13,1	13,2	13,5	13,7	13,8	14	13,9	13,8	14,2	14,4	14,8
Healthy Life Years at birth - males	**CZ**	:	:	:	:	:	:	:	62.8 (p)	:	:	57.9 (b)	57,8
Life expectancy at birth - females	**CZ**	76,8	77,5	77,6	78,2	78,3	78,5	78,6	78,7	78,6	79,2	79,2	79,9
Life expectancy at 45 - females	**CZ**	33,4	33,9	34,1	34,5	34,5	34,8	34,8	34,9	34,7	35,3	35,3	36
Life expectancy at 65 - females	**CZ**	16,2	16,6	16,7	17	17	17,3	17,3	17,3	17,2	17,6	17,7	18,3
Healthy Life Years at birth - females	**CZ**	:	:	:	:	:	:	:	63.3 (p)	:	:	59.9 (b)	59,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**DK**	72,7	73,1	73,6	74	74,2	74,5	74,7	74,8	75	75,4	76	76,1
Life expectancy at 45 - males	**DK**	30,2	30,5	30,9	31,1	31,3	31,6	31,7	31,8	32	32,4	32,8	32,8
Life expectancy at 65 - males	**DK**	14,1	14,4	14,6	14,9	15	15,2	15,2	15,4	15,6	15,9	16,1	16,2
Healthy Life Years at birth - males	**DK**	61,6	61,7	61,6	62,4	62,5	62,9	62,2	62.8 (e)	63 (e)	68.3 (b)	68,4	67,7
Life expectancy at birth - females	**DK**	77,9	78,3	78,6	79	79	79,2	79,3	79,4	79,8	80,2	80,5	80,7
Life expectancy at 45 - females	**DK**	34,4	34,9	35	35,4	35,2	35,5	35,6	35,6	35,9	36,4	36,6	36,8
Life expectancy at 65 - females	**DK**	17,6	17,9	18	18,3	18,1	18,3	18,3	18,2	18,5	19	19,1	19,2
Healthy Life Years at birth - females	**DK**	60,7	61,1	60.7 (e)	61.3 (e)	60,8	61,9	60,4	61.0 (e)	60.9 (e)	68.8 (b)	68,2	67,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**DE**	73,3	73,6	74,1	74,5	74,8	75,1	75,6	75,7	75,8	76,5	76,7	77,2
Life expectancy at 45 - males	**DE**	30,7	31	31,4	31,7	32	32,2	32,5	32,6	32,7	33,3	33,4	33,8
Life expectancy at 65 - males	**DE**	14,8	14,9	15,2	15,4	15,6	15,8	16,1	16,2	16,2	16,7	16,9	17,2
Healthy Life Years at birth - males	**DE**	60	60,8	61.9 (e)	62.1 (e)	62.3 (e)	63.2 (e)	64.1 (e)	64.4 (e)	65 (e)	:	55 (b)	58,5
Life expectancy at birth - females	**DE**	79,9	80,1	80,5	80,8	81	81,2	81,4	81,3	81,3	81,9	82	82,4
Life expectancy at 45 - females	**DE**	36,4	36,5	36,9	37,1	37,3	37,5	37,6	37,5	37,5	38	38,1	38,5
Life expectancy at 65 - females	**DE**	18,7	18,8	19,1	19,3	19,4	19,6	19,8	19,6	19,5	20,1	20,1	20,5
Healthy Life Years at birth - females	**DE**	64,3	64,5	64.3 (e)	64.3 (e)	64.3 (e)	64.6 (e)	64.5 (e)	64.5 (e)	64.7 (e)	:	55.1 (b)	58

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**EE**	61,5	64,3	64,3	64,1	64,9	65,5	64,9	65,3	66,1	66,4	67,3	67,4
Life expectancy at 45 - males	**EE**	23,4	24,5	24,9	24,3	25,2	25,3	24,9	25,3	25,6	25,8	26,2	26,3
Life expectancy at 65 - males	**EE**	12	12,2	12,5	12,2	12,6	12,8	12,7	12,8	12,7	13	13,1	13,2
Healthy Life Years at birth - males	**EE**	:	:	:	:	:	:	:	:	:	49.8 (b)	48	49,4
Life expectancy at birth - females	**EE**	74,3	75,6	75,9	75,4	76	76,2	76,4	77	77,1	77,8	78,2	78,6
Life expectancy at 45 - females	**EE**	32,4	33	33,3	32,9	33,5	33,6	33,7	34	34,1	34,6	35	35,1
Life expectancy at 65 - females	**EE**	16,1	16,4	16,8	16,5	17	17	17,3	17,3	17,4	17,8	18	18,3
Healthy Life Years at birth - females	**EE**	:	:	:	:	:	:	:	:	:	53.3 (b)	52,2	53,7

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**IE**	72,8	73,1	73,4	73,4	73,4	74	74,5	75,2	75,9	76,4	77,3	77,3
Life expectancy at 45 - males	**IE**	30,1	30,5	30,7	30,9	30,8	31,5	31,9	32,4	33	33,4	34,1	34,1
Life expectancy at 65 - males	**IE**	13,5	13,9	14	14,2	14,1	14,6	15	15,4	15,9	16,2	16,8	16,8
Healthy Life Years at birth - males	**IE**	63,2	64	63,2	64	63,9	63,3	63,3	63.5 (e)	63.4 (e)	62.5 (b)	62,9	63,3
Life expectancy at birth - females	**IE**	78,3	78,7	78,7	79,1	78,9	79,2	79,9	80,5	80,8	81,4	81,7	82,1
Life expectancy at 45 - females	**IE**	34,8	35,1	35,2	35,5	35,3	35,7	36,4	36,9	37	37,6	37,9	38,2
Life expectancy at 65 - females	**IE**	17,2	17,4	17,6	17,8	17,6	18	18,5	18,9	19,2	19,7	20	20,2
Healthy Life Years at birth - females	**IE**	:	:	:	:	67,6	66,9	66,5	65.9 (e)	65.4 (e)	64.3 (b)	64,1	65

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**EL**	75	75,1	75,4	75,4	75,5	75,5	75,9	76,2	76,5	76,6	76,8	77,2
Life expectancy at 45 - males	**EL**	32,6	32,6	32,9	32,8	32,9	32,8	33,2	33,4	33,5	33,7	33,9	34,3
Life expectancy at 65 - males	**EL**	15,9	16	16,2	16,1	16,2	16,1	16,5	16,6	16,7	16,9	17,1	17,5
Healthy Life Years at birth - males	**EL**	65,8	66,9	66,4	66,5	66,7	66,3	66,7	66.7 (e)	66.7 (e)	63.7 (b)	65.7	66,3
Life expectancy at birth - females	**EL**	80,1	80,2	80,4	80,3	80,5	80,6	81	81,1	81,2	81,3	81,6	81,9
Life expectancy at 45 - females	**EL**	36,5	36,6	36,8	36,7	36,8	36,8	37,2	37,2	37,2	37,5	37,8	37,9
Life expectancy at 65 - females	**EL**	18,2	18,3	18,4	18,3	18,4	18,4	18,7	18,7	18,7	18,9	19,2	19,4
Healthy Life Years at birth - females	**EL**	69.2 (e)	69,6	68,7	68,3	69,4	68,2	68,8	68.5 (e)	68.4 (e)	65.2 (b)	67,2	67,9

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**ES**	74,4	74,5	75,2	75,3	75,3	75,8	76,2	76,3	76,3	76,9	77	77,7
Life expectancy at 45 - males	**ES**	32,5	32,6	32,8	32,8	32,7	33,2	33,4	33,5	33,5	34	33,9	34,6
Life expectancy at 65 - males	**ES**	16,2	16,2	16,3	16,2	16,2	16,7	16,9	16,9	16,8	17,3	17,3	17,9
Healthy Life Years at birth - males	**ES**	64,2	65,1	65,5	65,2	65,6	66,5	66	66.6 (e)	66.8 (e)	62.5 (b)	63,2	63,7
Life expectancy at birth - females	**ES**	81,8	82	82,3	82,4	82,4	82,9	83,2	83,2	83	83,7	83,7	84,4
Life expectancy at 45 - females	**ES**	38,4	38,5	38,8	38,7	38,7	39,2	39,4	39,4	39,2	39,9	39,7	40,4
Life expectancy at 65 - females	**ES**	20,2	20,3	20,5	20,4	20,3	20,8	21	21	20,8	21,5	21,3	22
Healthy Life Years at birth - females	**ES**	67,7	68,4	68,2	68,2	69,5	69,3	69.2 (e)	69.9 (e)	70.2 (e)	62.5 (b)	63,1	63,3

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**FR**	:	:	:	74,8	75	75,3	75,5	75,7	75,8	76,7	76,7	77,3
Life expectancy at 45 - males	**FR**	:	:	:	32,4	32,6	32,9	33	33,1	33,1	33,9	33,9	34,4
Life expectancy at 65 - males	**FR**	:	:	:	16,5	16,6	16,8	17	17	17	17,7	17,7	18,2
Healthy Life Years at birth - males	**FR**	60	59,6	60,2	59,2	60,1	60,1	60,5	60.4 (e)	60.6 (e)	61.2 (b)	62	62,7
Life expectancy at birth - females	**FR**	:	:	:	82,6	82,7	83	83	83	82,7	83,8	83,7	84,4
Life expectancy at 45 - females	**FR**	:	:	:	39,1	39,2	39,4	39,4	39,3	39	40,1	40	40,6
Life expectancy at 65 - females	**FR**	:	:	:	21,2	21,2	21,4	21,5	21,3	21	22,1	22	22,6
Healthy Life Years at birth - females	**FR**	62,4	62,5	63,1	62,8	63,3	63.2 (e)	63,3	63.7 (e)	63.9 (e)	64.1 (b)	64,3	64,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**IT**	75,1	75,5	75,9	76,1	76,6	77	77,2	77,4	77,1	77,9	:	:
Life expectancy at 45 - males	**IT**	32,6	32,9	33,1	33,1	33,5	33,8	34,1	34,2	34	34,7	:	:
Life expectancy at 65 - males	**IT**	15,8	16	16,1	16,1	16,4	16,7	16,9	17	16,8	17,5	:	:
Healthy Life Years at birth - males	**IT**	66,7	67,4	68	67,9	68,7	69,7	69,8	70.4 (e)	70.9 (e)	67.9 (b)	65,8	:
Life expectancy at birth - females	**IT**	81,6	81,8	82,1	82,2	82,7	82,9	83,2	83,2	82,8	83,8	:	:
Life expectancy at 45 - females	**IT**	38	38,3	38,4	38,5	38,8	39	39,3	39,3	38,8	39,8	:	:
Life expectancy at 65 - females	**IT**	19,9	20,1	20,2	20,3	20,5	20,7	21	21	20,6	21,5	:	:
Healthy Life Years at birth - females	**IT**	70	70.5 (e)	71,3	71,3	72,1	72,9	73.0 (e)	73.9 (e)	74.4 (e)	70.2 (b)	67	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**CY**	:	:	:	:	:	:	:	76,4	77,4	76,8	76,8	78,8
Life expectancy at 45 - males	**CY**	:	:	:	:	:	:	:	33,7	34,2	33,9	34,2	35,4
Life expectancy at 65 - males	**CY**	:	:	:	:	:	:	:	16,3	16,8	16,7	16,8	17,7
Healthy Life Years at birth - males	**CY**	:	:	:	:	:	:	:	:	68,4	:	59.5 (b)	64,3
Life expectancy at birth - females	**CY**	:	:	:	:	:	:	:	81	81,6	82,1	81,1	82,4
Life expectancy at 45 - females	**CY**	:	:	:	:	:	:	:	37,4	37,7	38	37,6	38,3
Life expectancy at 65 - females	**CY**	:	:	:	:	:	:	:	19	19,3	19,5	19,1	19,7
Healthy Life Years at birth - females	**CY**	:	:	:	:	:	:	:	:	69,6	:	57.9 (b)	63,2

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**LV**	:	:	:	:	:	:	:	64,7	65,6	65,9	65,4	65,4
Life expectancy at 45 - males	**LV**	:	:	:	:	:	:	:	24,9	25,3	25,4	25	24,9
Life expectancy at 65 - males	**LV**	:	:	:	:	:	:	:	12,5	12,6	12,6	12,5	12,7
Healthy Life Years at birth - males	**LV**	:	:	:	:	:	:	:	:	:	:	50.6 (b)	50,5
Life expectancy at birth - females	**LV**	:	:	:	:	:	:	:	76	75,9	76,2	76,5	76,3
Life expectancy at 45 - females	**LV**	:	:	:	:	:	:	:	33,5	33,2	33,7	33,8	33,5
Life expectancy at 65 - females	**LV**	:	:	:	:	:	:	:	17	16,8	17,1	17,2	17,3
Healthy Life Years at birth - females	**LV**	:	:	:	:	:	:	:	:	:	:	53.1 (b)	52,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**LT**	63,3	64,6	65,5	66	66,3	66,8	65,9	66,2	66,4	66,3	65,3	65,3
Life expectancy at 45 - males	**LT**	24,5	25,2	26	26,2	26,4	26,7	26,2	26,1	26,1	26,1	25,3	25,1
Life expectancy at 65 - males	**LT**	12,9	13	13,2	13,3	13,4	13,7	13,5	13,3	13,3	13,4	13	13
Healthy Life Years at birth - males	**LT**	:	:	:	:	:	:	:	:	:	:	51.2 (b)	52,4
Life expectancy at birth - females	**LT**	75,1	75,9	76,6	76,6	77	77,5	77,6	77,5	77,8	77,7	77,3	77
Life expectancy at 45 - females	**LT**	33	33,6	34,1	34,1	34,5	34,8	34,7	34,6	34,8	34,7	34,3	34,2
Life expectancy at 65 - females	**LT**	16,9	17,2	17,3	17,4	17,6	17,9	17,9	17,8	18,1	17,9	17,6	17,6
Healthy Life Years at birth - females	**LT**	:	:	:	:	:	:	:	:	:	:	54.3 (b)	56,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**LU**	73	73,3	74	73,7	74,4	74,6	75,1	74,6	74,8	75,9	76,7	76,8
Life expectancy at 45 - males	**LU**	30,5	30,7	31,2	31,2	31,8	32	32,5	32,3	31,9	33,1	33,3	33,5
Life expectancy at 65 - males	**LU**	14,7	14,8	14,8	15,2	15,3	15,5	16	15,9	15,3	16,5	16,7	17
Healthy Life Years at birth - males	**LU**	:	:	:	:	:	:	:	:	:	59.1 (b)	62,2	61
Life expectancy at birth - females	**LU**	80,6	80,2	80	80,8	81,4	81,3	80,7	81,5	80,8	82,3	82,3	81,9
Life expectancy at 45 - females	**LU**	37,3	37,1	36,7	37,3	37,5	37,7	37,4	37,7	37	38,5	38,4	38
Life expectancy at 65 - females	**LU**	19,7	19,5	19,2	19,5	19,8	20,1	19,7	20	18,9	20,5	20,4	20,3
Healthy Life Years at birth - females	**LU**	:	:	:	:	:	:	:	:	:	60.2 (b)	62,1	61,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**HU**	65,4	66,3	66,7	66,5	66,7	67,6	68,2	68,3	68,4	68,7	68,7	69,2
Life expectancy at 45 - males	**HU**	24,7	25,1	25,4	25,3	25,3	26	26,4	26,4	26,3	26,6	26,4	26,8
Life expectancy at 65 - males	**HU**	12,2	12,3	12,5	12,5	12,5	13	13,2	13,2	13	13,4	13,3	13,6
Healthy Life Years at birth - males	**HU**	:	:	:	:	:	:	:	:	53.5 (p)	:	52 (b)	54,2
Life expectancy at birth - females	**HU**	74,8	75	75,5	75,6	75,6	76,2	76,7	76,7	76,7	77,2	77,2	77,8
Life expectancy at 45 - females	**HU**	32,2	32,4	32,7	32,8	32,6	33,2	33,5	33,6	33,5	33,8	33,8	34,3
Life expectancy at 65 - females	**HU**	16	15,9	16,3	16,4	16,2	16,7	17	17	16,9	17,3	17,2	17,7
Healthy Life Years at birth - females	**HU**	:	:	:	:	:	:	:	:	57.8 (p)	:	53.9 (b)	57

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**MT**	74,8	74,8	75,2	74,9	75,3	76,2	76,6	76,3	76,4	77,4	77,3	77
Life expectancy at 45 - males	**MT**	32,5	32,3	32,1	32	32,1	32,7	33,4	33	33,2	34,1	33,8	33,6
Life expectancy at 65 - males	**MT**	15,5	14,8	14,6	14,6	15	15,1	15,7	15,3	15,6	16,3	16,2	16,1
Healthy Life Years at birth - males	**MT**	:	:	:	:	:	:	:	65.1 (p)	:	:	68.5 (b)	68,1
Life expectancy at birth - females	**MT**	79,6	79,6	80,1	80	79,4	80,3	81,2	81,3	80,8	81,2	81,4	81,9
Life expectancy at 45 - females	**MT**	35,7	36,5	36,6	36,3	35,9	36,5	36,9	37,3	36,9	37,4	37,5	37,7
Life expectancy at 65 - females	**MT**	17,6	18,3	18,4	18,1	17,8	18,5	18,7	19,1	18,6	19,1	19,4	19,5
Healthy Life Years at birth - females	**MT**	:	:	:	:	:	:	:	65.7 (p)	:	:	70.1 (b)	69,2

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**NL**	74,6	74,7	75,2	75,2	75,3	:	75,8	76	76,3	76,9	77,2	77,7
Life expectancy at 45 - males	**NL**	31,6	31,6	32	32	32,1	:	32,6	32,7	32,9	33,5	33,8	34,2
Life expectancy at 65 - males	**NL**	14,7	14,8	15,1	15,1	15,2	:	15,6	15,6	15,8	16,3	16,4	16,8
Healthy Life Years at birth - males	**NL**	61,1	62,1	62,5	61,9	61,6	61,4	61,9	61.7 (e)	61.7 (e)	:	65 (b)	65
Life expectancy at birth - females	**NL**	80,5	80,5	80,7	80,8	80,5	:	80,8	80,7	81	81,5	81,7	82
Life expectancy at 45 - females	**NL**	36,9	36,9	37	37,1	36,9	:	37,1	37	37,2	37,7	37,9	38,1
Life expectancy at 65 - females	**NL**	19,2	19,2	19,3	19,4	19,2	:	19,4	19,3	19,5	19,9	20,1	20,3
Healthy Life Years at birth - females	**NL**	62.1 (e)	61,5	61,4	61.1 (e)	61,4	60,2	59,4	59.3 (e)	58.8 (e)	:	63.1 (b)	63,2

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**AT**	73,4	73,7	74,1	74,5	74,9	75,2	75,7	75,8	75,9	76,4	76,7	77,2
Life expectancy at 45 - males	**AT**	31	31,2	31,4	31,7	32	32,4	32,8	32,9	32,9	33,4	33,6	34
Life expectancy at 65 - males	**AT**	15	15,1	15,2	15,4	15,7	16	16,3	16,3	16,4	16,9	17	17,3
Healthy Life Years at birth - males	**AT**	60	62,3	62,2	63,4	63,6	64,6	64,2	65.6 (e)	66.2 (e)	58.1 (b)	57,8	58,4
Life expectancy at birth - females	**AT**	80,1	80,2	80,7	81	81	81,2	81,7	81,7	81,5	82,1	82,3	82,8
Life expectancy at 45 - females	**AT**	36,5	36,6	37	37,3	37,3	37,5	37,9	37,8	37,7	38,3	38,4	38,9
Life expectancy at 65 - females	**AT**	18,8	18,9	19,1	19,4	19,4	19,6	20	19,8	19,8	20,2	20,4	20,7
Healthy Life Years at birth - females	**AT**	:	:	:	:	:	68	68,5	69.0 (e)	69.6 (e)	60.2 (b)	59,6	60,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**PL**	67,7	68,1	68,5	68,9	68,8	69,6	70	70,3	70,5	70,6	70,8	70,9
Life expectancy at 45 - males	**PL**	26,7	26,9	27,1	27,4	27,3	27,9	28,1	28,3	28,4	28,5	28,6	28,8
Life expectancy at 65 - males	**PL**	12,9	12,9	13,1	13,4	13,3	13,6	13,7	13,9	13,9	14,2	14,3	14,5
Healthy Life Years at birth - males	**PL**	:	59,9	:	:	:	:	:	62,5	:	:	61	58,2
Life expectancy at birth - females	**PL**	76,4	76,6	77	77,4	77,5	78	78,4	78,8	78,8	79,2	79,3	79,7
Life expectancy at 45 - females	**PL**	33,6	33,7	33,9	34,2	34,3	34,7	35	35,3	35,3	35,6	35,8	36,1
Life expectancy at 65 - females	**PL**	16,5	16,5	16,8	17,1	17,1	17,5	17,7	18	18	18,3	18,5	18,8
Healthy Life Years at birth - females	**PL**	:	66,8	:	:	:	:	:	68,9	:	:	66.6 (b)	62,5

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**PT**	71,7	71,6	72,2	72,4	72,6	73,2	73,5	73,8	74,2	75	74,9	75,5
Life expectancy at 45 - males	**PT**	30,7	30,6	31	31,1	31,3	31,6	31,9	31,9	32	32,6	32,4	32,9
Life expectancy at 65 - males	**PT**	14,7	14,6	14,9	14,9	15	15,4	15,7	15,7	15,7	16,3	16,1	16,6
Healthy Life Years at birth - males	**PT**	59,6	58,2	59,3	59,1	58,8	60,2	59,5	59.7 (e)	59.8 (e)	55.1 (b)	58,4	59,6
Life expectancy at birth - females	**PT**	79	79	79,3	79,5	79,7	80,2	80,5	80,6	80,6	81,5	81,3	82,3
Life expectancy at 45 - females	**PT**	35,9	35,9	36,3	36,4	36,4	36,9	37,1	37,2	37	37,9	37,6	38,5
Life expectancy at 65 - females	**PT**	18,1	18,1	18,4	18,5	18,5	18,9	19,1	19,2	19	19,7	19,4	20,2
Healthy Life Years at birth - females	**PT**	63,1	60,5	60,4	61,1	60,7	62,2	62,7	61.8 (e)	61.8 (e)	52 (b)	56,7	57,6

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**RO**	65,5	65,1	65,2	66,3	67,1	67,7	67,5	67,3	67,7	68,2	68,7	69,2
Life expectancy at 45 - males	**RO**	26	25,6	25,8	26,4	26,9	27,3	27	26,7	26,8	27,3	27,4	27,7
Life expectancy at 65 - males	**RO**	12,8	12,4	12,7	13	13	13,4	13,3	12,9	13	13,3	13,4	13,6
Healthy Life Years at birth - males	**RO**												:
Life expectancy at birth - females	**RO**	73,5	72,8	73,3	73,8	74,2	74,8	74,9	74,7	75	75,5	75,7	76,2
Life expectancy at 45 - females	**RO**	31,8	31,4	31,8	32,1	32,3	32,7	32,7	32,4	32,7	33,1	33,1	33,5
Life expectancy at 65 - females	**RO**	15,3	14,9	15,3	15,5	15,5	15,9	16	15,7	15,8	16,2	16,1	16,5
Healthy Life Years at birth - females	**RO**												:

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**SI**	70,8	71,1	71,1	71,3	71,8	72,2	72,3	72,6	72,5	73,5	73,9	74,5
Life expectancy at 45 - males	**SI**	28,6	29	29	29,1	29,3	29,7	29,8	30	29,8	30,7	31,1	31,6
Life expectancy at 65 - males	**SI**	13,6	13,8	14	13,9	14,1	14,2	14,5	14,5	14,3	15	15,2	15,8
Healthy Life Years at birth - males	**SI**	:	:	:	:	:	:	:	:	:	:	56.3 (b)	57,6
Life expectancy at birth - females	**SI**	78,5	79	79,1	79,2	79,5	79,9	80,4	80,5	80,3	80,8	80,9	82
Life expectancy at 45 - females	**SI**	35	35,4	35,5	35,6	35,8	36,2	36,5	36,6	36,5	37	37,1	37,9
Life expectancy at 65 - females	**SI**	17,6	18,1	18	18,1	18,3	18,7	19	19	18,7	19,4	19,3	20
Healthy Life Years at birth - females	**SI**	:	:	:	:	:	:	:	:	:	:	59.9 (b)	61

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**SK**	68,4	68,8	68,9	68,6	69	69,2	69,5	69,8	69,8	70,3	70,2	70,4
Life expectancy at 45 - males	**SK**	26,7	27	27	26,9	27,1	27,2	27,3	27,5	27,6	28	27,8	28
Life expectancy at 65 - males	**SK**	12,7	12,8	12,9	12,8	13	12,9	13	13,2	13,2	13,3	13,3	13,3
Healthy Life Years at birth - males	**SK**	:	:	:	:	:	:	:	:	:	:	54.9 (b)	54,3
Life expectancy at birth - females	**SK**	76,5	77	76,9	77	77,4	77,5	77,7	77,7	77,7	78	78,1	78,4
Life expectancy at 45 - females	**SK**	33,3	33,8	33,7	33,8	34	34,1	34,1	34,3	34,3	34,5	34,5	34,8
Life expectancy at 65 - females	**SK**	16,2	16,6	16,5	16,6	16,8	16,7	16,8	16,9	16,9	17,1	17,1	17,3
Healthy Life Years at birth - females	**SK**	:	:	:	:	:	:	:	:	:	:	56.4 (b)	54,4

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**FI**	72,8	73,1	73,5	73,6	73,8	74,2	74,6	74,9	75,1	75,4	75,6	75,9
Life expectancy at 45 - males	**FI**	30,4	30,7	31	31	31,2	31,6	32	32,1	32,3	32,6	32,8	33,1
Life expectancy at 65 - males	**FI**	14,6	14,7	15	15	15,2	15,5	15,7	15,8	16,2	16,5	16,8	16,9
Healthy Life Years at birth - males	**FI**	:	54,6	55,5	55,9	55,8	56,3	56,7	57.0 (e)	57.3 (e)	53.1 (b)	51,7	52,9
Life expectancy at birth - females	**FI**	80,4	80,7	80,7	81	81,2	81,2	81,7	81,6	81,9	82,5	82,5	83,1
Life expectancy at 45 - females	**FI**	36,7	37	37	37,3	37,5	37,5	37,8	37,8	38	38,6	38,8	39,2
Life expectancy at 65 - females	**FI**	18,7	18,9	19,1	19,3	19,5	19,5	19,8	19,8	20	20,7	21	21,2
Healthy Life Years at birth - females	**FI**	:	57,7	57,6	58,3	57,4	56.8 (e)	56,9	56.8 (e)	56.5 (e)	52.9 (b)	52,4	52,7

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**SE**	76,2	76,6	76,8	76,9	77,1	77,4	77,6	77,7	78	78,4	78,5	78,8
Life expectancy at 45 - males	**SE**	33	33,2	33,4	33,6	33,8	34,1	34,2	34,3	34,5	34,9	34,9	35,2
Life expectancy at 65 - males	**SE**	16	16,1	16,3	16,4	16,5	16,7	16,9	16,9	17,1	17,5	17,4	17,7
Healthy Life Years at birth - males	**SE**	:	:	62,1	61,7	62	63,1	61,9	62.4 (e)	62.5 (e)	62 (b)	64,2	67,1
Life expectancy at birth - females	**SE**	81,7	81,7	82	82,1	82	82	82,2	82,1	82,5	82,8	82,9	83,1
Life expectancy at 45 - females	**SE**	37,8	37,8	38,1	38,2	38	38	38,1	38,1	38,5	38,8	38,8	39
Life expectancy at 65 - females	**SE**	19,9	19,9	20,1	20,2	20	20,2	20,2	20,1	20,4	20,7	20,7	20,9
Healthy Life Years at birth - females	**SE**	:	:	60	61.3 (e)	61,8	61,9	61	61.9 (e)	62.2 (e)	60.9 (b)	63,1	67

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**UK**	74	74,3	74,6	74,8	75	75,5	75,8	76	76,2	76,8	77,1	:
Life expectancy at 45 - males	**UK**	31,2	31,5	31,8	32	32,1	32,6	32,9	33,1	33,2	33,8	34	:
Life expectancy at 65 - males	**UK**	14,6	14,9	15,1	15,3	15,4	15,8	16,1	16,2	16,3	16,8	17	:
Healthy Life Years at birth - males	**UK**	60,6	60,8	60.9 (e)	60.8 (e)	61.2 (e)	61.3 (e)	61.1 (e)	61.4 (e)	61.5 (e)	:	63.2 (b)	:
Life expectancy at birth - females	**UK**	79,3	79,5	79,7	79,8	79,9	80,3	80,5	80,6	80,5	81	81,1	:
Life expectancy at 45 - females	**UK**	35,7	35,9	36,1	36,2	36,2	36,7	36,9	36,9	36,8	37,2	37,4	:
Life expectancy at 65 - females	**UK**	18,2	18,4	18,5	18,6	18,6	19	19,2	19,2	19,1	19,4	19,5	:
Healthy Life Years at birth - females	**UK**	61.2 (e)	61.8 (e)	61.2 (e)	62.2 (e)	61.3 (e)	61.2 (e)	60.8 (e)	60.9 (e)	60.9 (e)	:	65 (b)	:

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

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2000	total	17,6e	17,3e	12,5	:	:	11,6	14,9	14,2	:	18,2	29,1	13,3	25,3	18,5	:	16,7	16,8	13,8	54,2	15,5	10,2	:	42,6	22,3	:	:	8,9b	7,7	18,4
	female	15,6e	15,2e	10,2	:	:	9,9	15,2	12,1u	:	13,6	23,4	11,9	21,9	13,9	:	14,9	17,6	13,2	56,1	14,8	10,7	:	35,1	21,3	:	:	6,5b	6,2	17,9
	male	19,7e	19,5e	14,8	:	:	13,4	14,6	16,3	:	22,9	34,7	14,8	28,8	25	:	18,5	15,9	14,3	52,5	16,2	9,6	:	50,1	23,3	:	:	11,3b	9,2	19
2004	total	16,1	15,6	11,9b	21,4	6,1	8,5	12,1	13,7	12,9p	14,9	31,7	14,2	22,3	20,6	15,6	9,5b	12,7	12,6	42b	14	8,7i	5,7b	39,4b	23,6b	4,2u	7,1	8,7	8,6	14,9i
	female	13,7	13,1	8,3b	20,7	6,5	6,7	11,9	:	9,7p	11,6	24,6	12,3	18,4	14,9	10,7	7,4u	12,7	11,4	39,5b	11,9	7,9i	3,7b	30,6b	22,4b	2,6u	6,4	6,9	7,9	14,2i
	male	18,5	18	15,6b	22,1	5,8	10,4	12,2	20,5	16,1p	18,3	38,5	16,1	26,2	27,2	20,5	11,6u	12,6	13,7	44,2b	16,1	9,5i	7,7b	47,9b	24,9b	5,8u	7,8	10,6	9,3	15,7i
2005	total	15,6	15,2	13	20	6,4	8,5	13,8	14	12,3p	13,3	30,8b	12,6	21,9	18,1	11,9	9,2	13,3	12,3	41,2	13,6	9	5,5	38,6	20,8	4,3u	5,8	9,3	11,7b	14
	female	13,6	13,1	10,6	20,6	6,6	7,5	14,1	10,7u	9,6p	9,2	25b	10,7	17,8	10,6	8,2	6,2u	9,6	11,1	39,3	11,2	8,5	4	30,1	20,1	2,8u	5,7	7,3	10,9b	13,2
	male	17,6	17,3	15,3	19,5	6,2	9,4	13,5	17,4u	14,9p	17,5	36,4b	14,6	25,9	26,6	15,5	12,2u	17	13,5	43	15,8	9,4	6,9	46,7	21,4	5,7u	6	11,3	12,4b	14,7
2006	total	15,3	15,1	12,6	18	5,5	10,9	13,8	13,2	12,3	15,9	29,9	13,1	20,8	16	19p	10,3	17,4	12,4	41,7	12,9	9,6	5,6	39,2p	19	5,2u	6,4	8,3p	12	13
	female	13,2	12,8	10,2	17,9	5,4	9,1	13,6	:	9	11	23,8	11,2	17,3	9,2	16.1p	7u	14	10,7	38,8	10,7	9,8	3,8	31,8p	18,9	3,3u	5,5	6,4p	10,7	11,4
	male	17,5	17,4	14,9	18,2	5,7	12,8	13,9	19,6u	15,6	20,7	35,8	15,1	24,3	23,5	21.6p	13,3u	20,9	14	44,6	15,1	9,3	7,2	46,4p	19,1	6,9u	7,3	10,4p	13,3	14,6
2007	total	14,8	14,5	12,3	16,6	:	12.4b	12,7	14,3	11,5	14,7	31	12,7	19,3	12,6	16p	8,7	15,1	10,9	37,3	12	10,9	5	36.3p	19,2	4.3u	7,2	7,9	8,6b	17,0b
	female	12,7	12,3	10,7	16,9	:	8.9b	11,9	:	8,7	10,7	25,6	10,9	15,9	6,8	12.3p	5.9u	11.1u	9,3	32,9	9,6	10,2	3,6	30.4p	19,1	2.7u	6,3	6,3	7,0b	15,8b
	male	16,9	16,7	13,9	16,3	:	15.7b	13,4	21,0	14,2	18,6	36,1	14,6	22,6	19,5	19.7p	11,4	19,2	12,5	41,1	14,4	11,6	6,4	42.0p	19,2	5.7u	8,1	9,7	10,2b	18,2b

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

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

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

Source : Eurostat, Labour Force Survey - Quarter 2 results

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

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
2001 Children		9.5e	12,9	19	8	:	8,9	11,2	10,4	5,3	6,4	9,2	7	3,9	10,7	:	3,4	13,5	7,9	6	4,1	:	3,6	6,8	3,8	9.3u	:	:	16,9
Adults (18-59)																													
Total		10.1e	13,8	17.3b	7,9	:	9,7	11	8,8	8,8	7,4	10,3	10,8	4,9	12,8	10	6,7	13,2	7,8	6,9	7,9	13,8	4,3	8,7	8,2	10	:	:	11,2
Men		8.8e	11,5	16.8b	6,2	:	8,9	10,9	7,4	6,4	6,6	8,9	9,1	3,4	12,3	10,1	5,3	12	5,7	5,4	6,2	12,9	3,7	7,7	7,1	9,6	:	:	9,1
Women		11.4e	16,2	17.8b	9,5	:	10,5	11,1	10,2	11,2	8,3	11,6	12,4	6,3	13,2	10	8,1	14,3	9,9	8,5	9,6	14,7	4,9	9,6	9,4	10,5	:	:	13,2
2002 Children		9.8e	13,8	18,7	7,6	5,6	9,3	10,1	10,8	5,1	6,6	9,6	7,2	3,9	10.6b	8,4	2,8	14,3	7,6	6	4,4	:	4,2	9.8b	3,8	12,1	:	:	17,4
Adults (18-59)																													
Total		10.2e	14,2	16,6	7,3	7,6	10	10,8	8,5	8,9	7,3	10,4	10,2	5,3	10.5b	9.1b	6,3	13	7,2	6,7	7,5	15,1	4,6	11.3b	8	10,9	:	:	11,3
Men		8.9e	11,9	16,1	5,6	7,2	9,4	10,6	7,3	6,5	6,6	9,1	8,6	3,9	10.7b	8.5b	5,6	12	5,8	5,3	6,2	14,1	3,9	10.1b	7	10,4	:	:	9,2
Women		11.4e	16,6	17	9,1	8	10,7	10,9	9,7	11,2	8	11,8	11,8	6,5	10.3b	9.7b	7	14	8,6	8,1	8,8	16,1	5,2	12.5b	8,9	11,4	:	:	13,3
2003 Children		9.8e	13,9	16,6	8,4	5,7	10,3	9	11,8	4,6	6	9,5	7	3,4	7,2	6,1	3.9i	12.6b	8	7	4,3	:	5	10,2	4	11,8	5,7	:	17
Adults (18-59)																													
Total		10.2e	14,4	15,3	7,7	8,6	10,6	10,9	8,9	8,5	7,2	10,6	9,7	5,2	8,7	7,4	7.5i	11.6b	7,9	8	7,4	14,8	5,5	11,1	8,7	10,1	10,9	:	10,9
Men		9e	12,7	14,7	5,8	7,8	10	11,3	7,6	6,2	6,5	9,5	8,1	4,3	8,9	7,4	6i	10.9b	6,2	6,7	6,1	13,7	4,8	9,8	7,8	9,3	11,6	:	8,9
Women		11.3e	16,2	15,8	9,7	9,3	11,2	10,5	10,2	10,8	7,8	11,8	11,3	6,1	8,6	7,4	9i	12.2b	9,7	9,3	8,6	15,9	6,1	12,4	9,6	10,9	10,3	:	12,9
2004 Children		9.8i	13,2	15,6	9	6	10,9	9,6	11,8	4,5	6,3	9,6	5,7	2,6	7,2	6,5	3,4	13,2	9,2	7	5.6i	:	4,3	11,1	3,8	12,8	5,7	:	16,8
Adults (18-59)																													
Total		10.3i	13,7	13,7	8	8,5	11,1	9,5	8,6	8,5	7,3	10,8	9,1	5	7,8	8,1	7,1	11,9	8,6	8	8.8i	15,8	5,3	11,1	7,5	10,8	11	:	11
Men		9.3i	11,3	13,2	6,4	8,3	10,8	10,2	7,2	6,2	6,7	9,5	7,9	3,8	7,1	8,3	5,7	11,1	6,8	6,7	7.6i	14,8	5	10,4	7	10	11,2	:	9
Women		11.4i	16	14,2	9,6	8,8	11,4	8,7	10,1	10,7	7,9	12,1	10,4	6,1	8,4	8	8,5	12,7	10,4	9,3	10i	16,8	5,7	11,7	8	11,6	10,9	:	13
2005 Children	9,7e	9.6e	12,9	14,5	8,1	5,7	10.7p	9,1	12	4,1	5,4	9,5	5,6	3,5	8,3	6,2	2,7	14,2	8,9	7	6,3	:	4,3	10,4	2.7u	13,8	6,6	:	16,5
Adults (18-59)																													
Total	10,3e	10.2e	13,5	13	7,4	7,7	11p	8,5	8,4	8,5	6,7	10,7	9,5	5,2	8,1	6,6	6,7	12,3	8,2	8	8,7	15,3	5,5	10,4	6,7	10,2	10,5	:	11
Men	9,3e	9.2e	11,6	12,6	5,8	7,7	10.9p	10,2	7,2	6,4	6,2	9,6	8,3	4,2	8,7	6,9	5,4	11,6	6,5	6,9	7,7	14	5,1	9,4	6,3	9,5	11	:	9,2
Women	11,2e	11.2e	15,4	13,5	9	7,8	11.2p	7	9,8	10,7	7,2	11,8	10,8	6,2	7,6	6,4	8,1	13,1	9,9	9	9,6	16,6	5,8	11,3	7,1	10,9	10	:	12,8
2006 Children	9,7e	9.6e	13,5	14,5	8,2	5	10.3p	8,2	11,3	3,6	5,1	9.5p	5,4	3,9	7,1	5,3	3,7	13,3	8,2	6,2	7,2	12,8	4,7	10	3,6	11,8	4,9	:	16,2
Adults (18-59)																													
Total	9,9e	9.9e	14,3	11,6	7,3	6,9	10.5p	6	7,9	8,1	6,3	10.9p	9,2	4,9	6,8	7	7,1	11,6	6,7	7,4	8,8	14,4	5,8	9,7	7,2	9,6	9,5	:	10,7
Men	8,9e	8.9e	12,3	11,1	5,8	6,4	10.3p	6,1	6,5	6,1	5,8	9.9p	7,8	3,7	7,5	7,2	5,4	10,6	5,2	6,2	7,8	13,2	5,3	8,8	6,6	9	10,1	:	8,8
Women	10,9e	10.9e	16,4	12	8,8	7,3	10.7p	5,8	9,3	10,1	6,8	12p	10,6	5,9	6,2	6,9	8,9	12,6	8,2	8,6	9,8	15,6	6,4	10,6	7,8	10,2	9	:	12,5
2007 Children	9.4e	9.3e	12	12,8	8	:	9,6	7,2	11,5	3,9	5,3	8,7	5,8	3,9	8,3	8,3	3,4	13,9	9,2	5,9	5,3	9,5	5,1	10	2,2	10,6	4,4	:	16,7
Adults (18-59)																													
Total	9.3e	9.2e	12,3	10,2	6,5	:	9,5	6	7,9	8	6,2	10	9,2	4,7	6,6	7	7	11,9	7,7	6,5	7,1	11,6	5,7	10,4	6,5	8,9	9,1	:	10,7
Men	8,2e	8.2e	10,6	10,1	4,9	:	9,1	6,1	6,7	6	5,8	9	7,9	4,2	6,7	7,3	6	10,8	6,2	5,3	5,9	10,4	5,3	9,3	5,5	8,1	9,6	:	8,8
Women	10.3e	10.2e	13,9	10,3	8,1	:	9,9	5,9	9,3	10	6,7	11,1	10,6	5,2	6,6	6,8	7,9	12,9	9,3	7,6	8,4	12,7	6,1	11,5	7,5	9,6	8,6	:	12,7

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

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

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

Source : Eurostat, Labour Force Survey - Quarter 2 results

6. Projected total public social expenditures

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

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

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

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

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

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

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

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

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

7a. Relative median income ratio of people aged 65+ (relative to the complementary age group 0-64) (%), 2007

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
Relative median income ratio (65+/0-64)	Total	0.84ps	0.84p	0,74	0.83i	0,81	0,7	0.62p	0.86p	0.65p	0.69p	0.83p	0,76	0.9p	0,86	0,57	0,65	0,69	0,96	0,97	0,79	0.83p	0,93	1,04	0.79p	0.89p	0,86	0,81	0,74	0,78	0,72

Source: SILC 2007, Income data 2006; except for UK, income year 2006 and for IE moving income reference period (2005-2006); [1] BG National HBS 2006, income data 2006; [2] with imputed rent data 2006 (see methodological note).

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

7b. Aggregate replacement ratio (%), 2007

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
Aggregate replacement ratio (Pensions 65-74 /Earnings 50-59)	Total	:	0,49	0,44	0.6i	0,51	0,39	0.37p	0,45	0,47	0,47	0,4	0,47	0,61	0,49	0,29	0,38	0,4	0,61	0,58	0,5	0,42	0,61	0,58	0,47	:	0,44	0,54	0,46	0,61	0,41
	Men	:	0,52	0,46	0.62i	0,51	0,38	:	0,47	0,4	0,41	0,46	0,52	0,61	0,56	0,34	0,33	0,38	0,59	0,6	0,52	0,49	0,62	0,64	0,5	:	0,51	0,53	0,46	0,63	0,42
	Women	:	0,49	0,45	0.58i	0,56	0,43	:	0,48	0,57	0,53	0,42	0,48	0,54	0,37	0,34	0,43	0,44	0,58	0,57	0,48	0,54	0,68	0,57	0,48	:	0,39	0,57	0,48	0,54	0,44

Source: SILC 2007, Income data 2006; except for UK, income year 2006 and for IE moving income reference period (2005-2006); [1] BG National HBS 2006, income data 2006; [2] with imputed rent data 2006 (see methodological note).

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

8a. Inequalities in access to health care (unmet need for care by income quintile for 3 reasons: too expensive, too long waiting time, too far to travel), SILC 2006

	EU-27	EU-25	BE	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
1st quintile	:	:	1,8	1,4	0,2	:	14,4	2,7	7,9	0,9	4,3	9,2	6,6	28,9	13,6	0,8	3,9	3,4	0,9	1	13,3	9,6	0,3	6,4	4,7	4,1	2,6
2nd quintile	:	:	0,4	0,7	0,3	:	7	2,1	7,8	0,9	1,4	5,1	4,7	20,5	10,5	0,1	3,2	1,9	0,3	0,5	11	6,8	0,2	3,4	3,3	3,9	1,7
3rd quintile	:	:	0,2	0,5	0,2	:	5,9	2,4	7,3	0,5	1,2	4	2,6	10,2	7,9	0,2	2,4	1,6	0,3	0,2	8,9	4,9	0,1	2,2	2,1	3,3	1,5
4th quintile	:	:	:	0,5	0,2	:	6,3	1,9	4,1	0,4	0,3	3,1	1,5	9,8	5,2	0,2	1,7	1,2	0,3	0,3	7,2	2,7	0,1	1,5	1,7	2	2,4
5th quintile	:	:	0,1	0,2	0,2	:	3,1	0,7	2	0,2	0,6	2,1	0,5	5,9	3,9	0,4	0,8	0,8	0,3	0,3	6,4	1,1	0,2	0,8	0,9	1,1	1,5

Source: SILC(2006)

* This data should be interpreted with care when comparing levels of across countries due to a problem in the translation of the questionnaire.

8b. Doctor's consultations

EU-27	EU-25	BE	CZ	DK	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
:	:	7,5	12,9	7,5	6,9	:	:	8,1	6,4	7,0	2,0	5,2	6,8	6,0	12,9	1,9	5,6	6,7	6,6	3,9	7,2	10,4	4,3	2,8	5,1

Notes: (:) = data not available

Source: OECD Health Data. Calculated as the number of contacts with an ambulatory care physician divided by the population. Includes contacts in out-patient wards.

9. At-risk of poverty rate anchored at a fixed moment in time (poverty threshold of 2005), 2007

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
Total population	Total	:	14p	14	:	7	11		14p	8	12	20	17	13	20	10	10	8	14	10	11	9	13	13	18	:	10	5	11	9	16
	Men	:	14p	14	:	7	10		13p	8	11	19	16	12	18	9	10	7	13	10	10	9	12	13	17	:	8	5	10	9	15
	Women	:	15p	15	:	8	11		15p	8	12	20	18	14	21	12	10	8	15	10	11	10	15	12	19	:	11	5	11	9	17
Children aged 0-17	Total	:	17p	16	:	13	9		13p	9	14	23	20	16	25	7	11	11	21	16	14	13	17	18	21	:	9	9	9	10	19
People aged 18-64	Total		13p	12		7	10		14p	8	11	18	14	12	17	6	10	7	13	10	9	8	11	12	15	:	8	5	10	9	13
	Men	:	12p	11	:	6	11		13p	9	10	18	13	11	16	5	10	7	13	10	8	7	10	13	14	:	8	5	10	10	12
	Women	:	14p	13	:	7	10		15p	8	11	19	15	13	19	8	10	7	14	10	10	9	13	12	16	:	8	5	9	8	13
People aged 65+	Total	:	17p	22	:	3	16		15p	6	13	22	23	13	22	39	9	5	8	4	13	8	16	4	26	:	17	3	18	8	24
	Men	:	14p	19	:	1	13		12p	4	11	20	22	12	18	35	5	1	7	2	16	7	11	3	24	:	9	2	14	5	21
	Women	:	18p	24	:	4	17		17p	7	15	24	25	14	25	42	10	6	8	6	11	9	19	5	27	:	22	4	20	11	27

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); [1] BG, RO (:) data not available; [2] with imputed rent (see methodological note).

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available n.a.=forthcomimg

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

10. Employment rate of older workers (% of people aged 55-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	total	:	35,8	22,9	:	37,1	52	37,7	50,2	41,7	39	35,1	28,3	27,7	:	36,3	39,5	25,1	17,3	:	33,9	28,4	32,1	49.6b	51,5	23,9	22,8	36,2	63	49
	male	:	46,6	32,1	:	53,2	61,3	47,2	62	60,2	56	52,6	32,5	41,4	:	48,1	54,4	35,2	27	:	47,5	40,5	41,5	62.9b	59,5	31,8	39,1	38,4	66,1	59,1
	female	:	25,5	14	:	22,9	42	28,3	41,6	23,1	23,5	18,8	24,4	15	:	27,5	28,3	15,5	9,6	:	20,3	17,1	24,1	38b	44,5	16,1	9,4	34,1	60	39,2
2000	total	36,9	36,6	26,3	20,8	36,3	55,7	37,6	46,3	45,3	39	37	29,9	27,7	49,4	36	40,4	26,7	22,2	28,5	38,2	28,8	28,4	50,7	49,5	22,7	21,3	41,6	64,9	50.7b
	male	47,1	46,9	36,4	33,2	51,7	64,1	46,4	55,9	63,2	55,2	54,9	33,6	40,9	67,3	48,4	50,6	37,2	33,2	50,8	50,2	41,2	36,7	62,1	56	32,3	35,4	42,9	67,8	60.1b
	female	27,4	26,9	16,6	10,3	22,4	46,6	29	39	27,2	24,3	20,2	26,3	15,3	32,1	26,7	32,6	16,4	13,3	8,4	26,1	17,2	21,4	40,6	43,8	13,8	9,8	40,4	62,1	41.7b
2002	total	38,5	38,7	26,6	27	40,8	57,9	38,9	51,6	48	39,2	39,6	34,7	28,9	49,4	41,7	41,6	28,1	25,6	30,1	42,3	29,1	26,1	51,4	37.3b	24,5	22,8	47,8	68	53,4
	male	48,4	48,8	36	37	57,2	64,5	47,3	58,4	65	55,9	58,4	38,7	41,3	67,3	50,5	51,5	37,7	35,5	50,8	54,6	39,6	34,5	61,9	42.7b	35,4	39,1	48,5	70,4	62,6
	female	29,1	29,2	17,5	18,2	25,9	50,4	30,6	46,5	30,8	24	21,9	30,8	17,3	32,2	35,2	34,1	18,4	17,6	10,9	29,9	19,3	18,9	42,2	32.6b	14,2	9,5	47,2	65,6	44,5
2004	total	40,6	41	30	32,5	42,7	60,3	41,8	52,4	49,5	39,4	41,3	37,3	30.5b	49,9	47,9	47,1	30,4	31,1	31,5	45,2	28.8b	26,2	50,3	36,9	29	26,8	50,9	69,1	56,2
	male	50,3	50,7	39,1	42,2	57,2	67,3	50,7	56,4	65	56,4	58,9	41	42.2b	70,8	55,8	57,6	38,3	38,4	53,4	56,9	38.9b	34,1	59,1	43,1	40,9	43,8	51,4	71,2	65,7
	female	31,6	31,7	21,1	24,2	29,4	53,3	33	49,4	33,7	24	24,6	33,8	19.6b	30	41,9	39,3	22,2	25	11,5	33,4	19.3b	19,4	42,5	31,4	17,8	12,6	50,4	67	47
2005	total	42.3p	42.5p	31,8	34,7	44,5	59,5	45.4p	56,1	51,6	41,6	43.1b	37,9	31,4	50,6	49,5	49,2	31,7	33	30,8	46,1	31,8	27,2	50,5	39,4	30,7	30,3	52,7	69.4b	56,9
	male	51.5p	51.8p	41,7	45,5	59,3	65,6	53.5p	59,3	65,7	58,8	59.7b	40,7	42,7	70,8	55,2	59,1	38,3	40,6	50,8	56,9	41,3	35,9	58,1	46,7	43,1	47,8	52,8	72b	66
	female	33.5p	33.7p	22,1	25,5	30,9	53,5	37.5p	53,7	37,3	25,8	27.4b	35,2	20,8	31,5	45,3	41,7	24,9	26,7	12,4	35,2	22,9	19,7	43,7	33,1	18,5	15,6	52,7	66.7b	48,1
2006	total	43.5p	43.6p	32	39,6	45,2	60,7	48.4p	58,5	53,1	42,3	44,1	37.6p	32,5	53,6	53,3	49,6	33,2	33,6	30	47,7	35,5	28,1	50,1	41,7	32,6	33,1	54,5	69,6	57,4
	male	52.6p	52.8p	40,9	49,5	59,5	67,1	56.4p	57,5	67	59,2	60,4	40.1p	43,7	71,6	59,5	55,7	38,7	41,4	50,4	58	45,3	38,4	58,2	50	44,5	49,8	54,8	72,3	66
	female	34.8p	34.9p	23,2	31,1	32,1	54,3	40.6p	59,2	39,1	26,6	28,7	35.2p	21,9	36,6	48,7	45,1	27,8	27,1	11,2	37,2	26,3	19	42,8	34,5	21	18,9	54,3	66,9	49,1
2007	total	44,7	44,9	34,4	42,6	46	58,6	51,5	60	53,8	42,4	44,6	38,3	33,8	55,9	57,7	53,4	32	33,1	28,5	50,9	38,6	29,7	50,9	41,4	33,5	35,6	55	70	57,4
	male	53,9	54,1	42,9	51,8	59,6	64,9	59,7	59,4	67,9	59,1	60	40,5	45,1	72,5	64,6	60,8	35,6	41,7	45,9	61,5	49,8	41,4	58,6	50,3	45,3	52,5	55,1	72,9	66,3
	female	36	36,1	26	34,5	33,5	52,4	43,6	60,5	39,6	26,9	30	36,2	23	40,3	52,4	47,9	28,6	26,2	11,6	40,1	28	19,4	44	33,6	22,2	21,2	55	67	48,9

b= break in data series u= unreliable or uncertain data

Source : Eurostat - Labour Force Survey, Annual averages.

11. In work at-risk-of-poverty rate after social transfers by gender (Age 18+), 2007

		EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
In work	Total	8ps	8p	4	:	3	4	:	7p	8	6	14	11	6	10	6	10	8	9	6	4	5	6	12	10	4p	5	5	5	7	8
	Men	8ps	9p	4	:	3	5	:	7p	6	6	15	12	7	12	6	9	8	9	7	5	5	6	13	10	5p	5	5	5	7	8
	Women	7ps	7p	4	:	3	3	:	8p	9	6	12	9	6	7	7	10	8	9	5	2	5	6	10	9	3p	4	5	6	6	8

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); (1) BG National HBS 2007, income data 2007; (2) with imputed rent data 2006 (see methodological

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

12. Activity rates (% of population aged 15-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	68,0	63,5	:	72,0	79,7	70,8	72,2	65,6	63,2	63,0	68,4	59,0	:	69,8	72,1	62,1	58,7	:	73,0	71,0	65,7	70.6b	68,9	68,2	69,3	72,3	76,2	75,4
	Male	:	77,4	72,8	:	80,0	83,8	79,2	79,0	78,2	77,6	77,3	75,2	73,6	:	76,4	78,2	75,9	66,6	:	82,6	80,3	72,8	79.3b	75,7	72,6	77,2	75,6	79,0	83,2
	Female	:	58,7	54,0	:	64,0	75,6	62,2	66,4	52,9	49,0	48,9	61,9	44,6	:	63,9	66,5	48,1	51,2	:	63,2	61,7	58,8	62.3b	62,3	63,6	61,7	69,1	73,5	67,4
2000	Total	68,6	68,7	65,1	60,7	71,3	80,0	71,1	70,2	68,2	63,8	65,4	68,7	60,1	69,1	67,2	70,8	64,1	60,1	58,0	75,2	71,0	65,8	71,4	68,4	67,5	69,9	74,5	77,3	75.4b
	Male	77,1	77,4	73,7	66,2	79,1	84,2	78,9	75,6	79,9	77,4	78,8	75,2	74,1	81,4	72,7	74,5	76,3	67,9	80,5	84,1	80,1	71,7	79,2	75,0	71,9	76,8	77,2	79,8	82.8b
	Female	60,1	60,0	56,4	55,6	63,6	75,6	63,3	65,3	56,3	50,5	52,0	62,4	46,3	57,7	62,1	67,3	51,6	52,7	35,2	66,0	62,0	59,9	63,9	61,9	62,9	63,2	71,9	74,8	68.2b
2002	Total	68,6	69,0	64,8	61,9	70,6	79,6	71,7	69,3	68,6	64,2	66,2	69,1	61,1	71,2	68,8	69,6	65,2	59,7	58,5	76,5	71,6	64,6	72,7	63.4b	67,8	69,9	74,9	77,6	75,2
	Male	76,8	77,3	73,2	66,4	78,6	83,6	78,8	74,6	79,2	77,6	79,1	75,5	74,3	81,3	74,1	73,6	76,7	67,1	80,1	84,5	79,6	70,6	80,0	70.4b	72,5	76,7	77,0	79,4	82,3
	Female	60,5	60,7	56,3	57,5	62,7	75,5	64,4	64,4	57,8	51,0	53,1	63,0	47,9	61,8	63,9	65,8	53,6	52,7	36,7	68,3	63,7	58,7	65,6	56.6b	63,0	63,2	72,8	75,8	68,3
2004	Total	69,3	69,7	65,9	61,8	70,0	80,1	72,6	70,0	69,5	66,5	68,7	69,5	62.7b	72,6	69,7	69,1	65,8	60,5	58,2	76,6	71.3b	64,0	73,0	63,0	69,8	69,7	74,2	77,2	75,2
	Male	77,0	77,5	73,4	66,4	77,9	84,0	79,2	74,4	79,9	79,0	80,4	75,3	74.9b	83,0	74,3	72,8	75,6	67,2	80,2	83,9	78.5b	70,1	79,1	70,0	74,5	76,5	76,4	79,1	82,0
	Female	61,6	62,0	58,2	57,2	62,2	76,2	65,8	66,0	59,0	54,1	56,8	63,9	50.6b	62,8	65,3	65,6	55,8	54,0	36,0	69,2	64.2b	57,9	67,0	56,2	65,0	63,0	72,0	75,2	68,6
2005	Total	69.8p	70.3p	66,7	62,1	70,4	79,8	74.3p	70,1	70,8	66,8	69.7b	69,5	62,5	72,4	69,6	68,4	66,6	61,3	58,1	76,9	72,4	64,4	73,4	62,3	70,7	68,9	74,7	78.7b	75,3
	Male	77.3p	77.8p	73,9	67,0	78,4	83,6	80.6p	73,6	80,6	79,2	80.9b	75,1	74,6	82,9	74,4	72,1	76,0	67,9	79,1	83,7	79,3	70,8	79,0	69,4	75,1	76,5	76,6	80.9b	81,9
	Female	62.3p	62.7p	59,5	57,3	62,4	75,9	68p	66,9	60,8	54,5	58.3b	64,1	50,4	62,5	65,1	64,9	57,0	55,1	36,9	70,0	65,6	58,1	67,9	55,3	66,1	61,5	72,8	76.3b	68,8
2006	Total	70.2p	70.6p	66,5	64,5	70,3	80,6	75.3p	72,4	71,8	67,0	70,8	69.4p	62,7	73,0	71,3	67,4	66,7	62,0	59,2	77,4	73,7	63,4	73,9	63,6	70,9	68,6	75,2	78,8	75,5
	Male	77.5p	78p	73,4	68,8	78,3	84,1	81.3p	75,8	81,5	79,1	81,3	74.8p	74,6	82,7	76,2	70,5	75,3	68,7	79,7	83,9	80,5	70,1	79,5	70,7	74,9	76,4	77,1	81,2	82,1
	Female	62.9p	63.2p	59,5	60,2	62,3	77,0	69.2p	69,3	61,9	55,0	60,2	64.1p	50,8	63,8	66,7	64,6	58,2	55,5	38,3	70,7	67,0	56,8	68,4	56,6	66,7	60,9	73,3	76,3	69,2
2007	Total	70,5	70,9	67,1	66,3	69,9	80,2	76,0	72,9	72,4	67,0	71,6	70,2	62,5	73,9	72,8	67,9	66,9	61,9	58,4	78,5	74,7	63,2	74,1	63,0	71,3	68,3	75,6	79,1	75,5
	Male	77,7	78,2	73,6	70,6	78,1	83,9	81,8	77,5	81,4	79,1	81,4	74,9	74,4	82,9	77,6	71,0	75,0	69,0	77,6	84,6	81,7	70,0	79,4	70,1	75,8	75,9	77,2	81,4	82,2
	Female	63,4	63,7	60,4	62,1	61,5	76,4	70,1	68,7	63,3	54,9	61,4	65,6	50,7	65,4	68,3	65,0	58,9	55,1	38,6	72,2	67,8	56,5	68,8	56,0	66,6	60,8	73,8	76,8	69,0

Source : Eurostat - Labour Force Survey, Annual averages.

(b) break in series

13. Dispersion of regional employment rates*, selected years (%)

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2000		13.4	7.9	10.3	5.8	-	5.7	-	-	5.1	10.7	6.9	17.5	-	-	-	-	9.0	-	2.2	2.5	6.9	4.3	4.6	-	9.1	6.8	4.5	7.1
2004		12.2	8.7	7.0	5.6	-	6.2	-	-	4.1	8.7	7.1	15.6	-	-	-	-	9.4	-	2.3	3.5	6.4	3.5	4.9	-	9.0	5.5	4.4	5.8
2005		11.9	8.4	7.1	5.5	-	5.6	-	-	4.3	8.3	7.3	16.0	-	-	-	-	9.9	-	2.0	4.1	5.6	3.3	4.5	-	9.8	5.5	3.0	5.7
2006	11,4	:	8,7	7,3	5,2	:	5,2	-	:	3,7	7,8	7,5	16,3	-	-	-	-	9,1	-	2,2	3,4	5,1	3,1	3,6	:	8,6	5,4	2,9	5,5
2007	11,1	:	8,6	7,1	4,6	:	4,8	-	:	3,5	7,5	6,6	16,3	-	-	-	-	9,7	-	2,2	3,8	4,5	3,3	4,6	:	8,3	5,6	2,4	5,4

* Coefficient of variation of employment rates across regions at NUTS2 level

e = estimate; p = provisional figure

Source : Eurostat - Labour Force Survey, Annual averages

14. Total health expenditure per capita

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
1990		1358	244	560	1544	1769	...	792	853	873	1449	1359	...	161	162	1532	...	...	1416	1631	290	636	81	311	...	1367	1592	965
1991		1488		541	1591			887	874	952	1553	1471				1630	578		1518	1728	346	754				1503	1576	1052
1992		1576		568	1666	1977		1009	974	1030	1649	1522				1757	615		1604	1870	366	805				1507	1617	1153
1993		1616		768	1772	1993		1040	1086	1086	1752	1534				1870	629		1673	2014	372	842				1393	1660	1209
1994		1654		817	1857	2129		1120	1227	1114	1813	1540				1904	709		1719	2183	375	872				1373	1665	1299
1995		1854		899	1871	2275		1204	1264	1193	1997	1538				1911	660		1799	2259	411	1036				1440	1746	1350
1996		1923		917	1979	2399		1280	1301	1249	2050	1613				1990	659		1862	2351	478	1117				1509	1861	1436
1997		1969		922	2060	2413		1395	1354	1298	2107	1728				1972	679		1916	2439	498	1186			564	1562	1886	1499
1998	1637	2042	289	926	2176	2483	474	1499	1382	1383	2190	1829	947	439	489	2083	763	1058	2054	2598	559	1210	246	1226	584	1622	1982	1569
1999	1717	2176	343	938	2281	2592	522	1626	1468	1450	2279	1879	984	473	498	2384	810	1103	2178	2726	573	1329	253	1303	599	1700	2129	1690
2000	1823	2377	386	980	2379	2671	513	1801	1429	1536	2421	2053	1074	482	559	2554	852	1247	2337	2859	583	1509	275	1447	603	1794	2284	1847
2001	1960	2484	484	1082	2521	2809	519	2128	1669	1636	2590	2215	1140	541	598	2738	971	1294	2556	2890	642	1569	312	1581	665	1913	2511	2021
2002	2087	2685	552	1195	2696	2937	561	2360	1792	1745	2780	2223	1228	611	681	3081	1114	1492	2833	3068	733	1657	368	1693	730	2089	2707	2165
2003	2226	3153	609	1340	2824	3090	646	2515	1928	2019	2988	2272	1335	653	793	3582	1302	1586	2988	3206	749	1824	415	1767	792	2210	2841	2259
2004	2347	3311	655	1388	3030	3162	740	2724	1991	2128	3117	2401	1335	796	756	4083	1327	1608	3156	3397	808	1913	427	1863	1058	2412	2964	2509
2005	2454	3421	734	1447	3169	3251	846	3126	2283	2260	3306	2496	1550	860	862	4153	1440	1733	3192	3507	843	2029	507	1959	1130	2523	3012	2580
2006		3488		1490	3349	3371		3082	2483	2458	3449	2614				4303	1504		3391	3606	910	2120				2668	3202	2760

Source: OECD health data 2008 for OECD Member States and WHO health for all database for the others

Context 1: Growth rate of GDP at constant prices (2000) - percentage change over previous year

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2000	3,9	3,9	3,7	5,4	3,6	3,5	3,2	9,6	9,2	4,5	5,0	3,9	3,7	5,0	6,9	4,2	8,4	5,2	:	3,9	3,7	4,3	3,9	2,1	4,4	1,4	5,0	4,4	3,9
2005	2,0	2,0	1,8	6,2	6,3	2,4	0,8	9,2	6,4	2,9	3,6	1,9	0,6	3,9	10,6	7,8	5,2	4,0	3,5	2,0	2,9	3,6	0,9	4,2	4,3	6,5	2,8	3,3	2,1
2006	3,1	3,1	3,0	6,3	6,8	3,3	3,0	10,4	5,7	4,5	3,9	2,2	1,8	4,1	11,9	7,8	6,4	4,1	3,2	3,4	3,4	6,2	1,4	7,9	5,9	8,5	4,9	4,2	2,8
2007	2,9	2,9	2,8	6,2	6,0	1,6	2,5	6,3	6,0	4,0	3,7	2,2	1,5	4,4	10,2	8,9	5,2	1,1	3,9	3,5	3,1	6,6	1,9	6,2	6,8	10,4	4,5	2,5	3,0
2008f	1,0	1,0	1,3	6,4	4,2	-0,6	1,3	-2,4	-2,0	2,9	1,2	0,7	-0,6	3,6	-2,3	3,4	1,0	0,9	2,1	1,9	1,7	5,0	0,2	7,8	4,0	7,1	1,5	0,5	0,7

Source : Eurostat, Structural indicators database

f = forecast

Context 1: GDP per capita in Purchasing Power Standards (PPS), (EU-27 = 100)

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2000	100,0	105,0	125,9	27,8	68,5	131,6	118,5	44,6	131,0	84,1	97,3	115,3	116,9	88,8	36,7	39,3	243,7	56,1	83,6	134,3	131,4	48,2	78,0	25,9	79,8	1,7	117,3	126,7	119,0
2005	100,0	104,1	119,4	34,5	75,9	123,6	116,9	61,1	144,1	92,8	102,0	110,8	104,7	90,9	48,6	52,9	254,1	63,2	78,2	130,8	124,8	51,3	76,9	35,0	87,4	2,0	114,3	120,3	121,8
2006	100,0	103,9	118,5	36,5	77,4	122,9	115,8	65,3	147,4	94,1	104,1	109,5	103,5	90,3	52,6	55,5	267,1	63,6	76,9	130,9	124,3	52,3	76,4	38,4	87,7	2,1	114,9	121,5	120,4
2007	100,0	103,7	118,2	37,3	80,2	120,1	114,8	68,0	150,4	94,9	105,5	109,2	101,5	90,7	54,7	59,5	266,5	62,6	77,8	131,0	124,0	53,4	76,2	42,2	89,3	2,2	115,9	122,2	119,2
2008f	100	103,6	114,7	38,5	80,6	116,3	112,4	64,8	140,1	94,1	101,7	105,7	97,6	89,3	52,6	59,9	261,1	61,5	76,4	129	121,5	54,3	73,7	44,3	89,3	69,1	114,1	118,1	115,5

f = forecast

Source : Eurostat, Structural indicators database

Context 2a: Employment rate (% of population aged 15-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	total	:	61,2	57,4	:	67,3	75,1	63,9	64,6	60,6	56,0	51,3	60,2	51,9	:	59,9	62,3	60,5	53,7	:	70,2	67,9	59,0	66.8b	64,2	62,9	60,6	64,6	70,3	70,5
	male	:	70,6	67,1	:	76,0	79,9	71,9	69,6	72,1	71,7	66,8	67,4	66,8	:	65,1	66,2	74,5	60,5	:	80,2	77,0	66,5	75.9b	70,4	67,2	67,8	67,8	72,8	77,3
	female	:	51,8	47,6	:	58,7	70,2	55,8	60,3	49,0	40,5	35,8	53,1	37,3	:	55,1	58,6	46,2	47,2	:	60,1	58,8	51,7	58.2b	58,2	58,6	53,5	61,2	67,9	63,6
2000	total	62,2	62,4	60,5	50,4	65,0	76,3	65,6	60,4	65,2	56,5	56,3	62,1	53,7	65,7	57,5	59,1	62,7	56,3	54,2	72,9	68,5	55,0	68,4	63,0	62,8	56,8	67,2	73,0	71.2b
	male	70,8	71,2	69,5	54,7	73,2	80,8	72,9	64,3	76,3	71,5	71,2	69,2	68,0	78,7	61,5	60,5	75,0	63,1	75,0	82,1	77,3	61,2	76,5	68,6	67,2	62,2	70,1	75,1	77.8b
	female	53,7	53,6	51,5	46,3	56,9	71,6	58,1	56,9	53,9	41,7	41,3	55,2	39,6	53,5	53,8	57,7	50,1	49,7	33,1	63,5	59,6	48,9	60,5	57,5	58,4	51,5	64,2	70,9	64.7b
2002	total	62,3	62,8	59,9	50,6	65,4	75,9	65,4	62,0	65,5	57,5	58,5	63,0	55,5	68,6	60,4	59,9	63,4	56,2	54,4	74,4	68,7	51,5	68,8	57.6b	63,4	56,8	68,1	73,6	71,3
	male	70,3	71,0	68,3	53,7	73,9	80,0	71,8	66,5	75,4	72,2	72,6	69,5	69,1	78,9	64,3	62,7	75,1	62,9	74,7	82,4	76,4	56,9	76,5	63.6b	68,2	62,4	70,0	74,9	77,6
	female	54,4	54,7	51,4	47,5	57,0	71,7	58,9	57,9	55,4	42,9	44,4	56,7	42,0	59,1	56,8	57,2	51,6	49,8	33,9	66,2	61,3	46,2	61,4	51.8b	58,6	51,4	66,2	72,2	65,2
2004	total	62,9	63,3	60,3	54,2	64,2	75,7	65,0	63,0	66,3	59,4	61,1	63,1	57.6b	68,9	62,3	61,2	62,5	56,8	54,0	73,1	67.8b	51,7	67,8	57,7	65,3	57,0	67,6	72,1	71,6
	male	70,3	70,9	67,9	57,9	72,3	79,7	70,8	66,4	75,9	73,7	73,8	69,0	70.1b	79,8	66,4	64,7	72,8	63,1	75,1	80,2	74.9b	57,2	74,2	63,4	70,0	63,2	69,7	73,6	77,8
	female	55,4	55,7	52,6	50,6	56,0	71,6	59,2	60,0	56,5	45,2	48,3	57,4	45.2b	58,7	58,5	57,8	51,9	50,7	32,7	65,8	60.7b	46,2	61,7	52,1	60,5	50,9	65,6	70,5	65,6
2005	total	63.4p	63.9p	61,1	55,8	64,8	75,9	66p	64,4	67,6	60,1	63.3b	63,1	57,6	68,5	63,3	62,6	63,6	56,9	53,9	73,2	68,6	52,8	67,5	57,6	66,0	57,7	68,4	72.5b	71,7
	male	70.8p	71.3p	68,3	60,0	73,3	79,8	71.3p	67,0	76,9	74,2	75.2b	68,8	69,9	79,2	67,6	66,1	73,3	63,1	73,8	79,9	75,4	58,9	73,4	63,7	70,4	64,6	70,3	74.4b	77,6
	female	56.2p	56.5p	53,8	51,7	56,3	71,9	60.6p	62,1	58,3	46,1	51.2b	57,6	45,3	58,4	59,3	59,4	53,7	51,0	33,7	66,4	62,0	46,8	61,7	51,5	61,3	50,9	66,5	70.4b	65,9
2006	total	64.4p	64.7p	61,0	58,6	65,3	77,4	67.5p	68,1	68,6	61,0	64,8	63p	58,4	69,6	66,3	63,6	63,6	57,3	54,8	74,3	70,2	54,5	67,9	58,8	66,6	59,4	69,3	73,1	71,5
	male	71.6p	72p	67,9	62,8	73,7	81,2	72.8p	71,0	77,7	74,6	76,1	68.5p	70,5	79,4	70,4	66,3	72,6	63,8	74,5	80,9	76,9	60,9	73,9	64,6	71,1	67,0	71,4	75,5	77,3
	female	57.2p	57.4p	54,0	54,6	56,8	73,4	62.2p	65,3	59,3	47,4	53,2	57.7p	46,3	60,3	62,4	61,0	54,6	51,1	34,9	67,7	63,5	48,2	62,0	53,0	61,8	51,9	67,3	70,7	65,8
2007	total	65,4	65,8	62,0	61,7	66,1	77,1	69,4	69,4	69,1	61,4	65,6	64,6	58,7	71,0	68,3	64,9	64,2	57,3	54,6	76,0	71,4	57,0	67,8	58,8	67,8	60,7	70,3	74,2	71,5
	male	72,5	73,0	68,7	66,0	74,8	81,0	74,7	73,2	77,4	74,9	76,2	69,3	70,7	80,0	72,5	67,9	72,3	64,0	72,9	82,2	78,4	63,6	73,8	64,8	72,7	68,4	72,1	76,5	77,5
	female	58,3	58,6	55,3	57,6	57,3	73,2	64,0	65,9	60,6	47,9	54,7	60,0	46,6	62,4	64,4	62,2	56,1	50,9	35,7	69,6	64,4	50,6	61,9	52,8	62,6	53,0	68,5	71,8	65,5

Source : Eurostat - Labour Force Survey, Annual averages.

b= break in data series

Context 2b: Unemployment rate (% of labour force aged 15+)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	9,3	9,3	:	6,4	4,9	8,8	9,2	7,5	10,8	15,0	11,1	11,3	:	14,3	13,2	2,7	8,4	:	3,8	4,5	10,2	5,1	5,4	7,4	12,6	11,4	8,2	6,1
	Males	:	8,0	7,7	:	5,0	3,9	7,1	9,9	7,7	7,0	11,2	9,5	8,8	:	15,1	14,6	1,9	9,0	:	3,0	3,8	8,5	4,1	5,5	7,3	12,2	10,9	8,4	6,8
	Females	:	11,2	11,6	:	8,1	6,0	11,1	8,3	7,3	16,7	21,1	12,9	15,4	:	13,6	11,7	4,0	7,8	:	5,0	5,4	12,2	6,3	5,3	7,5	13,1	12,0	8,0	5,3
2000	Total	8,7	8,6	6,9	16,4	8,7	4,3	7,2	12,8	4,2	11,2	11,1	9,1	10,1	4,9	13,7	16,4	2,3	6,4	6,7	2,8	3,6	16,1	4,0	7,2	6,7	18,8	9,8	5,6	5,5
	Males	7,5	7,4	5,6	16,7	7,3	3,9	6,0	13,8	4,3	7,4	7,9	7,6	7,8	3,2	14,4	18,6	1,8	7,0	6,4	2,2	3,1	14,4	3,2	7,8	6,5	18,9	9,1	5,9	6,0
	Females	10,1	10,2	8,5	16,2	10,3	4,8	8,7	11,8	4,2	17,1	16,0	10,9	13,6	7,2	12,9	14,1	3,1	5,6	7,4	3,6	4,3	18,1	4,9	6,4	7,0	18,6	10,6	5,3	4,9
2002	Total	8,9	8,7	7,5	18,1	7,3	4,6	8,2	10,3	4,5	10,3	11,1	8,7	8,6	3,6	12,2	13,5	2,7	5,8	7,5	2,8	4,2	19,9	5,0	8,4	6,3	18,7	9,1	4,9	5,1
	Males	8,0	7,8	6,7	18,9	5,9	4,3	7,1	10,8	4,7	6,8	8,1	7,8	6,7	2,9	13,3	14,2	2,0	6,2	6,6	2,5	4,0	19,1	4,1	9,1	5,9	18,6	9,1	5,3	5,6
	Females	10,0	10,0	8,6	17,3	9,0	5,0	9,4	9,7	4,1	15,6	15,7	9,8	11,5	4,5	11,0	12,8	3,7	5,4	9,3	3,1	4,4	20,9	6,0	7,7	6,8	18,7	9,1	4,6	4,5
2004	Total	9,1	9,1	8,4	12,0	8,3	5,5	9,5	9,7	4,5	10,5	10,6	9,6	8b	4,6	10,4	11,4	5,1	6,1	7,4	4,6	4.8b	19,0	6,7	8,1	6,3	18,2	8,8	6,3	4,7
	Males	8,2	8,1	7,5	12,5	7,1	5,1	8,7	10,4	4,9	6,6	8,0	8,7	6.4b	3,6	10,6	11,0	3,7	6,1	6,6	4,3	4.4b	18,2	5,8	9,1	5,8	17,4	8,7	6,5	5,0
	Females	10,1	10,2	9,5	11,5	9,9	6,0	10,5	8,9	4,1	16,2	14,3	10,6	10.5b	6,0	10,2	11,8	7,1	6,1	9,0	4,8	5.3b	19,9	7,6	6,9	6,8	19,2	8,9	6,1	4,2
2005	Total	8,7	8,7	8,4	10,1	7,9	4,8	9.4p	7,9	4,3	9,8	9,2	9.7p	7,7	5,2	8,9	8,3	4,5	7,2	7,3	4,7	5,2	17,7	7,6	7,2	6,5	16,3	8,4	7.4b	4,8
	Males	7,9	7,9	7,6	10,3	6,5	4,4	8.7p	8,8	4,6	6,1	7,0	8.8p	6,2	4,3	9,1	8,2	3,5	7,0	6,5	4,4	4,9	16,6	6,7	7,8	6,1	15,5	8,2	7.5b	5,1
	Females	9,7	9,8	9,5	9,8	9,8	5,3	10.3p	7,1	4,0	15,3	12,2	10.7p	10,1	6,5	8,7	8,3	5,8	7,4	9,0	5,1	5,5	19,1	8,7	6,4	7,0	17,2	8,6	7.3b	4,3
2006	Total	7,9	7,9	8,2	9,0	7,1	3,9	8.4p	5,9	4,4	8,9	8,5	9.5p	6,8	4,6	6,8	5,6	4,7	7,5	7,3	3,9	4,7	13,8	7,7	7,3	6,0	13,4	7,7	7,1	5,3
	Males	7,2	7,1	7,4	8,6	5,8	3,3	7.7p	6,2	4,6	5,6	6,3	8.8p	5,4	4,0	7,4	5,8	3,5	7,2	6,5	3,5	4,4	13,0	6,5	8,2	4,9	12,3	7,4	6,9	5,7
	Females	8,9	9,0	9,3	9,3	8,8	4,5	9.2p	5,6	4,1	13,6	11,6	10.4p	8,8	5,4	6,2	5,4	6,2	7,8	8,9	4,4	5,2	14,9	9,0	6,1	7,2	14,7	8,1	7,2	4,9
2007	Total	7,1	7,1	7,5	6,9	5,3	3,8	8,6	4,7	4,6	8,3	8,3	7,9	6,1	3,9	6,0	4,3	4,1	7,4	6,5	3,2	4,4	9,6	8,0	6,4	4,8	6,9	6,2	5,3	5,3
	Males	6,5	6,5	6,7	6,5	4,2	3,5	8,5	5,4	4,9	5,2	6,4	7,4	4,9	3,4	6,4	4,3	3,6	7,1	6,0	2,8	3,9	9,0	6,6	7,2	4,0	6,5	5,9	5,6	5,6
	Females	7,8	7,9	8,4	7,3	6,7	4,2	8,7	3.9u	4,2	12,8	10,9	8,5	7,9	4,6	5,6	4,3	4,7	7,7	7,6	3,6	5,0	10,3	9,6	5,4	5,8	7,2	6,5	4,9	5,0

Source: Eurostat - Harmonised unemployment series, Annual average
p = provisional value u = unreliable or uncertain data b= break in data series

Context 2c: Youth unemployment rate (% of labour force aged 15-24)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	19,5	22,1	:	12,8	7,3	15	15,2	11,3	29,9	33,1	25,6	29,9	:	26,8	25,5	6,9	15	:	7,6	6,4	22,5	10,7	15,8	17,8	25,1	23,5	16,1	13,1
	Males	:	17,7	20,2	:	11,5	7,1	12,3	16,7	11,6	21,3	25,9	23,3	25,4	:	27,4	30,1	6,5	16,6	:	7,4	5	20,2	8,5	15,6	16,9	26,6	22,8	16,4	14,8
	Females	:	21,6	24,5	:	14,4	7,4	17,9	13,1	11	40,2	42,4	28,3	35,5	:	26	18,4	7,3	13	:	7,9	7,9	25,1	13,2	16,1	18,8	23,4	24,3	15,8	11,3
2000	Total	17,9	17,6	16,7	33,7	17,8	6,2	10,6	23,9	6,8	29,1	24,3	20,1	27	10,1	21,4	30,6	7,1	12,4	13,7	5,7	5,3	35,1	8,8	20	16,3	36,9	21,4	10,5	12,6
	Males	16,7	16,2	14,5	36,1	18,5	6,6	9,4	23,8	6,8	21,5	18,1	18	23,1	6,9	21,2	32,3	6,5	13,6	14,9	4,9	4,7	33,3	6,6	22,2	14,6	39,7	21,1	11	13,7
	Females	19,3	19,3	19,5	30,7	17	5,7	11,9	24,1	7	38,1	32,5	22,5	31,9	13	21,6	28,3	7,9	10,8	12,3	6,5	6	37,2	11,5	17,2	18,3	33,8	21,6	9,9	11,4
2002	Total	18,9	18,5	17,7	37	16,9	7,4	14,2	17,6	8,5	26,8	24,2	19,7	23,1	8,1	22	22,5	7,7	12,7	17,1	5	6,7	42,5	11,6	23,2	16,5	37,7	21	11,9	12
	Males	18,1	17,5	17,2	40,1	16,6	7,3	13	14,3	9,3	19,9	19,2	18,2	19,4	7,9	20,4	22,6	6,1	13,2	17,6	5,2	6,4	41,9	9,8	24,3	15	39,5	21,2	12	13,7
	Females	19,8	19,6	18,3	33,2	17,2	7,5	15,4	22,5	7,6	35,3	31,1	21,7	27,8	8,3	24,3	22,2	9,6	11,9	16,7	4,8	7,1	43,3	13,9	21,8	18,6	35,5	20,9	11,8	10,2
2004	Total	19,2	19	21,2	25,8	21	8,2	15	21,7	8,9	26,9	23,9	21,8	23,5b	10,5	18,1	22,7	16,8	15,5	16,8	8	9,4b	39,6	15,3	21,9	16,1	33,1	20,7	16,3	12,1
	Males	18,7	18,4	20,2	27	22,2	8,9	15,2	21,2	9,3	19,1	19,4	20,8	20,6b	9,4	16	22,5	12	16,2	16,3	7,9	9b	37,7	13,5	24,2	13,9	34,7	22	15,7	13,4
	Females	19,8	19,7	22,4	24,3	19,5	7,4	14,8	22,4	8,5	36,3	30,1	23	27,2b	11,6	21,3	22,9	22,3	14,4	17,4	8,1	9,8b	41,9	17,6	18,9	19,2	31	19,4	16,9	10,7
2005	Total	18,4	18,3	21,5	22,3	19,2	8,6	14,1p	15,9	8,6	26	19,7	22,7p	24	13	13,6	15,7	13,7	19,4	16,4	8,2	10,3	36,9	16,1	20,2	15,9	30,1	20,1	21,1b	12,9
	Males	18,1	17,9	21	23,4	19,3	8,6	14,4p	16,6	9,1	18,7	16,7	21,3p	21,5	11,9	11,8	15,9	11,7	19,6	16,8	8	10,5	35,7	13,6	21,6	14,5	31	20,6	21,1b	14,5
	Females	18,7	18,7	22,1	21	19,1	8,6	13,8p	14,9	8	34,8	23,4	24,4p	27,4	14,2	16,2	15,3	16,2	19	16	8,4	10,1	38,3	19,1	18,4	17,8	28,8	19,5	21,1b	11,1
2006	Total	17,3	17,1	20,5	19,5	17,5	7,7	13,7	12u	8,6	25,2	17,9	21,3	21,6	10	12,2	9,8	16,2	19,1	15,9	6,6	9,1	29,8	16,3	21,4	13,9	26,6	18,7	21,5	14
	Males	16,9	16,7	18,8	18,9	16,6	7,9	14,8	10	9,1	17,7	15	20,1	19,1	8,9	10,5	10u	17u	18,6	17,2u	6,1	8,9	28,3	14,5	22,3	11,6u	26,4	19	21	15,7
	Females	17,7	17,5	22,6	20,3	18,7	7,5	12,5	14,7	8	34,7	21,6	22,9	25,3	11,1	14,7	9,6	15,2	19,8	14,3u	7,1	9,3	31,6	18,4	20,2	16,8u	27	18,4	22	12
2007	Total	15,4	15,3	18,8	15,1	10,7	7,9	11,9	10u	9,1	22,9	18,2	18,7	20,3	10,2	10,7	8.2u	15.2u	18	13,9	5,9	8,7	21,7	16,6	20,1	10,1	20,3	16,5	19,3	14,4
	Males	15,1	14,9	17,1	14,5	10,6	8,2	12,6	:	10	15,7	15,2	18	18,2	11	11,2	7u	13.5u	17,6	15,8u	5,6	8,3	20	13,5	21,1	9.4u	20,4	16,4	18,8	15,8
	Females	15,8	15,7	20,9	15,9	11	7,5	11,1	:	8,1	32,1	21,9	19,6	23,3	9,4	10u	10u	17.5u	18,6	11,6u	6,2	9,1	23,8	20,3	18,7	11.2u	20,2	16,6	19,8	12,5

Source: Eurostat - Harmonised unemployment series, Annual average
p = provisional value u = unreliable or uncertain data b= break in data series

Context 2d: Long-term unemployment rate by gender, selected years (% of the labour force 15+)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	4,4	5,6	:	2	1,3	4,5	4,2	3,9	5,8	7,5	4,5	6,8	:	7,9	7,5	0,9	4,2	:	1,5	1,3	4,7	2,2	2,3	3,3	6,5	4,1	2,6	1,9
	Males	:	3,6	4,5	:	1,5	0,9	3,4	4,4	4,7	3,1	4,9	3,8	5,3	:	8,3	7,9	0,7	4,5	:	1,3	1	3,5	1,7	2,2	3,3	6	4,3	3,2	2,4
	Females	:	5,5	7,1	:	2,6	1,7	6	4,1	2,8	10	11,6	5,3	9,1	:	7,5	7	1,1	3,8	:	1,8	1,8	6,3	2,8	2,5	3,3	7,1	3,9	1,8	1,2
2000	Total	4,1	3,9	3,7	9,4	4,2	0,9	3,7	5,9	1,6	6,2	4,6	3,5	6,3	1,2	7,9	8	0,6	3,1	4,4	0,8	1	7,4	1,7	3,5	4,1	10,3	2,8	1,4	1,4
	Males	4,2	3,3	3	9,6	3,5	0,8	3	6,7	2	3,6	2,8	2,9	4,8	0,5	8,3	9,4	0,5	3,5	4,5	0,6	0,9	6	1,4	3,6	4,1	10,3	2,8	1,7	1,9
	Females	4	4,8	4,6	9,2	5,2	1,1	4,6	5	1	10,2	7,4	4,3	8,4	2,2	7,5	6,5	0,6	2,5	4,2	1	1,2	9,1	2	3,4	4,2	10,2	2,7	1	0,9
2002	Total	4,6	3,9	3,7	12	3,7	0,9	3,9	5,4	1,4	5,3	3,7	3,1	5,1	0,8	5,5	7,2	0,7	2,5	3,3	0,7	1,1	10,9	1,7	4	3,5	12,2	2,3	1	1,1
	Males	4,6	3,3	3,2	12,5	3	0,7	3,3	6,3	1,8	3,1	2,3	2,6	4	0,5	6,4	7,6	0,6	2,8	3,5	0,6	1	9,7	1,4	4,1	3,4	11,9	2,5	1,2	1,4
	Females	4,5	4,6	4,3	11,4	4,6	1	4,8	4,4	0,8	8,6	5,9	3,5	6,9	1	4,6	6,8	0,9	2,2	2,4	0,9	1,2	12,3	2,1	4	3,6	12,5	2	0,8	0,7
2004	Total	4,2	4,1	4,1	7,2	4,2	1,2	5,4	5	1,6	5,6	3,4	3,9	4b	1,2	4,6	5,8	1,1	2,7	3,4	1,6	1,3b	10,3	3	4,5	3,2	11,8	2,1	1,2	1
	Males	3,7	3,6	3,7	7,3	3,4	1,1	4,8	5,6	2	3	2,2	3,5	2,9b	0,9	4,8	5,5	0,8	2,8	3,7	1,5	1,3b	9,6	2,6	5,2	3,1	11,3	2,3	1,4	1,2
	Females	4,7	4,7	4,7	7	5,3	1,3	6,1	4,4	1	9,4	5,1	4,3	5,5b	1,6	4,3	6,2	1,4	2,6	3	1,6	1,4b	11	3,4	3,6	3,4	12,4	2	1	0,6
2005	Total	4p	3,9p	4,4	6	4,2	1,1	5p	4,2	1,5	5,1	2,2b	4	3,9	1,2	4,1	4,3	1,2p	3,2	3,4	1,9	1,3	10,2	3,7	4	3,1	11,7	2,2	1,2p	1
	Males	3,6p	3,5p	3,8	6,1	3,4	1,1	4,7p	4,2	1,9	2,6	1,4b	3,5	2,9	0,8	4,4	4,2	1,2p	3,3	3,4	1,9	1,2	9,3	3,2	4,6	2,9	11,2	2,4	1,4p	1,3
	Females	4,5p	4,5p	5	6	5,3	1,2	5,5p	4,2	0,8	8,9	3,4b	4,5	5,2	1,7	3,7	4,5	1,2p	3,2	3,2	1,9	1,4	11,4	4,2	3,4	3,3	12,3	1,9	1p	0,7
2006	Total	3,6p	3,6p	4,2	5	3,9	0,8	4,7p	2,8	1,4	4,8	1,8	4p	3,4	0,9	2,5	2,5	1,4p	3,4	2,9	1,7	1,3	7,8	3,8	4,2	2,9	10,2	1,9	1,1	1,2
	Males	3,3p	3,2p	3,7	4,8	3,1	0,7	4,4p	3,1	1,8	2,6	1,2	3,7p	2,6	0,7	3	2,5	1,2p	3,3	3,1	1,6	1,3	7,1	3,3	4,7	2,4	9,4	2,1	1,2	1,5
	Females	4p	4p	4,9	5,2	4,9	0,9	5,2p	2,6	0,9	8	2,8	4,3p	4,5	1,2	1,9	2,4	1,6p	3,4	2,5	1,8	1,3	8,6	4,4	3,6	3,5	11,2	1,8	0,9	0,8
2007	Total	3.1	3.0	3.8	4.1	2.8	0.6	4.7	2.3	1.4	4.1	1.7	3.3	2.9	0.7	1.6	1.4	1.2	3.4	2.7	1.3	1.2	4.9	3.8	3.2	2.2	8.3	1.6	0.9	1.3
	Males	2.8	2.8	3.3	3.7	2.1	0.5	4.8	2.9	1.8	2.2	1.1	3.1	2.2	0.8	1.9	1.4	1.2	3.3	2.8	1.2	1.0	4.6	3.2	3.6	1.8	7.4	1.7	0.9	1.6
	Females	3.3	3.3	4.3	4.5	3.6	0.7	4.7	1.7	0.9	7.0	2.5	3.6	3.9	0.7	1.2	1.3	1.1	3.6	2.4	1.4	1.4	5.4	4.5	2.7	2.7	9.3	1.4	0.8	0.9

Source : Eurostat - Labour Force Survey, Annual averages

p = provisional value u = unreliable or uncertain data b= break in data series

Context 4: Old age dependency ratio (current and projected) - ratio between the total number of people aged 65 and over and the number of persons of working age (from 15 to 64)

	EU27	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
2010	25,9	26,1	25,3	21,8	25,0	31,2	25,0	16,7	28,2	24,4	25,8	31,0	18,0	25,2	23,2	21,1	24,2	21,2	22,8	26,0	19,0	26,6	21,3	23,9	17,0	25,7	27,8	24,7
2020	31,1	30,6	31,1	31,1	31,9	35,3	29,2	20,2	32,8	27,4	32,8	35,5	22,3	28,1	26,0	24,2	30,3	31,3	30,7	29,2	27,2	30,7	25,7	31,2	23,9	36,8	33,7	28,6
2030	38,0	37,6	36,3	35,7	37,9	46,2	34,4	24,6	38,5	34,3	39,0	42,5	27,4	34,6	34,7	30,8	34,1	39,1	40,0	38,1	36,0	36,6	30,3	40,8	32,3	43,9	37,4	33,2
2040	45,4	42,3	43,6	42,7	42,7	54,7	39,0	30,6	48,3	46,4	44,0	54,1	30,8	40,7	42,8	36,3	40,1	41,7	46,8	46,0	41,3	44,6	40,8	49,4	40,0	45,1	40,8	36,9
2050	50,4	43,9	55,4	54,8	41,3	56,4	47,2	40,4	57,0	58,7	44,7	59,2	37,7	51,2	51,1	37,8	50,8	49,8	45,6	48,3	55,7	53,0	54,0	59,4	55,5	46,6	41,9	38,0
2060	53,5	45,8	63,5	61,4	42,7	59,1	55,6	43,6	57,1	59,1	45,2	59,3	44,5	64,5	65,7	39,1	57,6	59,1	47,2	50,7	69,0	54,8	65,3	62,2	68,5	49,3	46,7	42,1

Source : Eurostat - EUROPOP2008 Trend scenario - baseline variant

Context 5a: Distribution of households by age and household type (private/institutional)

		EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Total	Total ('000)	441467	10296	7904	10230	5349	82277	1370	10628	40847	58514	3852	56996	690	2377	3484	440	10198	0	15986	8033	38230	10356	21681	1964	5379	5181	0	58789
	Private households (%)	98,7	98,6	99,3	99,3	98,7	99,0	98,8	96,6	99,4	97,8	98,4	99,3	99,4	99,0	99,3	98,3	97,5	-	98,6	98,9	98,9	99,0	98,5	99,3	98,4	98,1	-	98,2
	Institutional household (%	1,3	1,4	0,7	0,7	1,3	1,0	0,9	3,4	0,6	2,2	1,6	0,7	0,6	1,0	0,7	1,7	2,4	-	1,4	1,1	1,1	1,0	1,5	0,7	0,8	0,7	-	1,8
	Total ('000)	90525	2162	1531	2057	1161	15251	312	2011	7341	13426	1009	9833	180	541	846	98	2087	0	3532	1639	8851	2053	4847	376	1277	1135	0	13346
Children (0-17)	Private households (%)	99,4	99,9	97,9	99,8	99,4	99,7	99,2	97,8	99,9	99,2	99,6	99,9	99,9	99,4	99,3	99,0	96,9	-	99,7	99,7	99,2	99,5	98,3	:	98,3	99,1	-	99,3
	Institutional household (%	0,6	0,1	2,1	0,2	0,6	:	0,6	2,2	0,1	0,8	0,4	0,1	0,1	0,6	0,7	1,0	3,1	-	0,3	0,3	0,8	0,5	1,7	:	0,4	0,4	-	0,7
18-64	Total ('000)	279593	6390	5586	6759	3396	52516	852	6824	26547	35788	2420	36517	428	1485	2148	281	6565	0	10279	5152	24522	6610	15420	1299	3444	3269	0	36103
	Private households (%)	99,0	99,5	99,4	99,5	98,9	99,6	98,9	96,0	99,7	98,2	98,9	99,5	99,7	99,0	99,4	99,0	97,7	-	99,4	99,4	98,8	99,6	98,0	:	98,7	98,4	-	98,5
	Institutional household (%	1,0	0,5	0,6	0,5	1,1	:	0,9	4,0	0,3	1,8	1,1	0,5	0,3	1,0	0,6	1,0	2,2	-	0,6	0,6	1,2	0,4	2,0	:	0,6	0,3	-	1,5
65+	Total ('000)	71306	1744	1322	1411	792	14510	205	1792	6974	9299	423	10646	80	352	489	61	1546	0	2174	1242	4853	1693	3050	289	611	777	0	9341
	Private households (%)	96,4	93,9	99,6	97,7	96,7	96,3	98,1	97,5	97,7	94,3	92,8	97,9	96,4	98,7	98,9	93,7	97,5	-	93,5	95,8	98,8	96,4	99,6	:	97,0	95,1	-	95,4
	Institutional household (%	3,6	6,1	0,4	2,3	3,3	:	1,7	2,5	2,3	5,7	7,2	2,1	3,6	1,3	1,1	6,3	2,5	-	6,5	4,2	1,2	3,6	0,4	:	2,7	3,1	-	4,6
75+	Total ('000)	30917	774	481	570	379	6191	75	642	3036	4133	184	4762	34	126	178	25	619	0	972	582	1841	701	1063	110	238	340	0	4405
	Private households (%)	93,3	88,4	99,3	95,7	94,2	92,5	96,9	96,7	96,1	89,5	87,6	96,5	92,7	98,1	98,3	87,0	95,8	-	87,2	92,4	98,1	93,1	99,4	88,4	95,4	90,8	-	91,5
	Institutional household (%	6,7	11,5	0,7	4,3	5,8	7,5	2,9	3,3	3,9	10,5	12,4	3,5	7,3	1,9	1,7	13,0	4,2	-	12,8	7,6	1,9	6,9	0,6	5,3	4,2	6,0	-	8,5
	Hospitals (%)	19,9	5,3	14,0	4,9	:	:	3,6	20,4	12,5	13,8	27,8	1,5	5,8	2,0	5,2	9,8	11,8	-	20,8	19,4	18,5	3,3	30,7	:	13,3	27,9	-	44,6
	Old people's homes (%)	68,0	85,1	83,8	86,3	:	:	95,4	34,3	56,6	79,5	56,4	73,2	91,0	97,7	89,1	69,2	83,4	-	75,9	76,3	65,8	85,8	59,4	:	75,1	58,5	-	46,0

Source: Eurostat Census data collection 2000-01

Context 5b: Population living in private households by household type, 2007 (percentage of total population)

	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
- Single adults, no children	13	15		9	22	18	14	8	7	6	15	12	5	10	11	12	9	7	16	15	9	6	7	8	18	20	14
of which:																										:	
- Single men	5	7		4	10	7	5	4	2	2	6	5	2	3	3	5	3	3	7	6	3	2	2	2	8	9	6
- Single women	8	8		6	11	11	9	4	5	4	9	7	3	7	8	7	7	4	9	9	6	4	5	7	11	10	7
																										:	
- Under 65	7	9		5	15	12	8	4	4	3	8	6	3	5	6	8	5	3	11	9	4	2	3	3	12	12	8
- 65 and over	5	6		4	7	6	6	4	4	3	6	6	2	5	5	4	5	4	5	6	5	4	4	5	6	7	6
- Single parents	5	6		4	7	6	7	8	2	2	5	3	2	5	6	4	5	2	4	4	3	3	3	3	5	8	8
- 2 adults below 65, no children	13	15		14	18	16	11	10	9	10	16	9	8	10	9	12	11	9	17	13	8	9	8	7	19	16	17
- 2 adults, at least one aged 65+, no children	11	10		9	10	13	9	7	12	9	11	12	9	9	9	9	9	8	10	9	7	11	8	7	10	10	11
- 3 or more adults, no children	12	9		15	3	7	10	12	23	23	5	18	13	13	10	11	14	20	7	13	13	18	19	17	5	2	11
- 2 adults, 1 child	12	11		12	10	12	15	10	10	13	13	13	10	14	16	13	12	11	11	11	12	17	11	9	12	11	10
- 2 adults, 2 children	18	16		21	19	15	14	15	25	20	24	19	26	13	17	25	16	17	20	15	15	16	19	17	16	19	16
- 2 adults, 3 or more children	7	11		5	10	6	6	14	3	3	7	5	10	5	7	7	9	8	12	8	7	4	5	8	12	10	8
- 3 or more adults, with children	10	7		11	2	6	14	17	10	14	4	11	16	21	16	8	15	18	5	12	25	17	19	24	3	4	7

EU aggregates based on available country data

Source : Eurostat - European Labour Force Survey

Context 6a: General government debt - General government consolidated gross debt as a percentage of GDP

	EU-27	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
2000	61,7	107,8	74,3	18,5	51,7	59,7	5,2	37,7	101,8	59,2	56,7	109,2	58,8	12,3	23,7	6,4	54,2	55,9	53,8	66,4	36,8	50,4	24,7	26,8	50,3	43,8	53,6	41,0
2001	60,8	106,5	67,3	25,1	47,4	58,8	4,8	35,5	102,9	55,5	56,2	108,8	60,7	14,0	23,1	6,5	52,1	62,1	50,7	67,0	37,6	52,9	26,0	27,4	48,9	42,3	54,4	37,7
2002	60,2	103,4	53,6	28,5	46,8	60,3	5,6	32,2	101,5	52,5	58,2	105,7	64,6	13,5	22,3	6,5	55,8	60,1	50,5	66,4	42,2	55,5	25,0	28,1	43,4	41,3	52,6	37,5
2003	61,8	98,6	45,9	30,1	45,8	63,8	5,5	31,1	97,8	48,7	62,9	104,4	68,9	14,6	21,1	6,2	58,1	69,3	52	65,4	47,1	56,9	21,5	27,5	42,4	44,3	52,3	38,7
2004	62,2	94,3	37,9	30,4	43,8	65,6	5	29,4	98,6	46,2	64,9	103,8	70,2	14,9	19,4	6,3	59,4	72,1	52,4	64,8	45,7	58,3	18,8	27,2	41,4	44,1	51,2	40,6
2005	62,7	92,1	29,2	29,8	36,4	67,8	4,5	27,3	98,8	43,0	66,4	105,9	69,1	12,4	18,4	6,1	61,7	69,9	51,8	63,7	47,1	63,6	15,8	27	34,2	41,3	50,9	42,3
2006	61,3	87,8	22,7	29,6	30,5	67,6	4,3	24,7	95,9	39,6	63,6	106,9	64,6	10,7	18	6,6	65,6	63,9	47,4	62	47,7	64,7	12,4	26,7	30,4	39,2	45,9	43,4
2007	58,7	83,9	18,2	28,9	26,2	65,1	3,5	24,8	94,8	36,2	63,9	104,1	59,5	9,5	17	7	65,8	62,2	45,7	59,5	44,9	63,6	12,9	23,4	29,4	35,1	40,4	44,2
2008	*59,8*	*86,5*	*13,8*	*26,6*	*21,1*	*64,3*	*4,2*	*31,6*	*93,4*	*37,5*	*65,4*	*104,1*	*48,2*	*12,3*	*17,5*	*14,1*	*65,4*	*63,1*	*48,2*	*57,4*	*43,7*	*64,3*	*13,4*	*21,8*	*28,8*	*31,6*	*34,7*	*50,1*
2009	*60,9*	*86,1*	*10,6*	*26,4*	*21,1*	*63,2*	*5*	*39,2*	*92,2*	*41,1*	*67,7*	*104,3*	*44,7*	*17,7*	*20*	*14,6*	*66*	*63,2*	*47*	*57,1*	*43,4*	*65,2*	*15,4*	*21,1*	*29*	*30,2*	*33,8*	*55,1*
2010	*61,8*	*85,6*	*7,9*	*26,3*	*20,1*	*61,9*	*6,1*	*46,2*	*91,9*	*44,4*	*69,9*	*103,8*	*41,3*	*23*	*23,3*	*14,5*	*66,2*	*63,1*	*45,9*	*56,9*	*42,9*	*66,6*	*17,1*	*20,1*	*29,3*	*29,8*	*32,4*	*60,3*

Source: Eurostat - General Government data (2000 to 2007) and ECFIN forecasts (2008-2009)

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

	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
Programme scenario																												
2005	63	93,3	:	30,5	35,8	67,7	4,8	27,6	107,5	43,2	66,8	106,4	70,3	11,9	18,7	6,2	58,4	74,7	52,9	62,9	42.5	63,9	:	29,1	34,5	41,1	50,3	42,8
2010	61	72	:	30	18	64	0	17	90	30	60	97	57	9	16	10	61	65	46	54	45	65	:	27	31	25	34	42
2030	79	31	:	43	23	37	-25	37	18	33	41	32	42	26	22	74	51	16	70	23	-33	64	:	65	16	26	-3	44
2050	180	83	:	188	98	65	-82	157	-56	198	66	1	172	92	76	240	155	-58	176	18	-163	208	:	270	66	96	-1	114
2005 budget scenario																												
2010	55	74	:	43,2	14,4	73,6	0,9	13,6	96,9	25,7	69,2	108,9	64,3	13	22,4	11,5	76,1	80,2	44,2	58,9	53,2	76,3	:	25,1	38,7	23,7	30,3	47
2030	33	52	:	95,7	-61,2	116,2	-39,3	7,9	165,2	-13,5	132,8	127,6	116,3	14,9	46,7	56,1	143,6	92,9	67,8	54,9	20	195,4	:	68,5	66,8	7,9	8	90,1
2050	76	129	:	320,3	-135,5	232,4	-117	100,4	451,3	42,6	269,9	208,9	269,9	49,6	135,7	179,1	247,6	79,6	177,7	67,5	-42,5	517,4	:	287,2	176,9	61,6	58,8	186,7

* Adjusted gross debt.

** aggregates exclude Greece

Source: Commission services, 2005/06 updated stability and convergence programmes.

Context 7a: Social protection benefits by group of functions (as a percentage of total benefits) - 2006

	EU-27	EU-25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
Sickness, health care	29.2p	29.2p	25,7	26	34,4	21,6	29.1p	31,2	41,1	28,7	31.2p	29.9p	26.8p	25,7	29.1p	32.1p	25,4	29	28,4	31.8p	25,5	20,4	29,2	34,8	32.1p	31.0p	26,2	26.0p	31.8p
Disability	7.5p	7.5p	6,4	9,1	8,6	14,9	6.2p	9,5	5,4	4,7	7.3p	6.1p	5.9p	3,9	7.3p	10.7p	13,2	9,6	6,3	8.5p	8,2	9,3	10	7,4	8.5p	8.7p	12,7	14.9p	8.7p
Family and children	8.0p	8.0p	7,1	7,4	7,6	13,1	11.1p	12,1	14,7	6,2	5.7p	8.6p	4.5p	10,8	10.2p	9.0p	16,9	13	6,3	5.8p	10,4	4,4	5,1	8,9	8.6p	7.8p	11,6	9.8p	6.1p
Unemployment	5.6p	5.6p	11,9	2,2	3,2	7,2	6.3p	0,9	7,6	4,6	12.5p	6.9p	2.0p	6,1	3.7p	1.9p	4,9	3,1	3,4	5.0p	5,8	3	5,5	2,7	3.0p	3.5p	8,5	5.5p	2.4p
Old age and survivors benefits	46.2p	46.2p	47	52,9	43,1	37,9	44.3p	45,2	27,4	51,3	41.3p	44.3p	60.5p	46,1	48.3p	44.8p	36,7	42,2	52,8	41.4p	48,6	61,2	49,1	45	45.4p	45.3p	37,8	40.2p	44.7p
Housing and social exclusion	3.6p	3.6p	2	2,5	3,1	5,3	3.0p	1	3,8	4,5	2.0p	4.3p	0.3p	7,4	1.4p	1.6p	2,9	3,1	2,8	7.5p	1,5	1,8	1,2	1,2	2.5p	3.6p	3,2	3.6p	6.3p

e: Eurostat estimate; p: provisional

Context 7b: Social protection benefits by group of functions (as a percentage of GDP) - 2006

	EU-27	EU-25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
Total expenditure*	26,9p	27,0p	30,1	15,0	18,7	29,1	28,7p	12,4	18,2	24,2	20,9p	31,1p	26,6p	18,4	12,2p	13,2p	20,4	22,3	18,1	29,3p	28,5	19,2	25,4	14,0	22,8p	15,9p	26,2	30,7p	26,4p
Social protection benefits	25,8p	26,0p	28,7	14,5	18,1	28,3	27,6p	12,2	16,9	23,6	20,4p	29,2p	25,7p	18,1	11,9p	12,8p	20,0	21,8	17,9	27,5p	27,6	18,8	23,8	13,7	22,2p	15,3p	25,4	30,0p	25,9p
Sickness/Health care	7,5p	7,6p	7,4	3,8	6,2	6,1	8,0p	3,8	7,0	6,8	6,4p	8,7p	6,9p	4,6	3,5p	4,1p	5,1	6,3	5,1	8,7p	7,1	3,8	6,9	4,8	7,1p	4,7p	6,6	7,8p	8,2p
Disability	1,9p	1,9p	1,8	1,3	1,5	4,2	1,7p	1,2	0,9	1,1	1,5p	1,8p	1,5p	0,7	0,9p	1,4p	2,6	2,1	1,1	2,3p	2,3	1,7	2,4	1,0	1,9p	1,3p	3,2	4,5p	2,2p
Family/Children	2,1p	2,1p	2,0	1,1	1,4	3,7	3,1p	1,5	2,5	1,5	1,2p	2,5p	1,2p	1,9	1,2p	1,1p	3,4	2,8	1,1	1,6p	2,9	0,8	1,2	1,2	1,9p	1,2p	2,9	2,9p	1,6p
Unemployment	1,4p	1,5p	3,4	0,3	0,6	2,0	1,7p	0,1	1,3	1,1	2,6p	2,0p	0,5p	1,1	0,4p	0,2p	1,0	0,7	0,6	1,4p	1,6	0,6	1,3	0,4	0,7p	0,5p	2,2	1,6p	0,6p
Old age and survivors	11,9p	12,0p	13,5	7,7	7,8	10,7	12,2p	5,5	4,6	12,1	8,4p	12,9p	15,5p	8,3	5,7p	5,7p	7,3	9,2	9,5	11,4p	13,4	11,5	11,7	6,2	10,1p	6,9p	9,6	12,1p	11,6p
Housing and Social exclusion n.e.c.	0,9p	0,9p	0,6	0,4	0,6	1,5	0,8p	0,1	0,6	1,1	0,4p	1,2p	0,1p	1,3	0,2p	0,2p	0,6	0,7	0,5	2,0p	0,4	0,3	0,3	0,2	0,6p	0,6p	0,8	1,1p	1,6p
Administration costs	0,8p	0,8p	1,0	0,4	0,6	0,8	1,0p	0,2	1,3	0,6	0,5p	1,3p	0,7p	0,3	0,3p	0,4p	0,3	0,5	0,2	1,5p	0,5	0,4	0,5	0,2	0,5p	0,6p	0,8	0,7p	0,5p
Other expenditure	0,2p	0,2p	0,4	0,1	0,0	:	0,1p	:	0,0	0,0	0,0p	0,6p	0,2p	0,1	0,1p	0,0p	0,1	:	:	0,4p	0,4	0,0	1,0	0,0	0,0p	0,0p	:	0,0p	0,0p

* including administrative costs; e: Eurostat estimate; p: provisional

Context 8a: Adults aged 18-59 living in jobless households by household types, 2006, in % of total number of adults living in jobless households

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Alone without children	23,1	24,1	32,2	15,3	23,2	:	38,5	31,8	:	19,0	11,5	30,3	18,2	15,2	19,0	26,7	33,3	15,9	12,1	41,9	36,0	14,3	14,3	11,5	29,4	11,8	48,5	:	27,2
Alone with child(ren)	10,3	10,9	14,9	3,9	12,9	:	12,1	12,0	:	3,6	5,6	10,7	3,4	11,8	5,4	10,7	6,1	6,2	10,6	11,7	5,6	7,9	6,2	3,8	5,5	4,0	3,1	:	23,5
Couple without children	22,0	22,1	25,2	19,5	24,0	:	22,5	15,5	:	28,1	14,4	28,9	19,4	30,3	13,6	6,9	31,4	21,9	17,9	24,4	24,4	21,9	22,3	21,0	27,6	19,1	25,3	:	16,6
Couple with child(ren)	15,6	15,0	9,6	19,6	14,5	:	17,4	13,5	:	10,2	20,3	15,3	15,0	18,3	15,8	12,0	12,2	19,4	26,7	14,0	16,3	14,9	14,1	24,3	9,6	16,8	11,2	:	15,4
Other households without children - total	20,0	19,8	11,5	22,0	19,4	:	6,9	19,0	:	33,7	37,7	10,8	34,5	20,9	30,0	30,2	12,7	23,8	28,4	7,6	13,2	25,2	33,5	21,5	23,6	26,2	11,0	:	12,0
- without elderly (65+)	9,5	9,5	6,3	8,9	8,3	:	3,6	4,1	:	13,3	13,8	5,4	16,1	10,4	8,6	9,0	7,1	10,6	11,6	4,8	5,9	12,2	12,7	11,0	11,6	12,4	3,5	:	7,1
- with at least 1 elderly (65+)	10,4	10,4	5,2	13,1	11,2	:	3,3	14,9	:	20,4	23,9	5,4	18,4	10,5	21,4	21,2	5,6	13,2	16,8	2,8	7,3	13,0	20,8	10,5	12,0	13,8	7,5	:	4,9
Other households with child(ren) - total	8,9	8,1	6,5	19,7	5,9	:	2,6	8,2	:	5,5	10,6	4,1	9,4	3,5	16,2	13,4	4,3	12,8	4,4	0,4	4,5	15,8	9,7	17,9	4,3	22,1	0,9	:	5,3
- without elderly (65+)	6,9	6,4	5,6	13,6	4,6	:	2,3	3,6	:	3,6	7,3	3,5	7,8	2,3	12,6	6,0	3,5	10,7	3,0	0,2	3,5	11,6	7,1	11,3	3,7	18,7	0,7	:	4,6
- with at least 1 elderly (65+)	2,1	1,7	0,9	6,1	1,2	:	0,2	4,6	:	1,9	3,3	0,6	1,6	1,2	3,6	7,4	0,8	2,2	1,4	0,2	1,0	4,1	2,6	6,6	0,5	3,5	0,2	:	0,7
Total number in 1000	19386,3	17763	799,9	482,1	437,256		581,56	44,4749		467,909	233,7121	3486,4	2912,8	20,3106	87,6593	126,44	17,52665	640,3	15,38	217,5	406,1	2835	337,8	1142	84,94	305,3	276,7		3427,1

Source : Eurostat - European Labour Force Survey 2006, Spring results. Annual averages for FI.

Context 8b: Children aged 0-17 living in jobless households by household types, 2006, in % of total number of children living in jobless households

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Alone with child(ren) - no elderly	44,6	47,5	61,6	15,8	50,8	:	45,0	48,3	:	30,0	26,8	47,2	21,8	56,8	26,8	38,9	49,7	23,2	41,9	57,8	28,2	34,7	33,2	12,9	40,5	12,4	23,2	:	66,5
Alone with child(ren) - at least 1 elderly	0,4	0,3	0,0	1,2	0,3	:	0,2	10,7	:	1,2	0,8	0,3	0,2	1,1	0,0	1,1	0,7	0,1	1,2	0,0	0,2	0,2	1,4	0,6	0,0	0,0	0,0	:	0,3
Couple with child(ren) - total	39,9	38,4	25,4	50,1	35,9	:	48,4	25,6	:	52,5	49,5	44,8	59,2	38,7	41,8	24,6	41,1	52,5	46,4	40,9	58,1	35,7	39,3	58,2	47,8	51,8	73,4	:	26,1
- without elderly (65+)	38,8	37,3	24,8	47,9	35,7	:	48,0	25,6	:	46,2	45,5	43,3	57,5	37,6	36,7	23,0	35,9	51,9	45,5	39,8	56,4	34,7	36,9	57,2	47,3	51,3	72,8	:	25,4
- with at least 1 elderly (65+)	1,1	1,1	0,6	2,2	0,2	:	0,4	0,0	:	6,3	4,0	1,5	1,7	1,1	5,2	1,6	5,2	0,6	0,9	1,0	1,7	0,9	2,4	1,1	0,5	0,5	0,5	:	0,7
Other households with child(ren) - no elderly	15,1	13,7	13,1	32,9	13,1	:	6,4	15,4	:	16,2	22,8	7,7	18,9	3,4	31,3	35,5	8,6	24,2	10,5	1,3	13,5	29,3	26,1	28,2	11,7	35,8	3,4	:	7,0
- without elderly (65+)	10,5	9,9	11,5	19,9	10,2	:	5,8	5,0	:	7,2	15,5	6,0	13,0	1,1	25,8	11,7	6,0	19,3	6,0	0,6	9,2	18,7	15,9	15,8	5,7	28,9	2,3	:	5,7
- with at least 1 elderly (65+)	4,6	3,9	1,5	13,0	2,9	:	0,7	10,3	:	9,0	7,3	1,7	5,8	2,3	5,5	23,7	2,6	5,0	4,5	0,7	4,2	10,7	10,2	12,5	6,0	7,0	1,1	:	1,3
Total number in 1000	7036,67	6438	289,6	189,76	148,0428	59,58677	203,751	18,92742	117,92024	67,10845	63,63202	1261,13	523,48	7,01462	27,52685	36,5547	3,60966	247,037	8,075	69,681	112,52	854,32	85,391	409,05	12,074	129,1	53,446	0	2038,4

Source : Eurostat - European Labour Force Survey 2006, Spring results. Annual averages for FI.

Context 9a. Unemployment traps, 2006

For unemployed persons (previous work at 67% of Average Wage, full-time) returning to full-time work at 2 different wage levels. Including social assistance where applicable.

	Single person, no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
moving to % of AW	50	67	50	67	50	67	50	67
BE	86%	83%	75%	77%	72%	73%	76%	75%
CZ	66%	63%	62%	62%	84%	69%	74%	73%
DK	94%	91%	85%	91%	73%	89%	97%	94%
DE	79%	76%	97%	87%	97%	85%	91%	90%
EE	64%	64%	64%	64%	61%	61%	64%	64%
IE	93%	77%	-13%	12%	97%	88%	61%	53%
EL	68%	57%	83%	66%	86%	69%	57%	49%
ES	78%	80%	75%	80%	75%	79%	79%	82%
FR	80%	81%	89%	86%	89%	85%	81%	79%
IT	64%	72%	59%	63%	59%	61%	78%	71%
CY	63%	61%	35%	72%	91%	82%	77%	72%
LV	86%	88%	100%	100%	100%	100%	83%	85%
LT	82%	79%	78%	76%	92%	77%	82%	79%
LU	86%	88%	92%	86%	104%	102%	80%	86%
HU	77%	78%	74%	79%	88%	78%	74%	78%
MT	70%	61%	80%	64%	85%	68%	35%	34%
NL	96%	86%	77%	83%	92%	87%	72%	76%
AT	70%	67%	78%	72%	93%	81%	76%	76%
PL	98%	82%	81%	99%	100%	89%	81%	71%
PT	79%	82%	86%	87%	94%	85%	83%	85%
SI	87%	94%	84%	83%	100%	86%	92%	84%
SK	40%	44%	29%	35%	39%	30%	47%	49%
FI	84%	76%	84%	85%	89%	92%	77%	74%
SE	92%	87%	91%	91%	100%	95%	87%	87%
UK	78%	68%	66%	72%	74%	78%	44%	41%

Context 9b. Inactivity Trap at 67% of AW, 2005

Total increase in effective tax burden with and without childcare costs, Lone parents and two-earner couples with two children

	Lone Parents with two children, no childcare	Lone Parents with two children, with childcare	Two-earner Couple with 2 children, no childcare	Two-earner Couple with 2 children, with childcare
% of gross earnings in new job				
BE	74	76	49	56
CZ	69	84	36	51
DK	85	94	54	67
DE	84	90	52	65
IE	57	123	23	90
EL	16	20	16	26
FR	93	100	29	51
LU	71	77	24	37
HU	45	45	50	63
NL	79	81	37	58
AT	73	81	54	83
PL	64	72	43	51
PT	66	68	23	32
SK	56	73	64	81
FI	70	75	50	63
SE	64	69	30	41
UK	70	85	23	88

Transitions from labour-market inactivity to a full-time low-wage job (67% of AW). Person assumed to be aged 40 with 22 years of employment, children aged two and three. For couples the % of AW relates to 1 spouse only. Assumes full-time centre based care while in work and no childcare costs while out of work. Benefits available only on a temporary basis immediately following the transition into work are not taken into account.

Source: Joint Commission -OECD project using tax-benefit Models

Notes:

AETR = 1 - (change in net income / change in gross income). AETRx% is that part of additional gross earnings that is "taxed away" when moving from unemployment (full-time with previous earnings of x% AW) to full time employent (with current earnings of x% AW). AETRs are measure at the household level and take into account increasing taxes and contributions as well as reduced benefits.

Weekly working hours are 0/40 for the out-of-work/in-work situations.

Results do not take into account national minimum wage legislation. As a result, the "33%" and "50%" scenarios may in fact not be relevant for employees covered by minimum wage rules.

For one earner couple households the first spouse is inactive with 0 earnings. The 'x%' therefore relate to the second spouse only.

For two-earners couple households the first spouse's earnings are held fixed at 67% of AW. The 'x%' therefore relate to the second spouse only.

9c. Inactivity traps, 2006

For inactive persons entering work at 2 different wage levels1, 2006

	Single person, no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
moving to % of AW	50	67	50	67	50	67	50	67
BE	66%	65%	75%	71%	68%	65%	42%	47%
CZ	62%	53%	62%	62%	84%	69%	49%	48%
DK	104%	88%	90%	84%	90%	92%	65%	63%
DE	73%	68%	97%	87%	97%	85%	50%	50%
EE	46%	40%	46%	40%	61%	52%	25%	25%
IE	93%	77%	-13%	12%	97%	88%	33%	32%
EL	16%	18%	16%	16%	16%	16%	16%	18%
ES	48%	44%	62%	54%	62%	52%	18%	20%
FR	66%	62%	79%	73%	89%	81%	21%	25%
IT	14%	22%	-10%	-1%	-17%	-8%	40%	42%
CY	68%	52%	56%	75%	126%	96%	6%	6%
LV	61%	54%	100%	100%	100%	100%	45%	41%
LT	39%	37%	64%	55%	85%	71%	19%	22%
LU	80%	67%	88%	69%	82%	89%	16%	20%
HU	44%	43%	51%	49%	69%	61%	5%	13%
MT	71%	62%	81%	64%	86%	69%	35%	34%
NL	98%	85%	77%	74%	93%	88%	41%	44%
AT	70%	64%	78%	70%	93%	81%	25%	30%
PL	67%	59%	50%	75%	68%	66%	52%	50%
PT	41%	37%	58%	55%	58%	57%	18%	20%
SI	71%	73%	84%	75%	100%	86%	68%	63%
SK	28%	29%	35%	34%	47%	38%	22%	24%
FI	84%	72%	62%	64%	89%	92%	31%	32%
SE	92%	77%	65%	63%	100%	95%	29%	30%
UK	78%	68%	66%	72%	74%	78%	40%	38%

Notes:

AETR = 1 - (change in net income / change in gross income). AETRx% is that part of additional gross earnings that is "taxed away" when moving from inactivity (without entitlements to unemeployment benefits) to full time employent (with current earnings of x% AW). AETRs are measure at the household level and take into account increasing taxes and contributions as well as reduced benefits.

Weekly working hours are 0/40 for the out-of-work/in-work situations.

Results do not take into account national minimum wage legislation. As a result, the "33%" and "50%" scenarios may in fact not be relevant for employees covered by minimum wage rules.

For one earner couple households the first spouse is inactive with 0 earnings. The 'x%' therefore relate to the second spouse only.

For two-earners couple households the first spouse's earnings are held fixed at 67% of AW. The 'x%' therefore relate to the second spouse only.

Context 9d. Low wage traps - 2006

METR as wage increases by 33% of the AW wage level from two starting low wages

Income ranges:	*from 33 to 67% of AW*				*from 67 to 100% of AW*			
	Single person, no children	Lone parent	One-earner couple, 2 children	Two-earner couple, 2 children	Single person, no children	Lone parent	One-earner couple, 2 children	Two-earner couple, 2 children
BE	58%	52%	47%	58%	56%	56%	50%	55%
CZ	31%	43%	53%	24%	29%	55%	50%	29%
DK	82%	74%	92%	49%	51%	61%	59%	43%
DE	50%	66%	65%	51%	55%	54%	51%	54%
EE	25%	25%	19%	25%	25%	25%	25%	25%
IE	54%	-34%	77%	23%	30%	84%	57%	30%
EL	20%	16%	16%	20%	41%	41%	41%	41%
ES	26%	19%	17%	26%	29%	27%	25%	29%
FR	64%	96%	111%	37%	35%	25%	23%	33%
IT	34%	-2%	-11%	40%	38%	52%	49%	38%
CY	6%	93%	91%	6%	15%	15%	15%	15%
LV	32%	100%	100%	32%	32%	40%	65%	32%
LT	30%	30%	52%	30%	30%	30%	30%	30%
LU	50%	58%	110%	29%	42%	30%	18%	36%
HU	32%	35%	32%	32%	59%	64%	67%	59%
MT	24%	60%	30%	33%	43%	39%	39%	32%
NL	71%	49%	77%	41%	46%	56%	58%	46%
AT	37%	41%	62%	37%	45%	45%	45%	45%
PL	66%	94%	79%	35%	35%	57%	58%	35%
PT	22%	54%	56%	25%	35%	35%	55%	35%
SI	67%	50%	73%	34%	58%	89%	54%	43%
SK	24%	24%	28%	35%	30%	30%	18%	30%
FI	61%	62%	100%	33%	43%	55%	60%	43%
SE	55%	53%	89%	34%	36%	50%	39%	36%
UK	58%	85%	85%	33%	33%	56%	60%	33%

Notes:

For one earner couple households the second spouse's earnings are varied while the first spouse's earnings are held fixed at 0% AW (inactive).

For two earner couple households the second spouse's earnings are varied while the first spouse's earnings are held fixed at 67% AW.

[1] In computing METRs, weekly working hours are increased by the same fraction as earnings, i.e., it is assumed that hourly earnings remain at weekly AW / 40.

[2] In computing METRs, working hours are held constant at 40, i.e., earnings above 100% AW are a result of increasing hourly earnings rather than working hours.

Context 10: Net income of social assistance recipients as % of the at-risk of poverty rate threshold for 3 jobless households types, 2006

	LT	SK	PT	MT	EE	HU	ES	LV	CZ	BE	PL	LU	CY	FR	SI	AT	DE	FI	SE	DK	UK	IE	NL
single	0,3	0,5	0,5	0,5	0,5	0,5	0,6	0,6	0,6	0,7	0,7	0,8	0,8	0,8	0,8	0,8	0,9	1,0	1,1	1,1	1,2	1,2	1,3
lone parent, 2 children	0,7	0,6	0,7	0,4	0,6	0,9	0,6	1,3	0,8	0,9	0,9	0,8	0,8	0,8	1,0	0,9	1,2	0,9	0,9	1,0	1,2	1,0	1,1
couple with two children	0,7	0,5	0,8	0,3	0,5	0,9	0,4	1,1	0,8	0,6	0,7	0,7	0,7	0,7	0,9	0,8	1,1	0,9	0,8	0,9	1,0	1,0	0,9

Source : Joint EC-OECD project using OECD tax-benefit models, and Eurostat.

Context 11: At-risk-of-poverty rate before social transfers by gender and selected age groups

Before all social transfers except old-age and survivors' benefits

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
Total population	Total	25ps	26p	28	17i	20	27	28p	25p	25	33	24	24	26	24	21	27	26	23	29	22	21	25	27	24	24p	23	18	29	28	30
	Men	24ps	24p	26	15i	19	26	27p	24p	23	31	23	23	25	23	19	25	24	23	30	21	20	23	27	24	24p	21	18	27	26	28
	Women	26ps	27p	29	19i	21	29	29p	26p	27	35	25	25	27	25	23	29	27	24	29	22	22	26	26	25	24p	25	19	31	30	32
Children aged 0-17 years		33ps	33p	31	21i	31	24	24p	30p	28	39	27	29	36	32	20	30	29	33	44	29	25	36	35	27	34p	25	27	31	33	40
People aged 18-64 yea	Total	24ps	24p	26	15i	19	27	27p	25p	21	29	22	21	24	22	15	24	22	23	29	19	20	23	27	22	21p	21	17	28	27	25
	Men	23ps	23p	25	15i	18	25	26p	24p	21	27	21	20	23	21	13	23	22	22	29	17	18	22	28	21	22p	20	17	27	26	23
	Women	25ps	25p	28	15i	20	28	29p	27p	22	31	22	22	26	23	18	25	23	24	28	21	22	24	26	23	20p	22	17	29	28	27
People aged 65 years a	Total	23ps	24p	27	20i	12	34	37p	18p	36	42	28	31	18	24	55	37	34	10	11	23	17	17	12	29	21p	30	13	31	23	38
	Men	20ps	20p	24	10i	9	34	34p	15p	23	37	24	29	17	20	50	25	18	9	7	26	15	12	9	27	15p	23	6	26	12	34
	Women	26ps	26p	29	27i	14	35	39p	21p	42	47	31	33	19	27	59	43	41	10	13	21	19	21	13	31	25p	35	17	35	31	41

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); (1) BG National HBS 2006, income data 2006 and RO National HBS 2007, income data 2007; (2) with imputed rent data 2006 (see methodological note).

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

Context 12 already in 2.1

1. Employment rate gap by country of birth, 2005, 2006, 2007 annual averages

	Employment rate gap between persons born inside and outside the country			Employment rates by country of birth									Distribution of the population aged 15-64 by country of birth								
				2005			*2006*			*2007*			*2005*			*2006*			*2007*		
	2005	*2006*	*2007*	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25
BE	12,5	12,5	12,7	62,7	57,5	44,2	62,7	56,2	45,2	63,5	57,9	45,2	87,1	5,8	7,1	86,5	6,1	7,5	88,4	5,2	6,5
BG	:	-2,4	2,1	:	:	:	58,6	:	61,8	61,7	:	61,0	:	:	:	:	:	:	:	:	:
CZ	3,4	4,8	-2,3	64,9	59,0	67,2	65,4	58,3	65,2	66,1	61,2	71,4	98,1	1,4	0,6	98,1	1,3	0,6	99,1	0,3	0,6
DK	13,6	14,5	16,0	76,9	72,2	60,1	78,4	70,8	61,5	78,8	74,8	59,6	93,1	1,8	5,1	93,2	1,8	5,0	90,6	1,9	7,5
DE *	14,4	14,9	14,8	67,5	65,5	47,0	69,1	66,3	48,1	70,9	68,2	49,6	89,5	3,4	7,0	89,7	3,5	6,8	89,7	3,6	6,7
EE	-5,3	-4,7	-5,9	63,7	64,1	69,3	67,4	64,9	72,6	68,6	75,4	74,4	85,6	0,9	13,5	85,7	0,9	13,5	86,2	0,6	13,1
IE	:	:	:	:	:	:	68,2	:	:	68,4	:	:	:	:	:	:	:	:	:	:	:
EL	-6,4	-6,6	-5,1	59,6	55,0	67,9	60,5	55,5	68,8	60,9	58,2	67,5	92,0	1,2	6,9	92,5	1,0	6,5	92,3	1,2	6,4
ES	-6,8	-6,9	-4,6	62,5	64,2	70,2	63,8	65,7	71,6	64,9	69,9	69,4	88,0	1,9	10,1	86,4	2,0	11,7	84,9	4,0	11,1
FR	7,9	7,5	7,3	64,1	63,5	53,5	64,7	65,4	54,0	65,5	64,6	55,8	88,4	3,1	8,5	89,0	3,0	8,0	88,5	3,1	8,3
IT	:	-7,3	-7,8	:	:	:	57,9	58,9	66,4	58,0	64,9	66,2	:	:	:	92,4	1,3	6,3	92,0	2,1	5,9
CY	-2,2	-1,6	-0,6	68,1	57,4	75,8	69,3	62,1	75,3	70,8	64,8	75,2	82,9	5,1	12,0	82,7	5,6	11,7	82,3	6,4	11,2
LV	-4,2	-6,0	-5,0	62,8	56,1	68,4	65,7	(62,1)	72,7	67,7	(69,4)	73,1	88,0	1,4	10,7	89,4	1,0	9,6	87,8	1,3	10,9
LT	-5,1	-6,7	-6,4	62,4	:	68,7	63,3	73,2	69,7	64,7	72,3	70,9	(96,3)	(0,2)	(3,5)	95,9	0,4	3,8	95,9	0,4	3,8
LU	-9,4	-8,9	-11,9	59,8	70,7	60,0	60,0	71,2	55,3	59,2	72,9	60,0	59,7	34,6	5,8	59,6	34,4	6,0	58,3	35,6	6,0
HU	-5,8	-3,4	-7,6	56,8	53,1	64,5	57,3	(53,5)	62,4	57,2	(65,7)	62,6	98,2	0,3	1,5	98,3	0,3	1,3	98,5	1,1	0,4
MT	-4,1	-0,5	-3,4	53,7	(48,9)	61,9	54,8	56,1	54,9	55,5	55,8	60,2	95,3	1,5	3,2	95,4	1,7	3,0	95,5	1,4	3,1
NL	14,5	14,2	13,2	75,2	70,2	58,5	76,2	72,5	59,5	77,7	73,1	62,2	86,9	2,5	10,7	87,0	2,5	10,5	87,1	2,7	10,3
AT	7,7	8,2	7,7	69,9	65,3	61,0	71,6	67,8	61,6	72,7	(69,4)	63,0	83,7	4,7	11,5	83,0	4,9	12,1	82,8	5,4	11,7
PL	22,9	19,1	21,7	52,9	29,8	30,1	54,6	36,2	35,0	57,1	30,7	38,7	99,4	0,3	0,4	99,5	0,2	0,3	99,6	0,2	0,2
PT	-5,4	-4,3	-5,8	67,1	65,1	74,5	67,6	:	72,9	67,3	:	73,7	92,9	1,5	5,6	92,6	1,6	5,8	92,3	1,6	6,1
RO	(-1.9)	:	(-4.3)	57,6	:	:	58,8	51,9	:	58,8	67,7	(62,4)	:	:	:	:	:	:	:	:	:
SI	-1,3	-0,2	-0,2	65,9	59,4	67,9	66,6	51,3	68,4	67,8	64,1	68,2	92,1	0,6	7,2	92,5	0,7	6,7	91,9	0,5	7,6
SK	6,4	4,3	-5,6	57,8	49,0	61,6	59,5	54,8	(57,5)	60,7	67,7	(60,9)	99,1	0,7	0,2	99,3	0,6	0,1	99,5	0,4	0,1
FI	11,7	9,2	6,8	68,8	65,4	50,8	69,7	69,4	53,7	70,5	74,8	55,8	96,9	1,3	1,8	96,7	1,4	1,9	96,6	1,4	2,0
SE	13,8	13,5	13,1	74,3	71,8	54,8	75,1	72,5	56,9	76,2	72,7	58,9	86,4	4,6	9,0	85,1	4,6	10,3	84,7	4,7	10,6
UK	7,7	5,9	5,6	72,5	72,1	62,2	72,2	75,1	63,1	72,0	75,4	62,8	88,9	3,0	8,2	88,2	3,1	8,7	87,4	3,7	9,0
EU-27	4,6	2,7	2,6	64,8	65,6	58,2	64,7	66,6	60,4	65,6	68,6	60,8	91,1	2,4	6,4	91,3	2,2	6,4	91,0	2,6	6,4
EU-25	5,1	3,1	3,0	65,2	65,6	58,2	65,1	66,6	60,4	66,1	68,6	60,8	90,6	2,6	6,8	90,8	2,4	6,9	90,4	2,8	6,8
EU-15	7,2	4,7	4,5	67,4	66,2	57,9	66,7	67,1	60,2	67,4	68,8	60,5	88,9	3,1	8,0	89,3	2,7	7,9	88,8	3,2	7,9

Source: EU labour Force Survey, quarter 2. Data marked 'u' lack reliabilty due to small sample size. Empty cells correspond to data not avaialble or not reliable due to smal sample size

(1) In case "born in another EU25 country" is not reliable due to small sample size, the cell "Born outside the EU25" refers to "Born outside the country".

(2) Country of birth is not available for BG, DE and RO. Nationality is used instead.

2. Distrbution of the population by age and country of birth

	2005									2006									2007								
	Born in the country			**Born in another EU25 country**			**Born in another country outside the EU25**			**Born in the country**			**Born in another EU27 country**			**Born in another country outside the EU25**			**Born in the country**			**Born in another EU27 country**			**Born in another country outside the EU25**		
	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64
BE	19,4	53,3	27,3	8,3	54,1	37,6	14,2	67,4	18,4	19,4	52,8	27,8	10,3	53,1	36,6	13,5	67,0	19,5	19,0	52,5	28,5	11,4	52,8	35,8	14,6	66,1	19,2
BG	19,8	52,1	28,1							:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
CZ	18,9	51,8	29,3	6,7	50,7	42,6	13,3	71,0	15,7	18,6	51,8	29,6	8,4	49,5	42,1	13,8	70,5	15,7	18,4	51,8	29,8	11,1	49,7	39,1	12,2	71,9	15,8
DK	16,7	52,6	30,6	12,1	55,7	32,3	16,8	68,9	14,3	17,1	52,2	30,7	12,3	56,1	31,6	20,0	64,1	16,0	17,0	51,6	31,4	13,8	55,0	31,2	19,2	63,6	17,2
DE	17,7	53,7	28,7	13,3	59,4	27,3	19,5	61,2	19,3	18,4	53,8	27,8	:	:	:	:	:	:	18,4	53,2	28,4	:	:	:	:	:	:
EE	25,6	52,0	22,4				3,4	47,8	48,8	26,0	51,6	22,3	:	49,1	41,5	2,9	46,7	50,5	25,8	52,3	21,9	:	51,1	42,8	2,5	43,8	53,7
IE	23,3	52,8	23,9	16,5	68,8	14,7				22,5	53,1	24,4	:	:	:	:	:	:	21,9	53,3	24,7	:	:	:	:	:	:
EL	17,1	55,0	27,9	19,2	66,9	13,9	18,4	67,4	14,2	16,8	55,1	28,0	15,8	70,3	13,9	18,5	68,7	12,7	16,2	55,1	28,7	15,3	68,6	16,2	17,5	69,4	13,1
ES	17,6	56,8	25,7	7,8	69,4	22,8	19,6	71,3	9,1	16,9	56,6	26,6	13,7	69,0	17,3	18,3	72,9	8,8	16,5	56,1	27,4	13,3	72,6	14,1	17,6	72,0	10,4
FR	20,5	53,0	26,5	6,4	50,2	43,4	10,7	56,6	32,8	20,5	52,5	27,0	5,5	51,2	43,3	10,6	56,7	32,7	20,4	52,0	27,6	7,2	48,5	44,3	10,1	58,5	31,5
IT										15,7	55,2	29,0	11,8	73,3	14,9	15,1	74,0	10,9	15,7	55,0	29,3	10,5	75,1	14,4	14,5	73,6	11,9
CY	19,5	53,4	27,1	14,2	61,1	24,8	16,9	72,0	11,1	19,6	53,3	27,1	15,4	62,1	22,5	14,6	74,6	10,8	18,7	53,5	27,8	15,3	60,6	24,2	15,4	74,2	10,4
LV	25,2	52,6	22,2	11,3	38,7	50,0	3,4	45,3	51,3	25,0	52,3	22,7	:	42,3	52,4	4,1	46,1	49,9	25,3	52,5	22,2	(6.1)	40,7	53,2	4,2	46,3	49,5
LT	23,2	53,2	23,5				5,7 u	55,4	39,0	23,5	53,0	23,5	:	(72.4)	:	(6.8)	51,5	41,7	23,7	52,8	23,5	:	(59.3)	:	(5.9)	52,2	42,0
LU	21,5	52,2	26,4	9,7	64,9	25,3	14,8	70,4	14,7	21,7	51,0	27,3	9,4	64,8	25,8	15,6	64,9	19,5	21,7	51,7	26,5	9,6	65,9	24,5	16,1	66,3	17,6
HU	18,8	52,1	29,2	12,2 u	40,9	46,9	12,0	63,9	24,1	18,5	51,6	29,9	11,9	61,1	27,0	16,2	59,4	24,5	18,4	51,7	29,9	10,4	62,3	27,3	20,0	58,7	21,3
MT	22,5	50,4	27,1							22,6	50,3	27,1	:	(58.5)	:	(22.1)	67,6	:	22,8	49,8	27,4	:	(57.5)	:	(22.2)	66,7	:
NL	18,4	52,7	28,9	8,9	60,8	30,3	13,1	66,2	20,7	18,6	52,2	29,2	10,2	60,7	29,2	13,2	65,3	21,5	18,7	51,6	29,7	11,2	59,7	29,2	12,4	65,0	22,6
AT	18,4	55,0	26,6	12,0	55,9	32,1	16,2	62,5	21,3	18,6	54,9	26,6	10,4	59,6	30,0	16,2	62,2	21,6	18,6	54,5	26,8	11,0	61,7	27,2	15,6	62,2	22,2
PL	22,6	51,7	25,7				5,8 u	27,6	66,6	22,2	51,3	26,5	:	(25.0)	71,4	(10.6)	33,0	56,5	21,5	51,0	27,5	:	(18.5)	74,3	:	35,1	57,9
PT	18,6	54,3	27,2	22,3	70,5	7,2	15,4	72,2	12,3	18,1	54,3	27,6	18,2	76,6	5,2	15,4	70,6	14,0	17,6	54,3	28,1	16,5	79,1	4,4	14,1	70,6	15,3
RO										21,6	53,2	25,2	:	:	:	:	:	:	21,3	53,0	25,7	:	:	:	:	(77.2)	:
SI	20,2	54,0	25,8	6,3 u	53,1	40,6 u	5,0	58,0	37,0	19,6	53,9	26,5	(6.7)	53,9	(39.4)	6,1	55,2	38,7	19,3	53,8	26,9	:	61,6	(34.3)	5,1	53,3	41,5
SK	23,0	53,2	23,8							22,3	53,0	24,7	(9.2)	46,8	43,9	:	:	:	22,0	52,9	25,1	:	39,7	55,2	:	68,6	:
FI	18,1	50,0	32,0	24,1	61,0	14,8	22,1	64,6	13,3	18,0	49,4	32,5	17,8	70,9	11,4	23,9	61,7	14,4	18,3	48,8	33,0	13,4	73,7	12,9	23,0	60,6	16,3
SE	19,7	49,8	30,5	4,8	48,3	46,9	18,7	63,6	17,7	20,0	49,5	30,5	4,6	48,8	46,6	18,5	62,0	19,6	20,5	49,2	30,3	5,1	47,7	47,2	18,8	61,0	20,2
UK	19,4	52,3	28,3	15,8	59,5	24,7	14,4	64,8	20,8	19,4	51,9	28,7	18,2	60,9	21,0	14,1	64,9	21,0	19,6	51,2	29,2	19,0	61,9	19,1	14,0	65,6	20,3
										:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
EU-27	19,3	53,2	27,5	11,2	57,4	31,4	15,6	63,4	21,0	19,1	53,2	27,7	11,7	61,0	27,3	14,4	65,5	20,0	18,9	52,8	28,2	12,3	61,7	26,0	14,1	65,8	20,2
EU-25	19,3	53,3	27,5	11,2	57,4	31,4	15,6	63,4	21,0	18,9	53,2	27,9	11,7	61,0	27,3	14,4	65,5	20,0	18,8	52,8	28,4	12,3	61,7	26,0	14,1	65,8	20,2
EU-15	18,7	53,6	27,8	11,3	58,1	30,5	16,0	63,9	20,1	18,2	53,6	28,2	11,8	61,6	26,6	14,8	66,1	19,1	18,2	53,2	28,7	12,4	62,3	25,3	14,4	66,3	19,3

Source: EU labour Force Survey, quarter 2. Data marked 'u' lack reliabilty due to small sample size. Empty cells correspond to data not avaialble or not reliable due to smal sample size

(1) In case "born in another EU25 country" is not reliable due to small sample size, the cell "Born outside the EU25" refers to "Born outside the country".

(2) Country of birth is not available for BG, DE and RO. Nationality is used instead.

3. Distribution of the 15-64 by sex and country of birth

	2005						2006						2007					
	Born in the country		**Born in another EU25 country**		**Born outside the EU25**		**Born in the country**		**Born in another EU25 country**		**Born outside the EU25**		**Born in the country**		**Born in another EU25 country**		**Born outside the EU25**	
	Men	Wo men	Men	Wo men	Men	Wo men	Men	Wo men	Men	Wo men	Men	Wo men	Men	Wo men	Men	Wo men	Men	Wo men
BE	49,5	50,5	51,6	48,4	50,8	49,2	49,2	50,8	46,1	53,9	48,2	51,8	49,1	50,9	47,2	52,8	47,4	52,6
BG	50,5	49,5			55,4 u	44,6 u	48,4	51,6	41,7	58,3	37,8	62,2	48,4	51,6	41,8	58,2	46,6	53,4
CZ	49,9	50,1	49,6	50,4	45,8	54,2	48,9	51,1	45,8	54,2	47,4	52,6	48,9	51,1	44,4	55,6	48,5	51,5
DK	49,3	50,7	45,2	54,8	55,7	44,3	49,8	50,2	50,4	49,6	44,3	55,7	49,8	50,2	43,3	56,7	46,9	53,1
DE	49,8	50,2	47,5	52,5	49,1	50,9	48,8	51,2	52,7	47,3	51,2	48,8	48,8	51,2	52,6	47,4	51,1	48,9
EE	51,6	48,4	52,7	47,3	57,1	42,9	47,4	52,6	35,8	64,2	38,0	62,0	47,4	52,6	33,4	66,6	38,5	61,5
IE	49,8	50,2	48,1	51,9	48,3	51,7	49,7	50,3	:	:	:	:	49,8	50,2	:	:	:	:
EL	50,1	49,9	62,0	38,0	49,2	50,8	49,1	50,9	35,0	65,0	50,1	49,9	49,2	50,8	39,9	60,1	51,4	48,6
ES	49,4	50,6	53,2	46,8	50,1	49,9	49,4	50,6	48,5	51,5	49,4	50,6	49,5	50,5	49,7	50,3	49,0	51,0
FR	50,5	49,5	53,2	46,8	51,0	49,0	48,7	51,3	46,3	53,7	48,6	51,4	48,7	51,3	45,4	54,6	49,3	50,7
IT							48,7	51,3	36,4	63,6	49,6	50,4	48,7	51,3	40,4	59,6	49,8	50,2
CY	50,1	49,9	53,3	46,7	60,6	39,4	50,0	50,0	45,9	54,1	39,3	60,7	50,1	49,9	43,7	56,3	39,8	60,2
LV	51,2	48,8	57,2	42,8	56,5	43,5	46,8	53,2	46,5	53,5	40,5	59,5	47,1	52,9	43,0	57,0	39,5	60,5
LT	51,7	48,3			53,9	46,1	46,8	53,2	54,9	45,1	42,7	57,3	46,7	53,3	49,1	50,9	42,7	57,3
LU	49,2	50,8	49,6	50,4	53,4	46,6	51,2	48,8	50,4	49,6	46,3	53,7	50,5	49,5	51,2	48,8	44,9	55,1
HU	51,1	48,9	56,3	43,7	53,3	46,7	47,4	52,6	41,6	58,4	44,3	55,7	47,4	52,6	44,0	56,0	42,8	57,2
MT	49,7	50,3	53,0 u	47,0 u	47,7	52,3	49,7	50,3	51,8	48,2	44,9	55,1	49,7	50,3	43,2	56,8	48,9	51,1
NL	49,3	50,7	56,1	43,9	50,1	49,9	49,8	50,2	41,9	58,1	49,3	50,7	49,8	50,2	44,1	55,9	48,5	51,5
AT	49,8	50,2	57,5	42,5	50,5	49,5	48,8	51,2	43,0	57,0	49,5	50,5	48,9	51,1	43,2	56,8	49,6	50,4
PL	50,5	49,5	46,8	53,2	53,8	46,2	48,3	51,7	43,8	56,2	37,6	62,4	48,2	51,8	46,4	53,6	37,1	62,9
PT	50,5	49,5	52,1	47,9	52,4	47,6	48,4	51,6	48,0	52,0	48,1	51,9	48,5	51,5	47,5	52,5	47,6	52,4
RO							48,7	51,3	58,0	42,0	65,7	34,3	48,7	51,3	63,4	36,6	54,8	45,2
SI	49,2	50,8	54,9	45,1	49,0	51,0	48,9	51,1	45,1	54,9	51,8	48,2	49,0	51,0	38,3	61,7	53,2	46,8
SK	50,3	49,7	53,3	46,7	53,9	46,1	48,6	51,4	46,4	53,6	37,2	62,8	48,6	51,4	43,1	56,9	53,2	46,8
FI	49,7	50,3	48,3	51,7	53,8	46,2	48,8	51,2	51,2	48,8	43,9	56,1	48,8	51,2	53,2	46,8	46,3	53,7
SE	48,9	51,1	53,0	47,0	50,5	49,5	50,9	49,1	44,7	55,3	49,4	50,6	51,0	49,0	45,5	54,5	48,8	51,2
UK	50,6	49,4	53,1	46,9	51,6	48,4	48,9	51,1	46,4	53,6	48,4	51,6	48,8	51,2	47,4	52,6	48,5	51,5
EU-27	50,1	49,9	51,6	48,4	50,6	49,4	48,8	51,2	47,0	53,0	49,0	51,0	48,8	51,2	47,4	52,6	49,0	51,0
EU-25	50,1	49,9	51,6	48,4	50,6	49,4	48,8	51,2	47,0	53,0	49,0	51,0	48,8	51,2	47,4	52,6	49,0	51,0
EU-15	50,0	50,0	51,6	48,4	50,5	49,5	48,9	51,1	47,1	52,9	49,4	50,6	49,0	51,0	47,5	52,5	49,4	50,6

Source: EU labour Force Survey, quarter 2. Data marked 'u' lack reliabilty due to small sample size. Empty cells correspond to data not avaialble or not reliable due to smal sample size

(1) In case "born in another EU25 country" is not reliable due to small sample size, the cell "Born outside the EU25" refers to "Born outside the country".

(2) Country of birth is not available for BG, DE and RO. Nationality is used instead.

COUNTRY PROFILES[84]

SEC(2009) 255
{COM(2009) 58 final}

[84] The following text includes the corrections specified in SEC(2009) 255 final CORRIGENDUM of 24.2.2009.

Introduction

These 27 country profiles aim at providing a synoptic view of key trends, major efforts and challenges ahead in each of the Member States with respect to their policies in the fields of social inclusion, pensions and health and long-term care. They are based on the renewed, integrated National Strategies for social protection and social inclusion that Member States presented in September/October 2008. They complement the 2009 Joint Report on social protection and social inclusion.[85]

Each profile identifies those aspects of performance deserving to be highlighted in the context of the Open Method of Co-ordination or presenting greater risks and therefore calling for particular policy efforts in the area of social inclusion, pensions, healthcare and long term care. The concluding section of the country profiles lists for each country the key challenges that the Commission services have identified on the basis of the analysis. The preparation of the profiles have benefited from bilateral exchanges with the Member States.

Unless otherwise specified, all indicators used in the country profiles draw on the indicators which Member States have agreed to use in the context of the OMC on social protection and social inclusion, either from the overarching portfolio or from the detailed lists covering the three strands of the OMC: social inclusion, pensions and health care and long-term care. The annex to this document is a methodological note explaining the overarching indicators and providing details on the EU harmonised data sources used to calculate them. Where relevant and necessary, national sources are used to supplement the picture provided by the EU agreed indicators.

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[85] The Commission proposal for Joint Report on Social Protection and Social Inclusion 2009 was adopted on 13 February 2009 (COM(2009) 58; After treatment in the Social Protection Committee with possible amendments, the Joint Report will be adopted by the EPSCO Council of 9 March 2009.

Belgium

1. SITUATION AND KEY TRENDS

Although the forecasts for 2008 and 2009 are, as for the rest of Europe, not encouraging (expected growth: -1.9% in 2009), Belgium's economic growth gathered momentum in 2006 (3%) and 2007 (2.8%) compared to 2005 (1.8%). Public debt continued to fall in 2007 (to 84.9% of GDP). However, there was an unexpected deterioration of the public balance in 2007 and 2008. The inflation rate, though decreasing recently, has been sharply on the rise since the end of 2007, jeopardising the purchasing power, particularly of low-income families. The employment rate is rising but remains below the EU-25 average (62% compared to 65.8% in 2007), even though the female employment rate again rose rather strongly. The male employment rate still did not reach the level achieved in 2000. Regional disparities remain substantial (employment rate of 66.1% in Flanders, 57% in Wallonia, 54.8% in Brussels)[86]. The same conclusion applies to older people's employment rate: the trend is encouraging (it rose once again in 2007: +2.4 pts, to 34.4%) but the rate improved more for women than for men and the level remains significantly below the EU average (EU-25: 44.9% in 2007). On the other hand, the disabled people's employment rate is 17 pts below the general employment rate; there is also a much lower employment rate for people born outside the EU (46.3% in 2007) and for non-EU citizens (38.1%) compared to the others (respectively 58.1% and 61.2%[87]). As for unemployment, despite persistent regional disparities (4.4% in Flanders, 10.5% in Wallonia and 17.2% in Brussels[88]) and poor figures for people born outside the EU and non-EU citizens, the unemployment rate fell to 7.5% in 2007 (-0.8 pts compared to 2006). Youth unemployment is following the same positive trend (1.7 pts less than in 2005), although the rate remains above the EU-25 level. Long-term unemployment (as a percentage of unemployment) is also decreasing (from 51.7% to 50.4% since 2005) and more quickly for women than for men. Life expectancy at birth was 76.6 years for men and 82.3 years for women in 2006. Healthy life expectancy at birth remained stable between 2005 and 2006 (61.7 years for men; from 61.9 to 62.8 years for women) as well as healthy life expectancy at 65. Total gross social protection expenditure has increased slightly: it accounted for 28.7% of GDP in 2006 (+0.4 pts compared to 2005). Pensions and health represent the bulk of social protection expenditure (36.7% and 25.7%, respectively in 2006), even though health spending is decreasing.

2. OVERALL STRATEGIC APPROACH

Priorities and challenges are globally unchanged, but better coordinated. There are three key 'social challenges': tackling the budgetary burden of pensions in the context of an ageing population while ensuring adequate old-age benefits; providing sustainable access to quality health and long-term care services; and reducing the persistent risk of poverty. Five priority **areas** (axes) shape the action framework: promoting a global employment strategy; reducing the burden of taxes and social security contributions on low-skilled jobs; promoting entrepreneurship; strengthening the social protection system and fighting poverty; improving the environment and sustainable development policy. These main thrusts are supplemented by specific action lines. These are similar to the previous three key objectives when it comes to inclusion. They focus on three domains (reducing the public debt, developing the reserve fund and strengthening the social security financing scheme) for pensions**.** With regards to health care these combine achieving financial balance with improving the access to care services (for

[86] Ministry of Economic Affairs statistics 2008.
[87] Ministry of Employment statistics 2008.
[88] Ministry of Employment statistics 2008.

vulnerable groups). The last action line aims provide more specialised services as well as to improve their coordination as regards the long-term care policy. Improving the employability of people who are furthest from the labour market remains a major challenge, taking into account the recommendations inviting Belgium to 'enhance the labour market participation and reduce the tax wedge on low-skilled workers'. A specific priority axis refers to the strategy for sustainable development. As regards governance, the 'editorial committee' for drafting of the report guarantees the consistency between the different strands of the strategy, thanks to the presence of representatives of the main departments involved in the SPSI policy. One project ('on the ground' ombudsmen who's role is to know better the experience of people facing poverty) and a 'social inclusion' axis are in the federal ESF programme. The problem of gender equality is tackled with regards to homelessness, childcare facilities (in the context of female employment) and retirement age. The issue of disabled people is raised essentially in connection with the purchasing power: raising the minimum income, reducing the patient's contribution of, supporting home-help, assistance facilities and activation.

3. SOCIAL INCLUSION

3.1. Key trends

A limited progress is contrasting with certain aggravations or lacks of improvement. The positive points are the increase of the at-risk-of-poverty threshold (at €10 316 for a single person and €21 665 for a household with 2 children in 2006), the stability of the at-risk-of-poverty rate (which remained at 15% - after social transfers - in 2007 as well as the permanence of the in-work at-risk-of-poverty **rate**, of the at-risk-of-poverty **rate** for children under 18, of the share of children aged 0-17 living in a jobless household (12% in 2007) and of the share of early school leavers (12,3 % in 2007, still a bit lower than the EU-25 average for the same year: 14.5% in 2007). The relative at-risk-of-poverty gap is not improving (18% in 2007) but remains better than the EU-25 average as well.

On the other hand, however, important problems still deserve to be pointed out. The regional differences remain substantial as regards the at-risk of poverty rate (11.4% in Flanders, 17% in Wallonia and an estimated 26% of people below the national poverty threshold in Brussels) or early school leaving (24.6% in Brussels in 2007, against 12.3% at national level and 12.8% in Wallonia[89]). The situation of women and particularly older women is in some extent also a matter of concern as regards the risk of poverty, the in-work risk of poverty (growing from 24% to 28% for single women in 2006), the higher number of homeless women and the low impact of social transfers. In the opposite way, the rate of early school leaving is worse for boys (13.9% in 2007) than for girls (10.7%).

Older people's situation, and especially older women's situation as already said, is not improving either, particularly as regards the risk of poverty, which is higher than the EU average and the neighbouring countries, and as regards the impact of social transfers, which is lower in their case.

A significant imbalance also remains between non-EU (29.6% in 2007) and EU nationals: the unemployment rate gap is still high (29.6% against 9.8% in 2007), though decreasing slightly, whereas the employment rate is rising to 38.1% for non-EU nationals, compared to 61.2% for EU nationals during the same year[90]. Persistent differences can also be observed when making a comparison based on the place of birth.

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[89] Enquête sur les forces de travail (EFT) - IWEPS

[90] Statistics Ministry of Employment 2008.

Some other categories continue to be particularly exposed to the risk of poverty, like single persons, jobless households without children, unemployed persons and tenants. For the latter, the risk of poverty is almost three times higher than for home owners (28% against 10%).

Social benefits (except pensions) reduced the poverty risk by 44.5% (from 27% to 15%) in 2006, a greater reduction than the EU average, but reduced it by only 14.8% (from 27% to 23%) for people aged 65 and more, and by as little as 10.7% (from 28% to 25%, against a reduction of 16% in EU-25) for women aged 65 and more. The net income of social assistance recipients as a percentage of the poverty threshold was 72.7% for a single person, 64.8% for a married couple with two children and 85% for a lone parent with two children, which signals a downward trend to a drop compared to 2004.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The progress achieved is limited. At national level, none of the 2008 targets linked to the three 2006-2008 main objectives was met (except with regards to the women's and, to a lesser extent, the old-aged workers' employment rate), even though there are still important contrasting results between the different regions. The non-EU nationals' unemployment rate, though falling, remains particularly high. There is no indicator available to measure the progress of employment among disabled people. Despite the large number of measures described, the report does not provide clear evidence of the actual progress made on poverty's ground: beside improvement made, particularly as regards the elderly people's social covering in the area of pensions and health care or, more generally, the easing of criteria for benefiting from reduced out-of-pocket payments for health care, it can hardly be said that either the most disadvantaged people's employment rate or housing conditions have specifically known a real improvement. This lack of progress can perhaps be partly explained by the political difficulties that Belgium is going through and the delicate coordination among the country's different authorities and institutions. But more basically, the question should be raised whether the actions undertaken fit with the targets, and whether the actions should be more appropriate or better resourced.

3.3. Key challenges and priorities

Like the strategy presented, the three former objectives have been renewed: decent and affordable housing for everyone; getting risk groups to be proactive; breaking the cycle of child poverty. They incorporate the two "Inclusion" challenges set for Belgium in the 2007 Joint Report and make it possible to meet most of the main political priorities set out in the 2006-2008 National Report. The modernisation of social welfare systems appears under the "Activation" objective: the tax measure (employment premium and exemptions) is presented as an employment incentive. Furthermore, the need to improve access to high-quality services is covered by the three objectives, in particular through improved assistance for tenants, children attending school and jobseekers with the poorest job prospects. Special attention is paid to homeless women, and to the matter of childcare; there has in fact been in improvement as regards the female employment rate.

3.4. Policy measures

The report presents a wide range of measures, detailed by region, the impact and results of which are not always apparent. The planned measures are, as regards the 'housing' objective, in line with the measures taken over the last few years by the different authorities. They aim to improve the quality of the supply (by streamlining the procedures, setting priority rules or reducing the number of unhealthy dwellings) and to control the quantitative parameters (by increasing the stock of social housing, creating a tax on derelict buildings, monitoring prices more closely, adopting social measures regarding energy or developing housing subsidies).

The purpose of some other measures is to improve guidance services or governance tools (better participation of tenants' representatives in consultation committees, development of accommodation centres). Progress is also made on account of special measures for homeless people, especially for homeless women, the number of whom is growing, for instance by enabling them to obtain a mailing address or by increasing the supply of 'transit accommodation'. The 'Activation' objective is covered by initiatives aimed at increasing the motivation to work (via tax incentives and by reforming the unemployment benefit system with no evidence of a beneficial effect on inclusion so far, however), but also improving the follow-up of unemployed people, developing recruitment incentives towards employers (by making companies more sensitive to discrimination, by the obligation to include a social clause in public procurements or by promoting social responsibility issues), improving the training supply (skills validation, literacy courses, guidance) or enlarging childcare facilities. There is also a political will to promote low-skilled jobs (e.g. via service vouchers, the long-term indexation of which was decided by the end of October 2008). Flanders has established a subsidy to encourage companies to hire old-aged workers and has adopted a range of measures to reduce the risk of school failure and of youth unemployment. It has also launched initiatives for monitoring the groups exposed to poverty risk. Different actions for rationalising or assessing currently existing procedures are worth mentioning as well. Companies devoted to social integration and promoting a 'training by working' approach are also supported. Regarding child poverty, the measures are classed under five main objectives: raising families' purchasing power (via social benefits, wages, taxation or employment); fighting over-indebtedness (by preventive and curative measures); supporting parents; developing alternative measures to children's placement in institutions (by giving more support to host families and to family mediation), improving pre-school facilities (by increasing reception capacities in schools and in childcare services) and, finally, focusing on children at risk in school (through tailored financing of educational establishments, better benefits system, setting a ceiling for school expenses, improving remediation mechanisms and providing additional training for specialised personnel).

3.5. Governance

Coordination of the drafting of the social inclusion chapter is the responsibility of the 'Social integration' administration which is represented on the report's editorial committee, so that consistency between the different strands of the SPSI strategy can be achieved. Two working groups ('Actions' and 'Indicators') are open to representatives of all relevant organisations, institutions and poor people's associations. The follow-up tools used are to be improved via different channels: the 'Indicators' working group has added to the set of indicators available, even though an serious gap remains with regards to the statistics on immigrants; the introduction of a 'poverty barometer' should also refine the poverty indicators and studies carried out for measuring the impact of decisions taken in the sustainable development area will strengthen the visibility of the poverty aspect too. The Federal Government also wants the target groups to participate more fully and information campaigns are programmed in Flanders and Wallonia as well. However, effective use of feed-back from the target groups and grassroots organisations should be guaranteed. While the will to improve the quality of indicators must be welcomed, a special effort remains to be made, especially with regards to the capacity for making comparisons combining the different objectives and different dimensions of indicators e.g. childhood poverty and housing policy, nationality and education…).

4. PENSIONS

4.1. Key trends

The average age of exit from the labour market is steadily rising (from 59.4 years in 2004 to 61.6 years in 2007); this increase is similar for men and women. The dependence rate should be 26.1 in 2010 (25.9 in 2007), which would be better than the European average (25.9); it is expected to rise to 37.6 in 2030 and 43.9 in 2050. The replacement rate, lower than in France and the EU overall but close to the level in the Netherlands and Germany, remained virtually unchanged in 2007 in relation to 2006 (0.44, i.e. + 0.02 points).

4.2. Key challenges and priorities

Three key challenges were identified: as Belgian pensions are relatively low and the actual age of exit from the labour market, although steadily rising, is still low (a little higher than the EU average for men and a little lower for women), it is necessary to deal with the consequences of a lack of positive budget balance and of the increases in budgetary costs linked to ageing; secondly, statutory pension levels must be raised by adapting the replacement ratio and the calculation mechanisms; thirdly, the rate of cover for pensions from the second pillar must be increased while also increasing contributions. The challenge set out in the 2007 Joint Report to "guarantee the sustainability and adequacy of the pension systems while continuing to reduce the level of public debt and make the systems under the second pillar more accessible, particularly for women" has therefore been achieved only in part: although there was a further drop in Belgium's public debt in 2007 (84.9% of GDP, i.e. -3.3 points), it was not possible to achieve the aim of a positive budget balance in 2007 and 2008 in order to finance the "ageing fund", nor is this expected over the next few years. Furthermore, access to the second pillar has been fostered by a range of measures.

4.3. More people in work and working longer

A number of initiatives have been taken since 2006 to increase the employment rate among people over the age of 50. However, these have resulted in progress which, although tangible (+2.4 points in 2007), was only limited. The aim of these measures is as much to lengthen careers as to generally increase the number of people in employment. A "pension bonus" has for instance been introduced for workers who remain in employment after a certain age (60 or 62, depending on the category of worker) or who have completed a certain number of years in employment (with variable impacts, depending on the categories concerned); likewise, a tax concession is now granted if workers reach the statutory retirement age before obtaining a pension under the second pillar. Young people are encouraged to enter the labour market more quickly through the allocation of pension entitlements subject to the acceptance of a part-time job or participation in a part-time course. In addition to this, a targeted policy of reducing taxes and social security contributions aims to increase the number of young and older workers. Lastly, the statutory retirement age and duration of working life giving entitlement to a full pension will eventually become identical for men and women.

4.4. Privately managed pension provision

Use of pension schemes under the second or third pillar currently seem to be infrequent: in 2000[91], the premiums represented 1.4% and 3% of GDP respectively (but with very rapid growth in total premiums and in the number of contributors for the third pillar), in comparison to 11% of GDP for pensions from the first pillar. The data needed to judge whether these advantages are evenly distributed throughout the population are not available. One of the challenges set out in the report is to promote second-pillar pensions by improving the coverage rate for employees affiliated to this type of scheme or by exemption – under certain

[91] Latest available figures. See *Revue belge de sécurité sociale*, 2003-4, pp. 1077-1112; also: *Revue économique*, National Bank of Belgium, December 2007.

conditions – from social security contributions on the premiums paid (an increase in the level of contributions is, however, also envisaged). Access to second-pillar pensions has in fact already been made easier for the self-employed through the creation of sectoral pension funds. A legal framework in this field adapted to contractual workers in the public sector will eventually also be established. In accordance with the government agreement of July 2007, third-pillar pension schemes should likewise be encouraged and better managed.

4.5. Minimum income provision for older people

The situation of older people is not improving. The risk of poverty among people over the age of 65 is rising (from 21% to 23% between 2005 and 2006); it remains higher than the European average and even higher than in neighbouring countries. The situation of women over the age of 60 is deteriorating and remains worse than that of men; after the age of 75, it is similar for the two sexes but deteriorates in both cases. The difference in the income of people over 65 in relation to the poverty threshold has increased (from 14 to 17% between 2005 and 2006), and their income as a percentage of the median income of people aged 18-64 has fallen (from 0.73 to 0.71). Lastly, the impact of social transfers has weakened (from 19.2 to 14.8%; from 15.3 to 10.7% for women).

The aim of the authorities, reinforced by the will to maintain purchasing power in the context of crisis, is still to guarantee "a sufficient pension income for everyone and pension entitlements which make it possible to maintain a reasonable standard of living after retirement, in a spirit of equality and solidarity within and between generations". Particular emphasis is laid on the need to guarantee universal access to a sufficient first-pillar pension. The improvement of pension benefits is pursued in various ways: minimum pensions and the income guarantee for elderly persons (*garantie de revenu aux personnes âgées*, GRAPA) were last increased in May and August 2008, although in many cases this did not result in these amounts rising above the poverty threshold), simplified eligibility conditions and more favourable calculation mechanisms, an extension of the guaranteed minimum pension benefit to part-time workers (which above all affects women) and a general upgrading of pensions (in addition to index-linked changes). The pension/work combination has also been facilitated. Pensions are upgraded regularly through their automatic link to the index and through other increases of either a sporadic or structural nature (e.g. the wellbeing bonus). The pensions bonus mechanism for those still in employment over the age of 60 constitutes a further means of boosting pensions. The report also refers to the other specific or improved benefits existing for older people (in terms of care, social assistance or social housing).

4.6. Information and transparency

Efforts continue to improve the "customer focus" of the services offered by the administrative authorities dealing with pensions, among other things owing to an expansion of their clientele to younger population groups. Strategic approaches are taken to clarify users' rights ("Charters"), draw on new information technologies (Website), accelerate the processing of files, improve the quality of information disseminated by traditional means (telephone, post) and propose new services provided on request or automatically (since 2007, a pension estimate has been sent to everyone who is 55 years old).

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Belgian healthcare system is based on a compulsory insurance scheme which forms an integral part of the welfare system. Cover is practically universal, at 99.6% after the extension of cover for self-employed workers on 1 January 2008. Total health expenditure amounted to 10.4% of GDP in 2006, almost 71% of which was public expenditure and 29% private expenditure (patient's share and private insurance). Around 44% of the population subscribed to private insurance in 2005.

Patients are free to choose their provider and have direct access to specialists. Providers are generally remunerated upon provision of the service according to rates set jointly by their representatives, the social partners and the mutual insurance companies. Mutual insurance companies reimburse patients *a posteriori* for medical expenses; however, for a hospital stay or the purchase of medicines, the patient pays only their share, and the mutual insurance company pays the balance directly ("*tiers-payant*", direct billing system).

For many risk groups, the patient's personal share is reduced by the BIM (*Bénéfice de l'Intervention Majorée*, higher rate of state contribution) and the MAF ("*Maximum à facturer*", maximum to be billed) mechanisms. The BIM sets a higher rate of reimbursement of medical services for certain social categories of unemployed people and for households whose annual income does not exceed a certain threshold. The MAF sets a maximum amount (which varies according to household income) of annual expenditure per family on healthcare.

The Federal State has exclusive competence over the compulsory healthcare insurance scheme, but shares responsibility with the regions for the provision of healthcare and public health.

The Belgian strategy is underpinned by three main aims: to expand accessibility (by stabilising and even reducing the patients' share, lowering the price of medicines, improving provision where necessary, developing special provision for older people and maintaining the organisation of certain preventive measures); to guarantee the quality of care (mainly by establishing new governance tools, heightening the sense of responsibility of medical staff and promoting continuity of care); and to preserve the financial viability of the system (by setting standards, creating a fund, rationalising administrative procedures and encouraging a healthy lifestyle). 2007 and 2008 saw an expansion of the categories benefiting from the systems to reduce the patient's share and cap expenditure; a reduction in the cost of a number of medicines; the strengthening of strategies to achieve a higher return on investments and greater continuity of care; the creation of a fund for the future thanks to the application of budgetary growth standards since 2005; and lastly, following the development of supplementary insurance schemes, the adoption of measures relating to contributions and cover conditions.

5.1.2. Accessibility

Four directions have been taken: the maintenance of a broad, universal compulsory insurance scheme; the strengthening of financial protection mechanisms, particularly in the interest of certain groups; sufficient, appropriate and local healthcare; combating inequalities, particularly through preventive policy. It is imperative for the authorities that the financial sustainability of compulsory insurance be assured and that it guarantee universal access to healthcare. The extension of personal cover for the self-employed is in line with this logic, as

is the longer list of insured healthcare: free preventive dental care is now offered to young people until the age of 15 (with plans to increase the age limit to 18). Secondly, although studies indicate rates of unmet needs which are lower than the European averages and decreasing (0.6% of the population declared having postponed care in 2006, in comparison to 1.8% in 2004), worries in relation to maintaining sufficient financial protection mechanisms persist, reinforced by the crisis (purchasing power support). The aim is to reduce the contribution paid by certain categories of patients (reinforced systems to reduce contributions - "BIM" – and to cap expenditure by social category and household - "MAF"; direct billing of doctors' consultations to the mutual insurance company for certain people in economic hardship) and also to provide a universal reduction in expenses (reduction in the cost of certain medicines; ban on certain surcharges invoiced in hospitals). Thirdly, there are regulatory instruments intended to help improve rationalisation and guarantee a geographically balanced availability of general practitioners, specialists and hospital infrastructure, even though the problem of waiting lists is still almost non-existent. Lastly, regarding the combating of health inequalities, tools already in use are being strengthened: greater support for medical health centres, the establishment of "*Relais santé*" in Wallonia, the creation of a network of assistance services, ongoing awareness campaigns, ongoing vaccination or screening operations, and the creation of a Walloon Observatory.

5.1.3. Quality

The measures taken revolve around four aims: to improve the overall efficiency of the system, monitor the quality of services, offer multidisciplinary care and respect the rights and dignity of the patient. Measures which are already in place are being continued rather than introducing new initiatives. However, there is a plan to publish a report for the first time in 2009 on the performance of the health system, and a decision has been made to create a permanent representative cross-section of patients. New awareness-raising campaigns (on the use of antibiotics) have been organised. Lifelong learning for care providers is always encouraged, as is the formalised exchange of information between hospitals ("panel of doctors"). Multidisciplinary care continues to be promoted ("care roadmaps" between different establishments, the coordination of primary healthcare in Flanders, "health networks" in Brussels). A national plan to combat cancer for the period 2008-2010 has been launched. Lastly, various initiatives exist to guarantee respect for patients' rights when faced with cultural or linguistic barriers. Patient platforms work to improve the life quality of patients and their families, and groups of local residents in Brussels are taking part in health development projects.

5.1.4. Sustainability

According to the Study Committee on Ageing[92], total public health expenditure, which represented 7% of GDP in 2007, should rise to 8.9% of GDP in 2030 and 10.4% of GDP in 2050. Each year, a growth standard for public health expenditure sets the maximum authorised health insurance budget for compulsory care under a number of main headings (out-patient care, hospital care, medicines). This standard was met in 2006 and 2007, which in 2007 made it possible to create a "fund for the future of healthcare". Furthermore, the regulatory framework for supplementary health insurance, group insurance and individual insurance schemes (which are playing an increasing role) has been strengthened by protective measures to control the rise in contributions and guarantee the stability of cover conditions. System durability is also targeted through measures which can be evaluated in the longer term, such as administrative simplification measures or the promotion of a healthier lifestyle: for example, from the start of the 2007 school year, Flemish schools must develop a health policy and smoking has been prohibited in all work areas since January 2006.

[92] 2008 Annual Report

5.2. Long-term care

5.2.1 Description of the system

Long-term care is part of the integrated healthcare system. Even though it is difficult to deal with this type of healthcare separately, a differentiated, specific long-term care policy is gradually being introduced. Particular reference can be made here to services which meet specific long-term healthcare needs and services to help patients who have lost their independence.

The provision varies from one community to another, with coordination between federal and community-based structures, and also between the general health services and the long-term health services, for example via the integrated home-care services. Full use is therefore made of the complementarity between the different healthcare providers and welfare services.

5.2.2. Accessibility

The accessibility of long-term care has been improved through better reimbursement conditions and a more diverse provision. Since 2008, a new budget has been created to improve the MAF mechanism to benefit the chronically ill; furthermore, care specific to long-term patients has been added: for instance, the reimbursement of travel expenses for cancer patients was increased as of 1 July 2007; lump-sums for certain types of care have also been increased. The range of available healthcare continues to develop, offering suitable alternatives to hospitalisation as a means of encouraging home care wherever possible: short stays in day centres, family drop-in centres, care circuits and platforms and dependency insurance in Flanders.

5.2.3. Quality

The quality monitoring of institutions and the training of staff are organised in this field in the same way as for acute care. Follow-up, outcome standards and specific quality benchmarks also exist. A continuous assessment tool has been created: a feasibility study will run until 2009 and will be followed by implementation if the results of this study are positive. The opinions of patients' associations are also surveyed. Lastly, incentives for the long-term patient to stay in work or return to work also help to improve quality.

5.2.4. Long-term sustainability

The 2008 report by the Study Committee on Ageing forecasts that public expenditure on long-term care will increase from 0.9% to 2.1% of GDP between 2007 and 2050. Apart from the need to ensure budgetary scope for manœuvre, the challenge will therefore be to develop a long-term global vision of how to approach the issue of long-term care. Good governance and forecasting tools must be established. The Federal State is helping the Communities and regions to set up alternative forms of care, and also new healthcare functions and new synergies.

6. CHALLENGES AHEAD

It is important for Belgium to focus more closely on populations who are most at risk of exclusion: immigrant populations, the elderly (especially women), children in difficulty at school and single parents (once again, women in particular). Activation policies should include a more proactive approach in the fields of vocational training and lifelong learning.
A better evaluation of housing policy is also recommended in order to ascertain whether the measures adopted are actually helping to better meet the demand from economically disadvantaged populations. An analysis of the financial feasibility of the described measures would also be useful.

Given the poor situation in terms of government deficit in recent years and the economic downturn expected in 2009 and 2010, the budgetary conditions for ensuring the viability of the pensions system should be re-examined. There is a also a case to strengthen measures to encourage the employment of older people and to assess how each pension reform measure helps to fight poverty, in particular among the elderly.

While positive results have been achieved in relation to fostering the rationalisation and continuity of healthcare, a uniform standard of long-term care provided within each Community should also be ensured.

- Belgium is also asked to refine its strategy and monitoring tools, better adapt the measures taken to the objectives set, and improve evaluation tools. Coordination between the actions initiated at each level of authority should also be reinforced and regional disparities should be tackled. The measures to encourage victims of social exclusion and the associations representing them to voice their needs must have a real impact.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,7	125,9	2000	60,5	54,7	46,3	29,1	26,3	2000	6,9	5,6	8,5	16,7
2005	1,8	119,4	2005	61,1	68,3	53,8	27,5	31,8	2005	8,4	7,6	9,5	21,5
2008f	1,3	114,7	2007	62,0	68,7	55,3	27,5	34,4	2007	7,5	6,7	8,5	18,8

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	73,5	80,4	14,8	19,3	63,3	66,4	5,9	1995	8,2	78,5	n.a.		-
2000	74,6	81,0	15,6	19,7	65,7	69,1	4,8	2000	8,6	71,8	23,9	2005	0,8
2006	76,6	82,3	17,0	20,6	62.8b	62.8b	3,1	2006	10,4	71.4**	20.9d	2006	0,5

s: Eurostat estimate; b: break in series; d:change in methodology **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	27,4	43,1	23,6	13,0	8,8	2,7	8,8
2000	26,5	44,1	24,2	11,8	8,8	1,8	9,3
2006	30,1	47,0	25,7	11,9	7,1	2,0	6,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	25,8	25,4	10,4	6,2	0,9
2010	26,1	-0,3	0,0	0,2	0,0
2030	37,6	4,5	4,3	0,9	0,4
2050	43,9	6,3	5,1	1,4	0,9

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	15	17	13	23	18	18	21	15	3,9	2005	15
male	14	-	2	21	19	-	22	17	-	2006	14
femal	16	-	13	25	17	-	20	14	-	2007	14

People living in jobless households

	Children Total	% of people aged 18-59* Total	Male	Female
2001	12,9	13,8	11,5	16,2
2004	13,2	13,7	11,3	16,0
2007	12,0	12,3	10,6	13,9

Long Term unemployment rate

	% of people aged 15-64 Total	Male	Female
2000	3,2	2,9	3,5
2004	4,1	3,7	4,7
2007	3,8	3,3	4,3

Early school-leavers

	% of people aged 18-24 Total	Male	Female
2000	13,6	15	12,3
2004	11,9 (b)	8,3 (b)	15,6 (b)
2007	12,3	13,9	10,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,74	0,76	0,73	***Aggregate replacement ratio***	0,44	0,46	0,45

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
3	5	-1	DB	5	DC	100	55	16,3	NA	4,25

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Bulgaria

1. SITUATION AND KEY TRENDS

GDP growth reached 6.3% in 2006 and 6.2% in 2007. It will contract following the global financial crisis. Inflation for 2007 was high at 7.6% and is expected to increase further in 2008. The employment rate (15-64) increased from 58.6% (2006) to 61.7% (2007) but remained among the 10 lowest in the EU27. Female and male employment rates increased from 54.6% and 62.8% (2006) to 57.6% and 66% (2007), respectively. Unemployment declined from 9% in 2006 to a record low of 6.9% in 2007 with female unemployment falling from 9.3% to 7.3% and male unemployment from 8.6% to 6.5%. It will pick up again in 2009, reflecting falling output. Long-term unemployment was 4.1% in 2007 (5% in 2006) but remains among the five highest rates in the EU. Against a background of strong economic performance, the at-risk-of-poverty rate after social transfers (total) stood at 14% in 2006, compared with 15% in 2004. Women were more at risk of poverty (16%) compared to men (12%). The poverty threshold in Bulgaria in 2006 (annual basis) was BGN 1999 (€1022). In 2006-2007, population growth continued to be negative, contributing to one of the most unfavourable demographic situations in the EU. In an expanding economy, the GDP share of total social protection expenditure declined from 16% (2005) to 15% (2006). In 2005-2006, old-age social benefits stood at 47.6% of total benefits, while sickness and health care benefits dropped from 29% to 26%. During the same period, employers' social contributions, as a share of total social protection receipts, dropped significantly from 42.4% (2005) to 38.3% (2006), which was offset by an increase from 18.3% (2005) to 19.7% (2006) in the social contributions paid by insured persons and by an increase from 36.1% (2005) to 39.5% (2006) in the share of Government-paid social protection contributions.

2. OVERALL STRATEGIC APPROACH

The report outlines a clear strategy, demonstrating the positive role played by the OMC in policy development and the mobilising effect of setting quantitative targets. It offers a balanced and critical assessment of the achievements. The new overall approach steers policy actions and resources towards well-defined target groups: Roma, people with disabilities, children, elderly, single parent families, inactive persons, people with low educational level and those furthest from the labour market. The long-term priorities in the area of social inclusion are: a) equal participation of groups at risk in the labour market; b) equal access to services to prevent social exclusion; c) social inclusion of the most vulnerable ethnic groups; d) poverty reduction among people outside working age. In the area of pensions, the priority is to raise the standard of living of pensioners. Improving the access, quality and efficiency of services as well as pursuing deinstitutionalisation of long term care (LTC) and support to families with dependent members are the main priorities of the health and LTC strands. ESF co-funded actions are given as an example of coordination between the social protection and inclusion strategy and the Structural Funds. However, the targets of the report are not linked to the implementation of the operational programme, which provides significant resources for social inclusion.

3. SOCIAL INCLUSION

3.1. Key trends

16% of women (17% in 2004) live on a disposable income below the at-risk-of-poverty threshold. For women aged 65+, the at-risk-of-poverty rate stood at 24% (2006) compared with 9% for men aged 65+ in the same year. Another group severely exposed to the risk of poverty are children aged 0-17 years, with a rate of 16%, much higher than the average for the total population. The report points out that without any social transfers the at-risk-of-poverty rate would have been 40.5%. Following the progress on the labour market, in-work poverty stood at 6% compared to 8% for the EU. The share of people in jobless households (total) slightly improved from 11.6% (2006) to 10.2% (2007), but was still above the EU averages, particularly for children. With 12.8% of children living in jobless households in 2007 (9.4% for the EU), Bulgaria belongs to the group of countries where child poverty is above the EU average and where children have a significantly higher risk of living in poverty than the overall population. In 2007, half of all children aged 0-17 years and living in jobless households were living in a typical 'couple with children' household. The percentage of early school-leavers (total) improved from 18% in 2006 to 16.6% in 2007, as against 14.8% in the EU (2007). Nevertheless, increased economic opportunities have not translated into a significant reduction in poverty and better school integration for all.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

In 2006, the Government put forward twelve quantified targets for 2008 which form a holistic approach:

Employment: targets were achieved, with employment exceeding the target by 1.1 percentage points, while unemployment was already down to 6.9% in 2007 as against the target of 9% for 2008. Social inclusion and education: the target was to halve the number of pupils in mandatory school age dropping out of school, from 20% in 2006, but the recorded performance in 2007 showed an increase. It is not, however, possible to fully assess the progress made in increasing the number of persons from vulnerable groups in vocational training, set to increase by 20%, despite the many initiatives undertaken in this field. Even if the report states that many other targets are met on the basis of administrative data, the lack of statistically validated national aggregated data does not allow progress to be objectively assessed in terms of: i) increasing by 15% the number of children with special educational needs in mainstream and professional schools; ii) increasing by 20% the number of persons receiving social and health services within the community; iii) increasing by 10% the number of Roma schoolchildren taken out of segregated schools; iv) decreasing by 10% the number of persons in specialised institutions.

Overarching objective: An increase of at least 15% in total household income seems to be on track, as the Government reports an increase of 10.6% in household income in 2007 as against 2001. For the second overarching objective set in 2006, the Government reports an increase of 9.9% in the real growth of income from pensions for the last two years, compared with the target of 5% per annum. The minimum wage in 2008 rose to BGN 220 (€112). In addition, over the period 2006-2008 the Government continued its policy of lowering social contribution (including pension contribution) rates and introduced a flat 10% income tax.

The effect of these measures on low-income households and poverty reduction is likely to be neutral. As these measures were introduced recently, their future impact assessment will

indicate their contribution to poverty reduction. Children and women, as well as people above 65, remain highly exposed to poverty even in an overall economic environment generating more and better opportunities.

Regarding the 2007 challenge to improve the quality of care in institutions, progress has been made and new strategic documents adopted (the National Strategy for Children). However, fragmented competences[93] between the central authorities supervisory tasks and the local authorities management responsibilities over the institutions for people with disabilities, the poor interaction between the health care system, the social inclusion and protection arrangements and the education system and the proliferation of project-based activities with weak policy and institutional coordination need to be addressed in order to further boost progress in this area.

3.3. Key challenges and priorities

The new strategy has four policy objectives:

– Limiting the inter-generational transmission of poverty and social exclusion with a focus on child poverty (objective A);

– Active inclusion of those furthest from the labour market (objective B);

– Equal opportunities for the most vulnerable groups (objective C);

– Better governance of social inclusion policy (objective D).

The new objectives have a stronger focus on poverty reduction and on particular vulnerable groups and their formulation corresponds to the main challenges. Although the issue of quality improvements in the provision of institutional and community care, identified as a challenge in the 2007 Joint Report, is mainstreamed within policy objectives A and B, it would have been justified to make it a separate policy objective in light of the critical developments and weaknesses in 2007 concerning institutional care for children with disabilities. The report adds many new measures without, however, outlining the priorities, critically assessing their institutional feasibility and the challenges to deliver. The State budget and the ESF co-funded operational programme will be the main sources of financing, but there are no specific financial allocations per objective/group of measures to indicate their financial importance and relevance.

3.4. Policy measures

For each of the four policy objectives outlined above, policy measures are planned for 2008-2010:

Objective A:

This objective will be pursued in conformity with the National Strategy for Children 2008-2018 and comprises 6 main strands: 1) creation of an appropriate family environment, including foster care; 2) access to quality pre-school preparation; 3) access to quality health services; 4) de-institutionalisation; 5) protection of children from abuse and violence; 6) improved institutional capacity for child protection.
Concrete measures have been taken and new are planned within the overall commitment of the Government to de-institutionalisation and to improvements in the quality of social

[93] The Law on Social Assistance and its implementing rules subordinate the implementation of the quality assurance recommendations of the central supervisory bodies (Agency for Social Assistance and State Agency for Child Protection) for closing of institutions and of social services to a decision of the municipal council-owner of the specialised institution.

services for disabled children in institutions and in the community. Although the legislation allows the placement of children with in-born disabilities in institution as early as 0 years of age, the Family Code was amended to facilitate their adoption.

Objective B:

This objective targets young people in vulnerable situations, persons of working age on social assistance, persons with low or outdated education and skills, illiterate persons and inactive or discouraged persons. Labour market inclusion measures are part of the national employment plan and include subsidies for the labour costs of employers, public employment programmes, educational and vocational programmes, and literacy courses.

The Government is aware that some social groups are excluded from the increased economic opportunities. However, the design of some targets (number of persons living on social assistance) takes no account of their potentially adverse impact on low-income households in term of poverty reduction. In a period of economic slowdown and increasing unemployment, increasing the conditionality of access to an already low level of minimum income support (below the poverty line) would run counter to the political objective of social inclusion.

Objective C:

Some of the measures are part of the National Action Plan for the 'Roma decade'. Additional attention will be given to the effective implementation of anti-discrimination law, the development of integrated services and the acceleration of desegregation in education and others. The National Strategy for Equal Opportunities for people with disabilities 2008-2015 will be implemented through monitoring of accessibility, encouragement of social entrepreneurship among disabled people, increased funding of social services for people with disabilities, better mainstreaming of disability issues in the media, creation of 'sheltered jobs', and other measures. The report also refers to the introduction of paternal leave and the preparation of a methodology to detect gender differences in pay and to other measures.

Objective D:

The main action is the development of a long-term strategy for social inclusion with a focus on poverty. This will address the long-term challenges, while the three-year NAP for social inclusion under the OMC will deal with the emerging short- and medium-term challenges. There are plans for a new high level consultative body on social inclusion, composed mainly of state officials. Civil society organisations will participate in a separate consultative body together with central, regional and local officials.

The report mark important steps forward in the area of social inclusion governance. The broad nature of the policy objectives and the references to existing but as yet unevaluated strategies highlight the need for improving the links between overall policy formulation and the design of concrete implementation instruments. The use of quantitative analysis, particularly in areas such as Roma inclusion and policy for people with disabilities, could be very helpful in developing evidence-based policy making.

The Government set the following targets for 2010 (baseline: 2007) which are inter-linked across sectors and could be presented as follows:

At-risk of poverty: maximum 15%; decrease in at-risk-of-poverty rate among children: 15%; 10 percentage point decrease in at-risk-of-poverty rate among households with three children; 20% increase in average household income.

15% early school-leaving rate; 100% net enrolment in primary education and in pre-school education; doubling of the number of children with special educational needs in general and vocational schools; 30% increase in the number of Roma pupils taken out of segregated schools.

15% fewer children using social services in institutions; doubling the number of children at risk placed in foster families; 50% increase in social services offered within the community;

66.5% employment rate for the 15-64 age group, 60% for women, 27% for persons aged 15-24; 12% youth unemployment rate; 3.5% long-term unemployment; reduction of 2 percentage points in the share of persons with disabilities in overall unemployment; max. 10.5% of children living in jobless households; share of persons living in jobless households: 8%; 20% fewer persons living on social assistance; share of social expenditure in GDP: 17%.

3.5. Governance

The preparation of the current strategy marks a significant improvement in the consultation process. The Government launched an internet consultation on the draft strategy, giving the public the opportunity to react. The 2008-2010 strategy includes an analysis of the governance of social inclusion policy and outlines a plan for action, including the strengthening of the professional capacity of those involved in the design and implementation of social inclusion policies at central and local levels, the creation of a national consultative body on social inclusion, and improvement of the system for monitoring indicators. However, there is further scope for similar analysis concerning the other strands and for better policy coordination. Similarly, the strategy mentions the prevention of child abandonment and violence against children, but no concrete measures are outlined to improve the interaction between the hospital and social services to support the parents of children with disabilities. While it is encouraging that the Government has set quantified targets, there is a need for better coordination between the different national policy strategies. The strategy for life-long learning adopted in October 2008 set a target of 12% for early school-leaving in 2013, whereas the ESF aims to reduce this rate to 13% in the same year.

4. PENSIONS

The pension system comprises a mandatory public scheme (PAYG), a compulsory funded, defined-contribution scheme, where contributions are accumulated and capitalised in individual accounts, and a voluntary scheme. Pension contributions are calculated on the basis of 'insurable income', which is determined by the main economic activities carried out. While the minimum wage for 2008 was BGN 220 (€112), the minimum insurable income was BGN 240 (€122). The maximum insurable income ceiling was BGN 1400 (€716) in 2006/07 and BGN 2000 (€1022) in 2008. In some cases, employers pay social security contributions on the minimum insurable income and not on real wages.

In 2006, the overall social security contribution rate was reduced by 3% and, in 2007, by 6%, which led to a 6% reduction in the PAYG contribution rate followed by an additional reduction of 2% in 2007. As a result, at the end of 2007, the public pension contribution rate stood at 22% (32% in 2000). While in 2005 the ratio between employer/employee contributions was 70:30, it changed to 60:40 in 2008, reflecting the transfer of the insurance burden. The current retirement age is 63 years for men and 59.5 years for women, with the latter due to rise to 60 years in 2009.

4.1. Key trends

In 2007, some 2.23 million people (29% of the total population) came under the public pension scheme, 2.8 million people (37% of the total population) were insured in the mandatory funded scheme and 592 805 (7.7% of the total population) in the occupational schemes. The mandatory funded scheme comprises two types of pension funds: universal and professional. They will start paying out benefits in 2020 for the former and in 2011 for the latter. In 2008, the contribution rate for the funded scheme was raised from 4% to 5% (3% in 2006), shared between the employer (60%) and the employee (40%). Self-employed persons pay 100%.

The main public pension is called 'insurance and old-age pension'. At the end of 2007, the average monthly amount was BGN 177 (€91) and the minimum amount BGN 102.85 (€52.5). Approximately 30% of retirees receive pensions below BGN 120 while 54.5% receive BGN 160, thus indicating significant differences within the public pension scheme, attributable to differences between the lengths of periods of affiliation and past insurable income basis for paying contributions.

A particular feature of the public pension scheme is the inequality between different age cohorts: people aged 80 years+ (14% of the total) received, on average, individual pensions of BGN 139 (end 2007), people aged 70-79 years received 15% more, and people aged 60-69 years old 24% more. This age-related inequality is due to the methodology for setting pension levels, introduced after the entry into force of the social security arrangements in 2000, and to the fact that older pensioners were insured on a lower income basis compared to those who retired after 2000.

Public pension expenditure in 2007 increased by 11% compared to 2006. The GDP share of public pensions was 8.27% in 2007 (national data), and is projected to decline to 7.11% in 2027 but to increase again to 14.6% in 2050. Key trends for 2007-2008 also include the lowering of corporation tax from 15% to 10% and the introduction of a flat income tax rate of 10% as of 1 January 2008.

4.2. Key challenges and priorities

Long-term financial sustainability is a key challenge, as the public pension system is projected to be in deficit for the next 42 years. A law establishing a demographic reserve fund was consequently adopted in 2008. It will accumulate reserves over ten years from 90% of all privatisation revenue and 25% of any budgetary surplus. The fund can only be used to keep the public pension scheme in balance, and its future investment policy needs to be carefully chosen in view of the current financial crisis.

Pension adequacy is an ongoing challenge. Despite pension increases, the public continues to perceive pensions to be low. Public confidence in the pension system could be strengthened if pension adequacy is improved, which in turn will encourage people to refrain from grey non-contributory economic activities and to enrol in voluntary pension funds. To respond to this challenge, a reform was introduced in 2007 so that public pensions granted by the end of the

previous year are indexed each following July to ensure an increase equal to 50% of the increase in the consumer price index and 50% of the growth in average insurable income (gross salary). For 2006, the aggregate total replacement rate was 60%, with a significant gender difference: 62% for men and 58% for women[94]. The projected theoretical replacement rate for the PAYG scheme will decline significantly to reflect the transfer of part of the public pension contribution to the funded scheme (second and third pillars), where the replacement rate will gradually increase. Over all an increase in net theoretical replacement rates is expected with 15 percentage points between 2006 and 2046. The long-term challenge for the mandatory pension pillars will be how to address the issue of old-age poverty and how to ensure decent living conditions for older people, whose share in the total population is growing. Old-age dependency ratio in 2010 will reach 25.3 and will increase to 36.3 in 2030 and to 43.6 in 2040[95].

Improving adequacy and financial sustainability calls for more social security revenues. Eliminating the maximum ceiling on insurable income could bring in resources from the higher income deciles. Limiting the abuse of paying contributions on the minimum wage level in the private sector could also improve social security revenues. As an example, in 2006 the real annual growth of the average wage was 2.11% while the growth of insurable income was only 0.34%. Therefore, the policy of reducing social contribution rates needs to be reassessed against the artificially low levels of minimum insurable income on which rates are based. Another key challenge is the inclusion within the social security scheme of some 350,000 persons not paying social security contributions.

4.3. More people in work and working longer

Employment rates for older workers (55-64) stood at 39.6% in 2006 and improved to 42.6% in 2007 (EU averages: 43.5% and 44.7%). The average retirement age in 2006 was 67.7 years. However, the average age for first-time pensioners in the same year (new pensioners) was as low as 54.9 years. This results from the transitional arrangements still in force under the 2000 social security code for early retirement. In order to encourage longer working lives, each additional year of working after reaching the minimum of 37 contributory years for men and 34 for women will count for 3% (previously 1%) in the pension formula. As of 2009, each additional year of working beyond retirement age will count as 5 contribution years. The increase in the long-term unemployment rate (65% in 2005 and 68% in 2007) for people aged 50+ is a particular challenge if pension adequacy is to be ensured for this group. Unemployed persons over 50 years of age are enrolled in subsidised training and employment programmes in order to increase their employability. The ESF will support a special programme for active labour market measures targeting an additional 18 000 unemployed persons over the age of 50.

4.4. Privately managed pension provision

Private pension provision is based on voluntary contributions to private pension funds. Pension entitlements start at the same retirement ages as for the public pension scheme. Contribution rates are fixed in individual contracts. People are entitled to change funds against a fee and to receive a lump sum or a pension at a fixed age. Private pension funds are supervised by the National Financial Supervision Commission (NFSC). Only 42% of all privately insured persons are women and their acquired rights are less then those of men. According to the NFSC, the overall profitability of the private pension funds declined in 2008. A detailed analysis of their investment policy shows that between 2006 and 2007 they reduced their share of government bonds and banks deposits but acquired more risky assets such as commercial bonds, shares and equities.

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[94] BG national Household budget survey (2006), income data 2006

[95] Eurostat (2008) Convergence scenario.

4.5. Minimum income provision for older people

Minimum income support for older people exists in the form of the 'social pension for the elderly'. While the 'individual insurance and old-age pension' is set each year under the law governing the public social security budget, the 'social pension for the elderly' is decided by the Council of Ministers. As of 1 October 2007, it was BGN 76.23 (€39) per month or 42% of the monthly minimum wage for 2007 (BGN 180). At the end of 2007, 24.5% of all pensioners received various types of minimum pensions.

4.6. Information and transparency

All contributors to pension funds receive a yearly individual report on their acquired rights in a personal account showing the financial gains and the balance, and can ask for the annual financial report of their fund and for information about the fund's investment policy. They are also entitled to complain to the NFSC or to contact its call centre. Despite these legal requirements, there is a need to raise awareness about the importance of social security coverage, particularly among younger generations.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

The health care system is financed by mandatory contributions to the National Health Insurance Fund (NHIF), central government funding, voluntary health insurance with private health insurance funds, and co-payments from patients. General practitioners (GP) are mainly paid on a capitation basis under a collective framework contract with the NHIF. Secondary health care providers (public and private hospitals or collective practices) are paid partially by the NHIF for particular medical services (clinical pathways) and by the State budget for well-defined types of medical services.

5.1.1. Health status and description of the system

Life expectancy at birth for 2006 was 72.7 years (76.3 for women and 69.2 for men), showing a large gap with the EU benchmark and a marginal increase since 2004. Between 1986 and 2006, life expectancy at birth increased by only one year (1.2). Infant mortality was 9.2 in 2006 (11.6 in 2004), but remained the second highest in the EU. Leading mortality causes are cardio-vascular diseases (65.8%), cancer (15.9%) and respiratory diseases (4%). According to national data, disability-free life expectancy was 52.5 years for men and 66.8 for women in 2002. The report underlines a general negative trend affecting the health of pupils. Although aggregated statistically validated national data are not provided in the report, the Government emphasises the poor health status (shorter life expectancy at birth and communicable diseases) of the Roma population. According to the report, there are 260 000 persons recognised as disabled, of whom only 13% are in paid employment. People with disabilities face infrastructure barriers in accessing medical facilities, as well as limited capacity to provide expertise on disability issues.

5.1.2. Accessibility

The Government has developed a National Health Strategy seeking to ensure the financial sustainability and efficient and effective delivery of accessible good-quality health care services for the period 2008-2013. Health insurance covers mainly primary and hospital health care services. Some 5128 primary health physicians have a contract with the National Health Insurance Fund. Significant geographical disparities exist: 17.8% of primary health practices in less developed regions are unoccupied. 328 hospitals deliver hospital health care, of which 145 are general, 137 are specialised and 46 are dispensaries. 77% of these facilities are public (state and municipal property). Patients' access to specialised medical services is

subject to prior authorisation from their GP on the basis of a limited number of 'tickets' allocated by the NHIF, an arrangement limiting the access to specialised services. In 2007, the number of hospital beds increased by 1608, of which 68% were in private hospitals. In 2007, the ratio of beds per 10 000 persons was 59.5. However, the ratio for long-term treatment and care stood at 8.16/10 000 in the same year. The report underlines the persistent problems of access to emergency care.

5.1.3. Quality

The quality of health care services varies across the country and needs substantial improvements in non urban areas. In addition to the existing system for the accreditation of medical facilities independently of the Ministry of Health, a system for medical audits and monitoring will be established by an executive agency tasked with developing uniform criteria for assessing the efficiency and effectiveness of health care services.

5.1.4. Sustainability

Total health expenditure as a share of GDP was 7.7% in 2005. Total public health expenditure stood at 4.2% of GDP in 2007. Per capita health expenditure in 2006 was €132 (national data). Recently, the health insurance contribution was increased from 6% to 8%. Co-payments for health care services (official and unofficial) were between 20-40% of public health expenditure in 2006 and play an increasing role in a health care system suffering from under-financing. In this context, a significant proportion of paid health contributions is retained as a reserve outside the financing of the health system for which they were collected. The share of NHIF health care financing in total health expenditure rose to 66% in 2007, indicating a gradual increase in insurance-based health care financing. The central budget finances the regional health surveillance authorities, 12 psychiatric hospitals, 32 institutions for the long-term care of children, 28 centres for emergency health services, 63 haemodialysis centres and 4 regional blood transfusion centres. It also finances vaccination, expensive pharmaceuticals, prevention and health promotion activities at national level, medical care for uninsured pregnant women as well as capital investment and purchase of equipment in publicly owned hospitals.

The number of people with no health insurance is estimated at 1 million. The health care system continues to be under-financed given the needs for capital investment and renewal of medical technologies. At the same time the health care system continues to be unreformed with excessive hospital capacity. The lack of effective monitoring and spending control mechanisms highlights the need to progress with the implementation of an effective IT system both in the outpatient and inpatient care in order to enhance transparency and accountability of health care spending. Improved medical and continuous vocational training of general practitioners will contribute towards reducing undue referrals of patients to secondary health care services. In terms of human resources, the ratio of physicians per 10 000 people was 36.5/10 000 (medicine) and 8.4/10 000 (dental medicine) in 2007. Anaesthetics, emergency care, paediatrics, nephrology, gynaecology, radiology and psychiatry are experiencing a shortage of physicians. Only 1.7% of primary health care physicians hold a degree in 'general medicine'. The drop in the number of nurses is a major concern, and the ratio of physicians to nurses went down to 1/1.2 in 2007, a record low for the EU.

According to the report, improving financial sustainability should include better collection of contributions, a higher health contribution rate, increased public health expenditure, a methodology for setting costs per medical intervention, better negotiations between the NHIF and primary physicians (national framework contract), a new compulsory complementary health insurance, and tax rebates encouraging the take-up of voluntary complementary health insurance. Although these proposed measures should improve the overall sustainability and

accessibility of health care services, there are no specific mechanisms to limit income inequalities in access to health insurance outside the package of services provided by the NHIF.

In the context of falling profitability in the insurance industry, the NHIF should remain a solid central pillar of the health system while the introduction of mandatory complementary health insurance should be reassessed.

5.2. Long-term care

5.2.1. Description of the system

Formal long-term care (LTC) is offered mainly in specialised institutions owned by line ministries (in the case of services for children 0-3 years old) or by municipalities (in the case of care for the elderly or adults with disabilities) and in community based social services (day care centres, protected housing, centres of social rehabilitation). These facilities are financed through earmarked grants from the state budget to the municipalities and fees for services. Other types of institutions include facilities for physiotherapy and recovery from chronic illness. Few LTC facilities are run privately. The services provided by 'social' or 'personal' assistants are part of formal care provision. Informal care is provided within families to meet the needs of the elderly and people with disabilities. There are no studies or estimations of the magnitude of informal care.

5.2.2. Accessibility

Over the period 2006-2007, 30 new protected homes were established. By the end of 2008, 12 new day facilities will add to the existing 21 facilities for elderly people. The European Social Fund is a major contributor to the expansion of 'social' and 'personal' assistant services. The de-institutionalisation agenda, which has been developed nationally after successful pilot initiatives, includes an increasing supply of community-based services (day centres, protected homes, and centres for social rehabilitation) as well as a 9% decrease in the number of adults in institutions. These services also improve overall accessibility, an important objective of the LTC strategy.

5.2.3. Quality

Central supervisory institutions perform quality assessments and issue recommendations to the LTC providers. However, local authorities have full legal and financial powers over the facilities they own. They are also employers of the staff working in the facilities. The recommendations of the supervisory bodies concerning the quality of care, including proposal for closing of specialised institutions or of social services, need a decision of the municipal councils to be implemented. In the previous Joint Report, Bulgaria faced a particular challenge in achieving an overall improvement in community-based services and the quality of institutional care. In 2007-2008, the quality of institutional care for children with disabilities was reviewed by the Government in the light of serious weaknesses in the quality control and surveillance of institutions for abandoned children. An action plan was designed, some facilities for disabled children were closed and others are to be restructured[96]. A common methodology for calculating the minimum staff requirements for LTC institutions was prepared along with training master plans. The Government also launched a third national monitoring exercise to examine specialised institutions for people with disabilities, which resulted in 29 institutional plans for development.

[96] http://www.mlsp.government.bg/en/index.htm.

The quality of LTC facilities could be significantly improved by better surveillance, enhanced staff skills and better division of competences between the central supervisory bodies and the municipalities. There is a strong need for better governance and funding of the decentralisation of social services. Improved interaction between the health and long-term care systems, particularly with a view to preventing institutionalisation, could advance the overall de-institutionalisation policy.

5.2.4. Long-term sustainability

Long-term care expenditures stood at 0.17% of GDP in 2005, a figure among the 5 lowest in the EU. Measures were developed for introducing common standards for the financing of social services, which has led to increased provision of the most commonly used social services such as day care centres for elderly people, LTC homes for the elderly, centres for social integration, protected homes, and personal and social assistants. However, there are no indications that private investment in this sector is growing. The state budget remains the main source of financing for the tasks delegated to municipalities, which they co-fund. There are also modest fees paid by users on a means-tested basis. Private social services are paid for by users on a contract basis. Although regional strategies exist for the provision of social services, small municipalities are dependent on central budget financing to fund social services. Many of the social services (personal and social assistants) are provided by unskilled persons and are used to pay a salary to a family member. The low economic added value and social recognition of these services are factors restricting their development as a genuine economic sector.

6. CHALLENGES AHEAD

- To monitor the effects on low-income households of the conditionality of access to minimum income in terms of social inclusion and school integration. To this end, to undertake studies of vulnerable communities in order to monitor and critically evaluate whether policies correspond to real needs and to adjust the ESF programmes accordingly.

- To continue undertaking measures to increase social security revenue in order to improve the adequacy of pensions and the sustainability of the pension system by eliminating the abuse of paying contributions on the minimum wage as well as to include high wages in the insurance base and by facilitating longer working lives.

- To improve long-term forecasts for all social security branches, including health insurance, in order to set consistent contribution rates and avoid divergent rate changes in individual branches, thus improving the predictability of the overall social security burden and the consistency among policy measures in different policy strands (health, education, social inclusion, pensions and LTC).

- To assess the impact of introducing mandatory complementary health insurance in the context of unstable financial and insurance markets and improve access for all income groups to health care services through reforms seeking better efficiency in the delivery and coordination of primary and secondary health care services.

- To review and strengthen the coordination between health care and LTC systems and the relevant legislation in order to reinforce the follow-up of quality monitoring and to make the recommendations of the supervisory bodies fully executed by the providers of the LTC facilities. To this end, to make better use of the ESF to fund appropriate continuous training of staff working in long-term care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64						15+			15-24
				Total	Male	Female	15-24	55-64		Total	Male	Female	
2000	5,4	27,8	**2000**	50,4	54,7	46,3	19,7	20,8	**2000**	16,4	16,7	16,2	33,7
2005	6,2	34,5	**2005**	55,8	60,0	51,7	n.a.	34,7	**2005**	10,1	10,3	9,8	22,3
2008*f*	6,4	38,5	**2007**	61,7	66,0	57,6	n.a.	42,6	**2007**	6,9	6,5	7,3	15,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	67,1	74,6	12,5	15,2	n.a.	n.a.	14,8	**1995**	n.a.	n.a.	n.a.		-
2000	68,4	75,1	12,8	15,4	n.a.	n.a.	13,3	**2000**	6,2	58,7	40,9	**2005**	n.a.
2006	69,2	76,3	13,2	16,3	n.a.	n.a.	9,7	**2006****	7,7	60,6	38	**2006**	n.a.

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2006	15	52,9	26	2,2	7,4	2,5	9,1

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	25,0	n.a.	n.a.	n.a.	n.a.
2010	25,3	n.a.	n.a.	n.a.	n.a.
2030	36,3	n.a.	n.a.	n.a.	n.a.
2050	55,4	n.a.	n.a.	n.a.	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	14	16	12	18	18	22	18	14	**3,9**	**2005**	14
male	12		12	9	18		19	8	-	**2006**	n.a.
femal	16		12	24	17		18	16	-	**2007**	n.a.

	People living in jobless households			
	Children	% of people aged 18-59*		
	Total	Total	Male	Female
2001	19,0	17,3	16,8	17,8
2004	15,6	13,7	13,2	14,2
2007	12,8	10,2	10,1	10,3

	Long Term unemployment rate (% of people aged 15-64)				*Early school-leavers* (% of people aged 18-24)		
	Total	Male	Female		Total	Male	Female
2000	9,4	9,6	9,2	**2000**	n.a.	n.a.	n.a.
2004	7,2	7,3	7	**2004**	21,4	20,7	22,1
2007	4,1	3,7	4,5	**2007**	16,6	16,9	16,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	n.a.	n.a.	n.a.	***Aggregate replacement ratio***	n.a.	n.a.	n.a.

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
15	15	15	DB/DC	/	-	n.a.	/	n.a.	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Czech Republic

1. SITUATION AND KEY TRENDS

Economic growth reached 6% in 2007 (with GDP per capita at 80.2% of the EU average) but is projected to slow down to about 4.2% in 2008 and 1.7% in 2009. The open Czech economy is affected by the deteriorating situation of its main trading partners, and thus a fall in external demand has already had a negative effect on the export-oriented industrial sector. The unemployment rate is projected to rise. In 2007, the total employment rate of 66.1% was above the EU average, as was for older workers at 46% (55-64 cohort). The female employment rate (57.3%) has been increasing more slowly than the EU average (58.3%) and for the first time fell behind. The employment rate among the 15-24 age group increased to 28.5%. The unemployment rate (total 5.3%; men 4.2%; women 6.7%) has decreased substantially. Youth unemployment has fallen even more to 10.7% (2005: 19.2%), and for the first time is considerably lower than the EU average (15.3%). Long-term unemployment (2.8%) also dropped below the EU average, except for women (3.6%). On the other hand, activity rates have decreased (69.9% in 2007) with a significant difference between men (78.1%) and women (61.5%).

The at-risk-of-poverty rate is one of the lowest in the EU (2007: 10%)[97], but the threshold is one of the lowest as well. A higher poverty rate for children (16%) remains a problem, together with gender differences increasing with age. The fertility rate has been slightly increasing (2006: 1.33) but is still one of the world's lowest. The Czech Republic is projected to face rapid ageing: the old-age dependency ratio was 20.6% in 2008 but could reach 54.8% by 2050. Life expectancy at birth was 76.8 years (2006: men 73.5, women 79.9), below the EU average but increasing. Healthy life expectancy (2006: men 57.8, women 59.8) was below the EU average as well. Social protection expenditure was 18.7% of GDP in 2006, lower than the EU average, but projected growth based on 2004 figures is 7.1% by 2050. Of these, expenditure on pensions was 43.1% and on sickness and health care 34.4%.

2. OVERALL STRATEGIC APPROACH

The point of departure of the Report is that the social protection system is able to guarantee a low level of poverty and prevent social exclusion, but population ageing will negatively influence public finances and long-term sustainability, so there is a need for reform of pensions and health care. Social inclusion should be supported by the activation of people at risk of social exclusion by improving their social skills and employability, and by preventing and tackling inter-generational social exclusion. The first approved stage of the pension reform includes an increase in the retirement age and period of insurance and further attention will be paid to the private insurance. The main health and long-term care priorities focus on better health status of the population, sustainability, quality, integration of health and social services, modernisation of health insurance, and more investment in the long-term care sector. The main challenges are almost identical to those for 2006-2008, though with less attention paid to adequacy of social protection, access to health care and health inequalities.

The sustainable development perspective is not evident, but the link to the Lisbon strategy is present. There was quite strong economic growth and falling unemployment, to some extent supported by social policies. Flexicurity is receiving more attention but mostly in the form of work incentives (restricting social benefits). In contrast, growth and jobs policies did not significantly contribute to social cohesion, as the main focus has been on stabilising public

97 Source: EU-SILC (2007); income year 2006.

budgets. Child poverty has remained an important issue and the most disadvantaged groups have not profited much from economic growth. Gender equality and mainstreaming are neglected in the report as a whole. Therefore, a balanced, comprehensive approach to active inclusion, including adequate incomes, and efforts to ensure synergies between actions across the three pillars would be welcome. The Structural Funds along with the state budget will play a significant role in financing the majority of the report's objectives. The mainstreaming of social inclusion is still unsatisfactory, coordination is rather formal and public awareness is low. Pension reform is being discussed at the political level and with social partners, and cooperation on health care reform could be improved.

3. SOCIAL INCLUSION

3.1. Key trends

The Czech Republic has one of the lowest at-risk-of-poverty rates (10%) in the EU, but the threshold is one of the lowest as well, amounting to only €3251 (EU-25: €8368) per one-person household per year and €6828 (EU-25: €17573) for two adults with two dependants. The group below the threshold of 40% of median income is very small (2%), and there is a very low proportion of poor older people (65+ age group: 5%) due to the regular adjustment of pensions. Women (10%) are more at risk of poverty than men (9%), and the difference increases with age (65+ age group: women 8%, men 2%). Child poverty is quite high (16%), even if below the EU average. In addition, the at-risk-of-poverty rate of groups most at risk of poverty is higher than the EU average: the unemployed 48% (EU 42%), single-parent families with at least one child 37% (EU-25 34%) and households with three or more children 29% (EU-25 24%).

The number of people in jobless households (8% for children aged 0-17 and 6.5% in the 18-59 age group) is lower than the EU average. The rate of in-work poverty (3% for full-time workers and 4% for part-time workers among the18+ group) is also significantly lower than for the EU-25 (7% for full-time workers and 12% for part-time workers). The unemployment trap and the inactivity trap were 84% for an one-earner + 2 children family (at 50% of the average wage level), the low-wage traps were 53% and 50% (for 33-67% and 67-100% of the average wage level). The employment rate gap between persons born inside and outside the country was even negative -2.3% (2007). The role of social transfers (excluding pensions) is significant: without transfers, 20% of the population as a whole would fall under the poverty line, including 31% of children and 19% of people aged 18-64. The net income of social assistance recipients was 60% of the at-risk-of-poverty threshold for single persons, 80% for lone parents with 2 children and 80% for couples with 2 children. There is a lack of child care provision (only 2% of children below the age of 3 are cared for under formal arrangements as against the Barcelona target of 33%) and a large employment gap between women with and without children (60% as against 76%).

The situation regarding educational achievement is positive: low educational attainment is well below the EU average for all age groups, for example for the 25-64 age group it was 9.8% in 2005 (EU-25: 30.5%). Youth educational attainment (20-24 age group) is the highest in the EU, with 91.8% having completed at least upper secondary education in 2007 (men 91.3%, women 92.4%). The number of early school-leavers is very low (5.5% in 2006).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Assessing progress is complicated by the lack of data and quantified targets, few indicators and the omission of goals used in the 2006-2008 Report. The strategy is long-term and oriented to developing social services as a tool for social inclusion. Therefore, there has been only partial progress and the previously identified challenges are still valid. Overall, priority was given to decreasing social expenditure and promoting active inclusion. Thus - although the concept of active inclusion still mainly focus on active labour market policies - the system of social benefits was reformed to ensure more directness and motivation for the unemployed to enter the labour market (in January 2007, the subsistence minimum, the criterion for claiming social benefits, was complemented by a new, lower living minimum for those unwilling to cooperate with the labour offices). Moreover, automatic adjustment of the subsistence minimum in line with inflation was abolished in January 2008.[98] There was a significant tax reform in 2008: a flat-tax on personal income was introduced and the lower VAT band was increased. As a result, inflation has risen and a negative impact on income distribution is possible.

The Social Services Act (2007) introduced a specific care allowance to give persons in need of care a free choice to purchase services. However, the system is very costly, one problem being the possibility to spend the care allowance outside the social services system, and there is still no evidence of any improvement in quality and accessibility. The amendment of the Schooling Act now also guarantees access to basic education for all children of foreigners. Regarding the challenge concerning the most disadvantaged groups in the 2007 Joint Report, the Agency for Social Inclusion in Socially Excluded Roma Localities has been created and social field work has been ongoing, but its impact on the living conditions of the Roma is still only marginal. Almost no progress has been achieved in the social economy. Regarding the challenge of implementing social inclusion at regional/local levels, not much has been achieved, apart from more frequent use of community planning of social services (186 municipalities are involved, the target was 200). The objective of decreasing poverty in single-parent families with children was partly achieved as the at-risk-of-poverty rate decreased from 41% to 37%. The ESF has already contributed substantially to social inclusion, especially by supporting employment and social services.

3.3. Key challenges and priorities

The priority objectives of the current report are similar to those for 2006-2008 and respond to the challenges identified by the 2007 Joint Report; they target the most disadvantaged groups, families and governance. The priorities take into account that the poverty rate is low and concentrated among some population groups and that social protection systems face a financial sustainability challenge. Mainstreaming social inclusion, especially at regional/local levels, continues to be considered important. In principle, the strategy will follow already established pathways and its focus on developing social services and decreasing social welfare dependency has even been strengthened, thus putting aside the issue of adequacy of social benefits and active employment policies, which are considered only in relation to the NRP 2005. This is unfortunate because unemployment is the main reason for poverty. More attention could be paid to broader aspects of child poverty. Reliance on the ESF is substantial, but the full potential of the Structural Funds is not exploited and there is little connection with the ERDF investment programmes, although they aim to finance infrastructure for education, social, health services, development in socially excluded localities, etc. The priorities do not take into account gender equality issues, particularly the gender differences in poverty.

[98] On the other hand, since January 2007 housing expenditure has been taken out of the subsistence minimum and the normative expenditures used for the calculation of housing benefit have been twice adjusted for inflation

3.4. Policy measures

The first priority aims to increase the integration and labour market participation of socially excluded persons through the social services; coordination with other policies is limited. The focus is on the most disadvantaged groups, such as the long-term unemployed, people with disabilities, older people, people from different socio-cultural backgrounds, children and youth, third country nationals, victims of crime and domestic violence, the homeless, ex-prisoners. Attention is paid to increasing employability, promoting equal opportunities in education and preventing criminality. Social field work will be carried out to reduce social exclusion. The activities of the Agency for Social Inclusion in Socially Excluded Roma Localities are only in the initial stages, but the pilot programme for local development strategies should be implemented in 2008-2011. Towns with significant social problems have prepared crime prevention concepts for 2008-2011. Special 'mediators' have been employed to facilitate communication between the police, minorities and socially excluded localities. Special strategies have been designed for third country nationals and older workers but they still need to be properly implemented.

Compared to the 2006-2008 Report, the second priority is now limited only to families with special needs. Given that child poverty is a broader problem, this narrowed focus does not seem to be sufficiently justified. Social services play a key role and the main goals are active inclusion through a reformed social benefits system, social and legislative child protection and support for young people leaving institutions or foster care. At present, the Czech Republic is among the countries with the highest number of children in institutions, so support for other forms of care is highly advisable. Other relevant issues, such as social benefits adequacy, housing, education or active labour market policies, are not mentioned. Only few measures have been proposed for reconciling family and working lives and tackling unemployment among women after parental leave, despite the fact that it is the EU highest (2007: CR: 43.2%, EU: 12.6%) and increasing, and supporting childcare facilities.

The third priority aims to support policy making, communication and partnership at all levels of public administration, and focuses on the development of social services. Priority is given to community planning of social services with the aim of including all 'delegated' municipalities by 2010 and ensuring training for all relevant actors. The continued support for the transformation and modernisation of institutional social services is welcome. There is a new and potentially very useful measure for the social economy with arrangements prepared for 2009. Adequate attention is paid to housing, particularly for people at risk of social exclusion, through financial contributions. About 8-10 pilot projects will be selected and comprehensive social inclusion activities will be carried out for the Roma communities. This priority is almost entirely co-financed by the Structural Funds, which offers an opportunity to develop innovative approaches, but also poses a threat to sustainability.

These general priorities are not developed into specific measures; the indicators used for the 2006-2008 Report were not evaluated and are no longer used. Only few targets are set in the 2008-2010 Report, which could be at least partly achieved because of positive trends: to decrease the number of at-risk-of-poverty households, especially those with more members (though predicted slow down of economy could affect current development); to involve all 'delegated' municipalities in community planning of social services.

3.5. Governance

The NAP/incl. was prepared by the Ministry of Labour and Social Affairs in cooperation with the Committee on Social Inclusion. The process seems to be rather technical, and even if the Committee provides a forum for cooperation among various actors, it does not have any real competence for coordination and initiative for strategic planning and impact assessment.

Several NGOs are members of the Committee, but the broader involvement of civil society and people experiencing poverty is still a challenge. No political or public discussion has taken place on the report. Ownership of the strategy is low and social inclusion mainstreaming is underdeveloped. Gender mainstreaming is missing and gender equality bodies were not involved in the preparation. No budget allocations, timetable or clear and quantified targets have been provided and the role of relevant actors in implementation could be better specified. Monitoring and evaluation should be more developed. There is no proper assessment of the progress achieved, with only few common EU indicators used and no national indicators. The use of indicators from the Structural Funds programming documents is welcome, but the indicators should also take into account the difference between the processes.

4. PENSIONS

4.1. Key trends

The Czech pension system consists of the universal public mandatory PAYG pillar, a voluntary supplementary pillar, i.e. private pension insurance with a state contribution, and life insurance. The pension contribution rate is 28% of gross income and is split between employee (6.5%) and employer (21.5%). Pensions consist of a basic amount (flat rate, at present approx. 9.4% of average gross monthly pay) and a percentage based on the insurance period and gross earnings. The minimum insurance period is 25 years. The basic pension scheme will be under significant financial pressure, so the reforms so far introduced, such as prolonging working life and restricting early retirement, are aiming to improve its sustainability. The retirement age is being raised gradually, in 2008 to 61 years and 10 months for men and varying between 56 years, 4 months, and 60 years, 4 months, for women (depending on the number of children raised). To support longer working lives, benefits are being reduced for early retirement and increased when pensions are deferred. Private pensions schemes still do not have significant weight, even if the number of participants has been steadily increasing. To support this type of insurance, tax incentives were introduced as of January 2000. The relative income of older people (0.81% for 65+, men 0.83%, women 0.80%) is lower than the EU-25 average (0.84%) and has slightly decreased (0.83% in 2004).

4.2. Key challenges and priorities

The main challenge is to ensure the long-term financial sustainability of the pension system, since population ageing is one of the fastest in the EU. The old-age dependency ratio was projected to rise from 19.7% to 54.8% of GDP between 2004 and 2050 and public pension expenditure from 8.5% to 14% of GDP. However, according to national projections future level of expenditure could be reduced to about 10.2% of GDP in 2050 as a result of the first stage of the pension reform. At present, the system ensures relative adequacy. At 5%, the at-risk-of-poverty rate for older people is very low. In 2007 the aggregate replacement ratio was slightly over the EU-25 average, 51% in total (men 51%, women 56%). According to projections of the theoretical replacement rates, the net retirement income as a ratio of work income at the point of retirement is expected to drop by twenty-one percentage points between 2006 and 2046 for a worker retiring at age 65. Compensation for this negative trend should be sought in longer working lives and broader use of private pensions.

The challenge of securing sustainability (including adequacy and increasing the employment of older people), identified in the 2007 Joint Report, has been partly addressed. Pension reform is being formulated and so far three steps have been proposed. The first step to come into force in January 2010 comprises parametrical changes to the PAYG system with the aim of gradually increasing the pensionable age to 65 years for men and for women without

children or with just one child and to 62-64 years for other women. The period of insurance needed to acquire a pension entitlement will be gradually lengthened to 35 years. The second and third steps of the reform, which will concern private pensions, are to be discussed in 2008-2009. The vision is to introduce an option to transfer a small part of the contribution under the statutory PAYG scheme into the private system.

All the proposals in the 2005 Pension Report are being pursued and should be implemented within the reform. Pensions are indexed once a year on the basis of prices (100%) and real wages (at least 1/3). A new measure now allows for adjustment of pensions on an ad hoc basis when inflation exceeds 5% (previously 10%).

4.3. More people in work and working longer

The employment rates of older workers have increased (2007: 46%, men 59.6%, women 33.5%) as a result of economic growth and pension policy measures, mainly the increase in retirement age. Further support is needed to increase the employment of older women, which is lower than the EU average (36%). Since many of them provide long-term care to their relatives, more in-depth analysis is necessary for an integrated approach. Incentives to work longer are still insufficient for workers on low wages. Not much attention is paid to increasing the human potential of older workers; their participation in training and upgrading is very low but the ESF could help. The labour market is still not favourable to flexible forms of employment, such as part-time work, which has a negative impact particularly on women. The lack of care facilities for children aged 0-3 prevents or postpones the return of women to work after parental leave and contributes to their lower employment.

While rising the effective labour market exit age (60.7 in 2007) is lower than the EU average (61.2). Early retirement is still widespread; it can be claimed up to three years before the normal pension age after at least 25 years of contributions. The number of people claiming early retirement sharply decreased in 2002-2003 but started to increase again in 2004, reaching 31 811 in 2007 (compared to 69875 entering standard retirement). However, the first phase of the pension reform provides for further reduction in early retirement benefits.

4.4. Privately managed pension provision

The system of privately managed pensions was established in 1994 as a voluntary, supplementary system with state subsidies. At present, it has 4 million members. Coverage in the age group 15-64 is 46.5%. However, average contribution per head is still very small and stagnating (at 2% of average wages since 1999). The state contribution is an average CZK100 per month while 23% of participants also receive an employer contribution of around CZK500 per month. Moreover, since its creation it has been used mostly as a savings mechanism, with 71% of payments taking the form of a lump sum. At present, there are 10 funds with assets of around CZK 167 billion, but the system is still underdeveloped and its contribution to pensioners' income is negligible.

4.5. Minimum income provision for older people

Pensions decrease poverty by 18%, while the at-risk-of-poverty rate for older people at 5% (men 2%, women 8%) is low and significantly lower than the EU average of 19%, but with significant gender differences increasing with age (75+: 7%, men 2%, women 10%). Striking gender differences emerge when measured at 70% of median income (men 9%, women 23%). The reason for lower female pensions is lower income during working life; the gender pay gap was still relatively high at 18% in 2006 (EU-27: 15%). The subsistence minimum is used as a safety net in the case of low pensions. They are adjusted each January for inflation and wage growth (at least 1/3 of real growth in wages). In addition, old-age pensioners are allowed to receive income from gainful activity. Yet various factors, such as high inflation, in

particular increasing energy and housing prices, represent a threat to the continued ability of the pension system to ensure a decent standard of living for pensioners. One risk group in terms of the adequacy of pensions are the self-employed, who minimise their social security contributions.

4.6. Information and transparency

The public insurance body in the Czech Republic is the Czech Social Security Administration, which is also responsible for providing regular information to scheme members. The Association of Pension Funds in the Czech Republic provides information about private supplementary pension insurance and individual pension funds publish information on their web pages. The social partners are taking part in discussions on the reform.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Practically all the population is covered by compulsory universal health insurance financed through an earmarked payroll tax on employees, employers and the self-employed and by state budget contributions. Private insurance is negligible. Primary health care (about 95% is private) is organised by municipalities and delivered in municipal health centres, polyclinics, and the private premises of general practitioners (GP), dentists and gynaecologists. A GP referral gives access to specialists, polyclinics and hospitals. 75% of specialist outpatient facilities are private, whereas hospitals are mostly public. Life expectancy at birth increased to 76.8 years in 2006 (men 73.5, women 79.9), but together with the indicator for healthy life years (men 57.8, women 59.8 in 2006) is still lower than the EU average.

The main objectives of the report are in line with those set out in the 2006-2008 Report, but less attention is paid to health inequalities, availability, and maintaining coverage of the system. There are some disadvantaged groups with a lower health status, especially people from deprived localities (mostly Roma) and the homeless. More policy measures should be designed to address population ageing and cooperation between health and long-term care. So far, a new option to provide out-patient care in social service facilities and social services in health care facilities has been introduced. The Government has recently announced a health reform but without assuring the comprehensiveness of the strategy and with shortcomings in its preparation in terms of communication and cooperation with stakeholders. It is not clear to what extent some of the measures under discussions, such as the privatisation of faculty hospitals and transformation of public health insurance funds into joint-stock companies, would ensure accessibility, quality and sustainability.

5.1.2. Accessibility

In principle, health care services are broad and freely accessible to the entire population except for certain groups of third country nationals. General access to care is considered good: self reported unmet need for medical care is one of the EU lowest at 0.7% in 2006 (EU: 3.1), only a little higher in the lowest income group (1.4%) and similarly for dental care (CZ 0.9%, EU 5%). No significant regional inequalities or waiting lists exist. The Structural Funds will be used to improve the health infrastructure. Reduction in capacity of acute hospital beds, which was one of the EU's highest, took place because of inadequate staffing and low medical treatment. The establishment of one-day health care services is a positive development. A more general system of co-payments is not in place but is being discussed; so far, there are co-payments for a few services (prostheses, dental care, and medicines). Statutory fees introduced in January 2008 for GP visits, emergency treatment, hospitalisation

and the prescription of medicines have led to a decrease in the use of care. Newborn children have recently been exempted from payments. There is an annual financial ceiling (but not all kinds of fees are included) and recipients of social benefits ‘in material need’ do not pay fees. Even if the fees do not seem to have negative effect on accessibility, it is necessary to monitor and evaluate their impact on low-income groups, the chronically ill and older persons.

5.1.3. Quality

The independent accreditation agency, the United Association Commission, has been carrying out external evaluations of the quality of health care in hospitals since 1998. Otherwise, there is no national system of quality and safety evaluation. The proposed Act on Health Care Services and Conditions for their Provision aims to establish a system for evaluating quality and safety as a voluntary process. Furthermore, no effective mechanism for dealing with patient’s complaints is in place and patients are not sufficiently informed about their rights. Therefore, the steps described in the Report are welcome. As an initial step, the Information Portal for Safety and Quality in Health Care was launched in June 2008. To increase patient safety, health care providers will be obliged to establish internal regulations concerning the handling of medications and medical documentation. The National Programme for Improving Quality in Health Care should become an information source. The National Network of Health Promoting Hospitals is under preparation to promote international cooperation. The Expert Forum for the Creation of Health Care Standards has been established for treatment standards. On the other hand, it is not evident that health technology assessment is being used effectively.

5.1.4. Sustainability

Total health care expenditure (6.8% of GDP, PPP1490 per capita in 2006) is below the EU average and has been slightly decreasing since 2005 in GDP terms (7.5% in 2004) but growing in absolute terms per capita. The share of public expenditure was 88% (2006), one of the highest in the EU. Public expenses are projected to increase by 2% of GDP by 2050 (EU-25: 1.6%) due to population ageing. The 2007 Joint Report challenge of improving efficiency and reducing waste has been partly addressed. Statutory fees helped to reduce overuse of care and led to decrease in the number of visits to specialists, hospitalisation and its length, the number of prescriptions and expenditure on medications. However, at present the new regional governments intend to pay statutory fees in the regional facilities on behalf of the patients from the regions' budgets.. No measures were presented to attract and retain staff. Lifelong learning will be supported by the ESF in particular; specific legislation has been prepared for the further education of medical professionals, which will also regulate specialist training. Disease prevention and the promotion of healthy lifestyles are still an issue; it is necessary to address risk factors such as smoking, fitness levels, eating habits and obesity (14.8% of the population in 2005 according to OECD data), and specific diseases.[99] A positive aspect is that the report mentions preventive screening for selected cancer types paid for by public insurance and the creation of special Network of Comprehensive Oncology Centres, and several activities on healthy lifestyles.

5.2. Long-term care

5.2.1. Description of the system

Long-term care is provided within the health care system (mainly public health insurance) and as part of social services (the state budget). Expenditure was quite low (0.3% of GDP in 2005, EU-25: 0.9%) and is projected to grow by 0.4% by 2050 (EU-25: 0.6%). The bodies responsible are the regional authorities and municipalities but several NGOs have an

[99] Coverage of mammography screening for women aged 50-69 was only 18.6% in 2006; and only 38.8% of women aged 20-69 were screened for cervical cancer in 2002 (EU-15: 60-70%)

important role especially in out-patient care. The 2007 Joint Report challenge of enhancing coordination between health and social care and different stakeholders and to improve access to long-term care has been addressed partly by the Social Services Act (2007), which introduced the concept of the social-health care bed.

5.2.2. Accessibility

Access to long-term care is not regarded as problematic by the population.[100] The regional authorities are obliged to carry out strategic planning of social services. The number of beds in health care is adequate, but there is a shortage of beds in social care. Due to population ageing, the increasing demand for geriatric services and hospices will have to be addressed. Attention is being paid to support for home care provided by public agencies, health care facilities, private doctors and NGOs. Home care has developed considerably and now covers, with few exceptions, the entire territory.[101]

5.2.3. Quality

The objective of the previous report to introduce quality standards has been met. All service providers have to be authorised and fulfil specific registration conditions, including demonstration of quality standards. Monitoring is performed by the social services inspection. Moreover, criteria have been established for the competencies of social workers, whose continuing education is at present financed by the ESF. Care outside institutions is a priority; the Government has adopted a strategy for transforming institutional care into other types of care, and a further system of planning for social services should help to support home and community care. However, it has so far been little used. The care allowance introduced by the Social Services Act has given clients a tool to freely choose services according to their needs and thus contribute to the development of better quality services.

5.2.4. Long-term sustainability

Social services are financed from various sources (state, founder's budgets, clients' payments, revenue, gifts) and the ESF plays an important role in strategic planning, training, and some services. The care allowance has become an important financial tool, for both professional services and family caregivers. However, it requires more funding than anticipated and is easily used outside the social service system, so less money than expected is paid to providers. Out-patient services in particular are often in a worse financial situation and there has been no corresponding decrease in institutional care and rise in family care. The proposed legislative change is intended to restrict the allowance only to the actual purchase of social service. More support for informal carers is needed. Much still needs to be done to support the coordination of health and social care and implement the ageing strategy.

6. CHALLENGES AHEAD

- To take further steps to improve the situation of vulnerable groups (e.g. the Roma), particularly those living in disadvantaged regions and localities, including by enhancing the implementation of social inclusion policies at regional and local level, with further emphasis on integrated and balanced active inclusion policies.

- To support the reconciliation of work and family life and increase the employment of women, including by supporting childcare facilities, with a view to improving the financial sustainability of the pension system.

[100] According to Special EUROBAROMETER 283, 2007, 80% of people consider they will be provided with the appropriate help and long-term care if needed (EU-27: 71%)

[101] In 2007, social field work was provided in 121 573 cases and there were 71 642 people in institutional care

- To take further pension reform steps and encourage the creation and take-up of jobs for older workers and increase their employability so as to help balance financial sustainability and pension adequacy.

- To improve health care efficiency through more rational use of resources (notably through a stronger focus on primary health care while reducing the high dependency on specialist and hospital in-patient care) and by adjusting staff numbers; to allocate more public funding to effective and targeted health promotion and disease prevention.

- To ensure that reforms (e.g. privatisation of funds) are properly thought through on the basis of past experience and the experience of other countries.

- To enhance coordination between health and social care and between different stakeholders and to improve access to long-term care services, including by ensuring a sufficient quantity and quality of staff.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,6	68,5	2000	65,0	73,2	56,9	36,4	36,3	2000	8,7	7,3	10,3	17,8
2005	6,3	75,9	2005	64,8	73,3	56,3	27,5	44,5	2005	7,9	6,5	9,8	19,2
2008f	4,2	80,6	2007	66,1	74,8	57,3	28,5	46,0	2007	5,3	4,2	6,7	10,7

* Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	69,7	76,8	12,7	16,2	n.a.	n.a.	7,7	1995	7	90,9	9,1		
2000	71,7	78,5	13,8	17,3	n.a.	n.a.	4,1	2000	6,5	90,3	9.7b	2005	1,2
2006	73,5	79,9	14,8	18,3	57,8	59,8	3,1	2006	6,8	88	11,5	2006	0,7

s: Eurostat estimate; p: provisional; b: break in series *THE: Total Health Expenditures

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	17,4	39,8	37,2	2,3	11,9	1,3	7,5
2000	19,5	43,4	33,6	3,5	8,4	3,4	7,7
2006	18,7	43,1	34,4	3,2	7,6	3,1	8,6

* including administrative costs

Age-related projection of expenditure (AWG)

EPC-AWG	Old age dependency ratio eurostat	Expenditure (% of GDP) Level in 2004 and changes since2004: Total social expend.	Public pensions	Health care	Long-term care
2005	20,6	19,3	8,5	6,4	0,3
2010	21,8	-0,5	-0,3	0,4	0,0
2030	35,7	1,7	1,1	1,4	0,2
2050	54,8	7,1	5,6	2,0	0,4

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20		Anchored at-risk of poverty Total - fixed 2005 threshold
Total	10	16	8	5	18	19	19	7	3,5	2005	
male	9	-	8	2	19	-	21	14	-	2006	2878
femal	10	-	9	8	17	-	19	7	-	2007	3251

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	8,0	7,9	6,2	9,5
2004	9,0	8,0	6,4	9,6
2007	8,0	6,5	4,9	8,1

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	4,2	3,5	5,2
2004	4,2	3,4	5,3
2007	2,8	2,1	3,6

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	n.a.	n.a.	
2004	6,1	5,8	6,5
2007	n.a.	n.a.	

*: excluding students; i: change in methodology; b: break in series

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0.81	0.83	0.8	***Aggregate replacement ratio***	0.51	0.51	0.56

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
-21	-15,6	-15,6	DB	/		100	/	28	/	

* (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)

Denmark

1. SITUATION AND KEY TRENDS

The slow-down in economic activity in 2008 has been rapid and pronounced, most likely leading to a contraction of GDP in 2008 and 2009. Denmark already meets all the EU employment targets. The employment rate (77.1% in 2007) is historically high and the unemployment rate (3.8% in 2007) at its lowest level since the early 1970s. Although starting to diminish, employment remained at a high level in 2008, but is expected to fall over the coming year. Similarly, the unemployment rate of around 3.5% in 2008 should be lower than in 2007, but is expected to increase in 2009. Long-term unemployment (0.6% in 2007) and youth unemployment (7.9% in 2007) are among the lowest in the EU. Gender differences are fairly small. Demographic effects have started to affect labour supply negatively.

The social protection system continues to provide universal basic protection against economic risks from unemployment, illness or dependency for all citizens. Total public social protection expenditure (29.1% of GDP in 2006) is persistently among the highest in the EU and projected to grow more than the EU average. Denmark has a compressed wage structure and the at-risk-of-poverty rate (12% in 2007) remains below the EU average. People with a foreign background and the unemployed are overrepresented in the lower income brackets. While growth in male (76.1 in 2006) and female life expectancy (80.7 in 2006) has been moderate, healthy life expectancy is among the highest in the EU (67.7 for men, 67.1 for women in 2006) and shows a positive trend. Infant mortality (3.8 in 2006) and perinatal mortality (3.3 in 2005) show a decreasing trend.

People with a foreign background constitute about 9.4% of the working age population, with 7.5% from non-EU25 countries. Migration patterns are changing, with a strong increase in labour migration and declining levels of humanitarian migration and family reunification. The employment rate gap between nationals and people with a foreign background is still significant (16.0 for Denmark in 2007, compared to the EU average of 2.6), although their employment situation has improved recently. The performance of children with a foreign background in the education system (upper secondary attainment rates, early school-leaving, reading literacy) remains significantly below that of native students.

2. OVERALL STRATEGIC APPROACH

Denmark's overall strategic approach builds on principles of universality, accessibility, gender equality, adequacy and sustainability. Systems are primarily financed from general taxes and important parts do not depend on labour market attachment. All citizens have access to health services, all citizens have the right to old-age pension and all citizens that meet the legal conditions are entitled to a comprehensive range of social services and provision. Key overall challenges remain to 1) increase the labour market participation of disadvantaged groups, 2) ensure equal access to a high-quality, efficient health care system and 3) support budgetary conditions for maintaining the universal pension system. Denmark has addressed all three overarching objectives of the Open Method of Coordination.

While no direct link is made with the Danish National Reform Programme, social inclusion policies are presented as reinforcing labour market initiatives. The National Strategy Report is the product of a process involving a wide range of stakeholders, including social partners, civil society, evaluators, regional authorities and relevant ministries. All initiatives of a legislative nature involve the Parliament. The ESF is contributing through the Objective 2 programme 'More and better jobs', but the funding is negligible in comparison to total expenditure on social inclusion in Denmark.

3. SOCIAL INCLUSION

3.1. Key trends

Denmark continues to have one of the lowest levels of income inequality in the EU. In 2007, 12% of the Danish population lived on an income of less than 60% of the median income. The proportion is significantly below the EU average for all population groups. There are no significant differences in the share of men and women, but people with a foreign background and the unemployed are over-represented in the lower income groups. The share of people living in jobless households continued to decrease in 2006 to 6.9% for adults and 5% for children. The employment rate of people with a foreign background and disabled persons remains significantly below the national average.

The upper secondary completion rate stood at 70.8% in 2007, which is below the EU average and considerably short of the EU and national targets of 85% by 2010 and 95% by 2015. The share of early school-leavers is below the EU average. The performance of children with a foreign background is below that of native students.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The Danish 2006-2008 National Strategy Report established nine priority areas for social inclusion and social protection (cross-cutting and basic activities, breaking the vicious circle of deprivation, teaching and education, employment, housing, integration, combating human trafficking, substance misuse, qualified everyday life) and the 2008 report includes information on the progress of policy plans in relation to these areas. Implementation seems most advanced in breaking the vicious cycle of deprivation and integration.
In the 2007 Joint Report, two challenges were identified for Denmark in the area of social inclusion:

– To further develop labour market tools to improve the integration of ethnic minorities within the labour market;

– To encourage more people with disabilities and older workers to stay on the labour market.

The 2008 NSR stresses that employment is crucial for social cohesion and inclusion and the financial sustainability of the welfare system. The two-year campaign 'A New Chance for Everyone' has a particular focus on social assistance and starting-allowance recipients (one third of the target group consists of people with a foreign background). Three years ago, one in six young people with a foreign background were dependent on social assistance or starting allowance. Today, the figure is one in eleven.

Older workers have been targeted through a temporary wage subsidy scheme in the private sector and by offering older people who lose their right to unemployment benefit a job in their local authority. A number of initiatives have been taken under the government's strategy 'Disability and work — an employment strategy for disabled persons'. Recent examples include a trial scheme with social mentors for persons with a temporary mental disorder. Another ongoing trial involves a 'flexi-job certificate', which states which safeguard requirements may apply to employment and provides information on assistance schemes.

The Welfare Agreement (2006) has been complemented by a new 'Job plan' (2008), which includes additional initiatives to enhance activation and work incentives to wean people off public benefits. The main measures aim to strengthen employment among people with a foreign background, older workers and persons with a reduced working capacity and to promote the recruitment of qualified foreign labour. The policy is a good example of how social inclusion and a strategy for growth and jobs can mutually reinforce each other. Nevertheless, attention should be paid to potential side-effects, as the 'Job plan' primarily focuses on increasing labour market participation through financial incentives for the unemployed.

Initiatives are also being taken under the 'Quality Reform' (launched in 2007) with the main aim of improving and securing the level of welfare for the population. The focal points are the future challenges that an ageing population will present, improvement of the quality, effectiveness and efficiency of the Danish health care system (including a cancer treatment plan), and initiatives to keep and recruit workers in the care professions. Although the plan has been criticised by various actors, it is a focused effort to deal with some of the challenges identified in the Joint Report.

3.3. Key challenges and priorities

The Danish NSR presents three key policy objectives for 2008-2010 in relation to poverty and social exclusion: 1) supporting disadvantaged children and youth, 2) supporting socially disadvantaged groups, and 3) social inclusion of people with a foreign background. The three objectives build on the focal areas of the 2006-2008 NAP, which indicates a high level of consistency. The focus on older workers and the disabled in the 2007 Joint Report has, however, not been carried forward in these objectives. Nevertheless, the selected priorities are highly relevant, although the focus is broad and the objectives and expected outcomes could be specified further.

3.4. Policy measures

Supporting disadvantaged children and youth

The measures target disadvantaged children, young people and parents. Action areas are: early and cohesive intervention, academic proficiency and early learning, youth education, special social problems, networks, parental responsibility, and documentation and impact. The actions respond to three of the seven key policy priorities adopted by the EU (tackling disadvantages in education and training, eliminating child poverty, increasing labour market participation).There are clear arrangements for the effective delivery of the policies. A weakness is the lack of a gender dimension, as gender is of great importance in for example youth education. There is also no specific reference to the number of children living in poverty or how other welfare reforms influence the situation for children and young people in low-income families.

Supporting socially disadvantaged groups

The measures target disadvantaged adults, including drug and alcohol abusers, the mentally ill and the homeless. Housing, health and employment are the main areas, and actions respond to four of the seven EU key priorities (ensuring decent accommodation, improving access to quality services, overcoming discrimination, increasing labour market participation). There is a good balance between prevention and alleviation in the actions. Gender aspects are also reflected.

Social inclusion of people with a foreign background

The measures target refugees and people with a foreign background and mainly focus on the barriers of language, cultural values and traditions that may limit labour market integration and access to resources and services. Actions respond to three of the EU key priorities (increasing labour market participation, tackling disadvantages in education and training, and overcoming discrimination). However, structural barriers are not explicitly mentioned, and it would be important to ensure a comprehensive approach that takes into account all mechanisms that could come into at play when the advanced Danish system of employment and social policies fails to deliver similar results for both people with a foreign background and the native population. There is also no specific reference to the risk of poverty and bad health among people with a foreign background or the living conditions of asylum-seekers, which have attracted recent attention. Nevertheless, the employment area is well developed and the delivery of policies is in place. Gender aspects are also well reflected, particularly in relation to education and employment.

3.5. Governance

The National Strategy Report is the product of a process involving a wide range of stakeholders, including interest groups representing disadvantaged people (e.g. the homeless, unemployed, drug users). A website has been launched to invite debate and comments from the public. A large-scale conference was held in spring 2008 to discuss the challenges of the Danish welfare system and priorities.

General indicators to monitor progress towards the achievement of each priority policy objective have not been identified in the report. Monitoring and evaluation arrangements exist, but relate more to the individual actions and programmes being implemented. There is also independent research on specific initiatives (e.g. the strategy to combat homelessness and initiatives for vulnerable children).

4. PENSIONS

4.1. Key trends

The ratio of persons aged 65 and above to 15-64 year olds is projected to increase from 23.6% (2008) to 37.8% in 2030 and 41.3% in 2050 (significantly below the EU27 average of 50.4% in 2050). Denmark has a well-balanced, multi-pillar pension system. The statutory public old-age pension has two elements. The first is a universal, non-contributory, residence-based scheme financed from general taxation on a pay-as-you-go basis. Benefits are taxable and consist of a flat-rate part and an income-tested part. The second is a funded defined-contribution scheme (ATP) financed from mandatory contributions from all employed persons and organised in a separate fund under tri-partite management. Pensionable age for both men and women is currently 65 years, while the average exit age was 60.6 in 2007.

Statutory pensions are supplemented by occupational pension schemes based on collective agreements and individual pension savings. Occupational pension schemes have expanded substantially and today cover around 90% of employees, who typically pay contributions of between 12% and 17% on gross wages. Most are fully funded defined-contribution schemes. The compulsory personal pension savings contribution (SP) has been suspended for 2009. A financial stability package for pensions with initiatives to ensure market stability and prevent forced sale of mortgage bonds owned by pension funds has been implemented.

The income of people aged 65+ relative to the 0-64 age group stands at 70% (2007), which is lower than in most other Member States, while the risk of poverty for the elderly population remains at a moderate level (18%), but higher than for the total population (12%). Under a broader definition of income, including imputed rent, the risk of poverty in Denmark for elderly people is almost the same as for the rest of the population.

Public pension expenditure is projected to increase from 9.5% to 12.5% of GDP between 2004 and 2050. As occupational pension schemes mature, they will contribute significantly to the income of future pensioners. At present, gross theoretical pension replacement rates are relatively low compared to almost all other Member States, but is expected to increase substantially, reflecting the maturing of occupational and voluntary pensions. The replacement rate should be seen in relation to the supplementary benefits (housing benefits, heating benefits, health allowances, reduced tax on owner-occupied housing) and services targeting pensioners (health and long-term care, including free home help). The aggregate replacement rate is 39% (2007).

4.2. Key challenges and priorities

The Danish pension system is intended to ensure i) a basic retirement income, ii) a reasonable replacement rate, and iii) solidarity between generations, by maintaining and expanding the three-pillar pension system and preserving a fair balance between the pillars.

In terms of adequacy, the Danish system is considered able to secure present and future pensioners a reasonable standard of living. Nevertheless, the growing importance of savings-based pension schemes requires more focus on persons at risk of having insufficient pension savings.

As concerns financial sustainability, public debt was further reduced to 26% of GDP in 2007. Gross debt developments are strongly affected by the response to the financial crisis, increasing the gross debt ratio in 2008. The government budget surplus (4.5% of GDP in 2007) could exceed 3% of GDP in 2008, but the downturn could push it close to balance over the following two years. The macro-fiscal framework, the 'Denmark 2015 plan', relies on counteracting the negative demographic impact and raising structural employment by 20 000 by 2015.

Regarding the modernisation of the pension system, Denmark stresses the increased need for information on pensions as an important challenge.

4.3. More people in work and working longer

The employment rate of older workers, while among the highest in the EU, drops drastically for the 60-64 age group, reflecting the influence of the voluntary early retirement benefit. The average exit age (60.6) from the labour force decreased slightly in 2007, but remains close to the EU average. Increasing the labour supply continues to be among the key challenges and priorities of the government, as it is considered essential to secure the financing of the welfare society over the longer term. Measures have addressed retirement age thresholds and activation and work incentives for older workers and people with a foreign background in particular.

The welfare reform (2006) introduced changes in retirement age thresholds, to become effective from 2019 onwards (the early retirement age will increase from 60 to 62 from 2019 to 2022, and from 65 to 67 for old-age pensions from 2024 to 2027, while from 2025 it will be indexed to life expectancy). However, the timing of this reform will mean that the most of the large age cohorts (baby-boomers) will have retired before it takes effect. Thus, it will not contribute to the labour supply over the shorter and medium term. In February 2008, as a part of the new 'Job Plan', further incentives were introduced for old-age and disability pensioners to maintain or resume labour market participation. The Job Plan also includes tax incentives for people who remain in employment until 65. Further reform measures are in the pipeline and advance policy advice has been provided by the Labour Market Commission, which will submit its full report by mid-2009. The Tax Commission is examining reform options and will submit its report in early 2009.

The strategy for ensuring the adequacy and financial sustainability of the pension system seems appropriate in the long run. A budget policy leading to quick debt reduction has already been sustained for several years. A continued budget surplus will help address ageing-related growth in public expenditure. Sustainability also relies on increasing structural employment, which will require further measures, especially to maintain older workers in employment and improve the labour market integration of people with a foreign background and other disadvantaged groups. The maturation of occupational pensions should contribute to the future adequacy of pensions. Nevertheless, the future contribution of private pensions would benefit from periodic reviewing, also taking into account aspects such as the impact of irregular attachment to the labour market and the gender pay gap on future pensioners.

4.4. Privately managed pension provision

The growing importance of savings-based pension schemes requires more focus on persons at risk of having insufficient pension savings. Temporary absence from the labour market (due to illness, unemployment, maternity, child-caring) will lead to reduced pension savings and thus to a smaller supplementary pension (although the old-age and ATP pensions are not influenced by absence from the labour market and thus mitigate the effect). The calculation of both public and occupational pensions is based on a gender-neutral principle. Women have a high employment rate and the prevalence of occupational pensions is as high for women as for men. However, women work part-time more often than men and the high and persistent gender pay gap (17%) in Denmark will have an effect on the income of female pensioners. Initiatives are ongoing to address the gender segregation of the labour market and raise awareness of the gender pay gap.

4.5. Minimum income provision for older people

The non-contributory, residence-based old-age pension constitutes the minimum level of income provision for older people in Denmark. The flat-rate part is tested against work

income above a significant level. The income-related part is tested against certain types of capital and pension income. A supplementary benefit is paid to those who have no other income than the full old-age pension. A personal allowance may be granted to old-age pensioners to cover reasonable necessary expenses following a specific assessment of their needs. This allowance may for example be granted to old-age pensioners who receive a reduced pension due to a residence period of less than 40 years. Social assistance may be granted to older persons who do not meet the requirement for a full or reduced old-age pension. Pension income is underpinned by a range of needs- and income-tested benefits targeting pensioners (e.g. housing and heating benefits, health allowances). The effective purchasing power of pensioners is also raised by age-related tax rebates (e.g. on owner-occupied housing) and discounts on drugs, transport, admissions and radio/TV. Health and long-term care services provided in the home are free. The old-age pension keeps the risk of poverty for older people at a moderate level, but current theoretical replacement rates are low.

4.6. Information and transparency

The complexity of the pension system and the growing importance of savings-based schemes are putting greater demands on the knowledge of individuals and decisions about their pensions. In addition to the obligation on pension schemes to disclose annual information and a common database, *PensionsInfo*, a public pension portal is being developed where citizens will get both general information on pensions and information on their own pension savings. The portal will also provide calculation functions allowing citizens to calculate the pension-related consequences of different choices (change of time of retirement, increased pension savings, savings needed to obtain a given pension, etc.). New rules have been introduced concerning the supervision of life insurance companies and multi-employer pension funds.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Denmark's tax-based, decentralised health care system provides universal coverage for all citizens. Following the administrative reform in Denmark in January 2007, the primary sector is financed by the regions and local authorities. Medical assistance and hospital treatment are free of charge for patients, and between 25-60% of the costs of specialist health services (dentists, psychologists, chiropractors and physiotherapists) are also covered. Local authorities are responsible for home nursing (offered free of charge on doctor's orders), and as of January 2007 also for some rehabilitation and health promotion and prevention. The secondary sector, consisting of hospitals, including psychiatric treatment, is operated by the five new regions. As mentioned, hospital treatment is free, but non-emergency treatment requires referral from a doctor.

While growth in male (76.1 years in 2006) and female life expectancy (80.7 years in 2006) has been moderate, healthy life expectancy is among the highest in the EU (67.7 years for men, 67.1 years for women in 2006) and shows a positive trend. Over the next decade, Denmark aims to achieve an increase of 3 years in life expectancy. Self-perceived general health is among the highest in the EU, also in the lowest income groups. Nonetheless, cancers result in premature deaths more often than in many other countries. Smoking has decreased significantly. In contrast, obesity is rising and excessive alcohol consumption, notably among young people, remains problematic.

5.1.2. Accessibility

As mentioned, the Danish health care system is universal and tax-financed, giving everybody access to health care free of charge. Self-reported unmet needs for medical care and dental care are among the lowest in the EU, also in the lowest income groups. Waiting times were reduced by 6 weeks (20%) from 2002 to 2006. Currently, the health care sector is facing a considerable short-term challenge in reducing the waiting-time backlog following the large-scale strike in the public sector in spring 2008.

The 2007 Joint Report identified 'safeguarding the current high level of protection, while satisfying increasing demands for health and welfare services in view of the ageing population' as a challenge for Denmark. Among the policy measures mentioned, patients' rights to free choice have been further improved. From October 2007 (though effective only from 1 July 2009 due to the public sector strike), all patients that have been waiting for at least one month for public hospital treatment can opt for a private hospital instead. Furthermore, as from spring 2009, all patients will have a free choice of general practitioner regardless of geographical distance. Considerable extra resources have also been channelled to the hospitals in order to shorten waiting times and reinforce efforts to treat heart and cancer patients.

Denmark is also increasingly focusing on social inequalities in health, acknowledging that disadvantaged groups generally have poorer health and fewer healthy years to live than the rest of the population. To achieve an increase of 3 years in life expectancy over the next decade, a Prevention Commission has been set up to examine and report (early 2009) on how to cost-effectively prevent lifestyle diseases and increase health, with a special focus on disadvantaged groups. It may be noted that as from August 2007 it is prohibited by law to smoke in workplaces, public indoor places and institutions, taxis, restaurants and cafés.

The issue of patients' rights to choose treatment across borders has not been addressed in the NSR.

5.1.3. Quality

The 2007 Joint Report identified 'taking the necessary steps to further improve the quality, effectiveness and efficiency of the Danish health care system, including measures to improve the organisation and performance of cancer treatments' as a challenge for Denmark.

In spring 2008, the first version of the Danish quality model for hospitals was approved. The model comprises 104 standards for good quality (accreditation standards). However, they will not be implemented until autumn 2009 due to the public sector dispute mentioned above.

There is a continued focus on earlier diagnosis and access to quality treatment, in particular for cancer. Pathways for individual types of cancer are being introduced gradually and will cover all cancer types by the end of 2008. Investment projects will be launched to ensure a modern and rational hospital structure to improve the quality of treatment and the efficient use of equipment. The website providing information on treatment quality and waiting times at different hospitals will be extended to include more treatment offers.

The quality of health care for the mentally ill has attracted some media attention, but this is not specifically mentioned in the NSR.

5.1.4. Sustainability

Danish public spending on health care is among the highest in the EU, both as a percentage of GDP (9.4% in 2005) and per capita (US$ PPP 3169 in 2005). Public expenditure on health care is projected to increase by 1% of GDP by 2050.

The 2007 Joint Report identified 'taking more actions to recruit people to work in the care professions and improve the working conditions' as a challenge for Denmark. The ageing population represents a double challenge for health and long-term care, as fewer people will have to care for more patients. Recent estimates indicate that the health care sector may have a staff shortfall of 20% by 2020. Following the public-sector wage negotiations in the spring, a Pay Commission (due to report in 2010) has been established to analyse, among other aspects, wage differentials, working conditions and a possible response to public sector recruitment problems.

The initiatives under the 'Quality Reform' and 'Quality Fund' are being implemented with the aim of maintaining or increasing welfare service standards and improving administrative efficiency. Denmark has initiated a 'debureaucratisation' effort to ensure that staff in the healthcare sector spend most of their working time on core activities, i.e. treating patients. The Prevention Commission can also be seen as an attempt to reduce the expected increase in the need for future health care services.

Every five years, starting in 2008/2009, conditions in the hospital sector will be compared with conditions in neighbouring countries in order to continually strive for excellence. Information on productivity and quality is regularly published to contribute to knowledge-sharing between hospitals. The 'debureaucratisation' initiative also involves developing further reliable and timely health statistics in areas such as waiting times, free choice, etc.

5.2. Long-term care

5.2.1. Description of the system

The basic principle of free and equal access for all citizens also applies to long-term care. Coverage is among the broadest in the EU. The local authorities are responsible for providing the various forms of long-term care services. The local authority grants assistance following individual assessment of the recipient's functional abilities and needs. Assistance mainly takes the form of home help or a cash subsidy to pay for assistants.

5.2.2. Accessibility

Danish long-term care aims to ease and improve the quality of everyday life and enhance the possibilities for individuals to manage on their own. Target groups comprise older people and (physically or mentally) disabled people. User involvement in the planning of assistance is considered a key principle. Permanent personal care and practical help is free. Fees may be charged for meal schemes, for example. Residents in social housing for the elderly or care homes pay a modest monthly rent and may have access to housing benefits or rebates depending on their financial situation.

Reducing waiting times and providing places in social housing or care homes constitutes a challenge. From January 2009, a care-home guarantee will ensure that older people with special needs for a social housing or care home place receive an offer within two months of being put on the waiting list. The Prevention Commission is working on proposals that may help postpone the need for public assistance.

5.2.3. *Quality*

The ongoing quality reform of the public sector should help improve the conditions for people in need of care and people employed in the care sector through measures to ensure e.g.:

- Attractive jobs within a better framework for the recruitment and retention of staff (particularly important as many nurses and other staff will retire in the coming years and recruitment poses challenges due to demographic factors and the relatively low attractiveness of these professions);

- A reduction in the number of different assistants visiting an individual and one permanent contact person for the recipient of home-help services;

- Modernised buildings, facilities and technology (one initiative addresses labour-saving technology in the social and health field, including old-age care);

Accreditation: an accreditation model will be tested in care homes/assisted-living accommodation areas to systematically support staff quality development.

5.2.4. *Long-term sustainability*

In the longer term, the challenge is to ensure the financial sustainability of the care sector without affecting the quality of care or limiting the groups in real need of assistance. Sufficient labour will be needed to tackle the important welfare tasks. It will also be crucial to continue developing resource-saving working methods and further knowledge and knowledge-sharing on the most efficient methods. Actions are ongoing to improve quality and efficiency and to release resources, including reducing administration expenses, streamlining procurement, reducing absence due to sickness, using new technology and improving work organisation.

Public expenditure on long-term care is projected to increase to 2.2% of GDP by 2050 (from 1.1% of GDP in 2004), while the EU25 average is projected to be 1.5% by 2050.

6. CHALLENGES AHEAD

- To continue increasing the social and labour market participation of people with a foreign background and other disadvantaged groups through a comprehensive approach covering both personal and structural barriers to social inclusion.

- To continue efforts to retain older workers longer in employment in view of the ageing population and the need to ensure the fiscal sustainability of the welfare system, including initiatives to counteract the negative impact of voluntary early retirement benefit.

- To intensify multi-faceted efforts addressing disadvantaged children and youth, in particular with a view to reaching the targets for secondary education attainment.

- To further improve the quality and efficiency of the Danish health care system, including measures to recruit and retain staff and to strengthen prevention initiatives to achieve a 3-year increase in life expectancy.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,5	131,6	**2000**	76,3	80,8	71,6	66,0	55,7	**2000**	4,3	3,9	4,8	6,2
2005	2,4	123,6	**2005**	75,9	79,8	71,9	62,3	59,5	**2005**	4,8	4,4	5,3	8,6
2008*f*	-0,6	116,3	**2007**	77,1	81,0	73,2	65,3	58,6	**2007**	3,8	3,5	4,2	7,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	72,7	77,9	14,1	17,6	61,6	60,7	5,1	**1995**	8,1	82,5	16,3		-
2000	74,5	79,2	15,2	18,3	62,9	61,9	5,3	**2000**	8,3	82,4	16,0	**2005**	0,3
2006	76,1	80,7	16,2	19,2	67.7b	67.1b	3,8	**2006**	9,5	84.1d	14.3d	**2006**	0,2

s: Eurostat estimate; p: provisional; b: break in series; d:change in methodology **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	31,9	37,7	17,8	14,8	12,4	6,8	10,6
2000	28,9	38,1	20,2	10,5	13,1	6,1	12,0
2006	29,1	37,9	21,6	7,2	13,1	5,3	14,9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	23,6	26,8	9,5	n.a.	n.a.
2010	25,0	0,2	0,6	n.a.	n.a.
2030	37,8	4,0	2,9	n.a.	n.a.
2050	41,3	4,8	3,0	n.a.	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate* Total	Children 0-17	18-64	65+	Poverty risk gap* Total	Children 0-17	18-64	65+	Income inequalities* S80/S20
Total	12	10	11	18	17	21	24	9	3,7
male	11	-	11	16	19	-	24	7	-
female	12	-	11	19	16	-	22	9	-

*without imputed rent

Anchored at-risk of poverty	Total - fixed 2005 threshold
2005	12
2006	11
2007	11

People living in jobless households

	Children Total	% of people aged 18-59* Total	Male	Female
2002	5,6	7,6	7,2	8,0
2004	6,0	8,5	8,3	8,8
2006	5,0	6,9	6,4	7,3

Long Term unemployment rate

	% of people aged 15-64 Total	Male	Female
2000	0,9	0,8	1
2004	1,2	1,1	1,3
2007	0,6	0,5	0,7

Early school-leavers

	% of people aged 18-24 Total	Male	Female
2000	11,6	13,4	9,9
2004	8,5	10,4	6,7
2007	12,4b	15,7b	8,9b

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,7	0,73	0,7	***Aggregate replacement ratio***	0,39	0,38	0,43

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions – Coverage rate (%): Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
7	20	-10	DB	30	DC	100	78	0,9	8,8	12,7

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Germany

1. SITUATION AND KEY TRENDS

After weak growth in 2005 (0.8%), GDP increased more quickly in 2006 and 2007, amounting to 2.9% and 2.5% respectively, and influenced the labour market positively: unemployment came down from 10.7% (2005) to 8.4% in 2007 (men: 8.5%; women: 8.3%). In 2007, the number of unemployed came down to a level last seen in 1994 (3.8 million). In November 2008 the unemployment rate declined to 7.1% (EU27: 7.2%).

With an employment rate of 69.4% in 2007, Germany almost achieved the Lisbon target while already meeting the target for female employment (64%) and older workers (51.5%) — the latter amounting to only 37.6% in 2000.

Vulnerable groups benefited from the progress; the number of people living in jobless households — which peaked in 2004 (11.1%) — came down to 9.6% in 2007.

In terms of unemployment, regional disparities continue to play a certain role (both between and within the *Länder*)[102]: in 2005, the employment rate in Eastern Germany (66%) was 3.6 percentage points lower than in Western Germany.[103]

However, partly as a result of the global financial crisis, growth has started to slow down in 2008 (1.3%) and the Commission and the German government expect it to become negative in 2009 (-2.3%, -2.25% respectively). The Commission forecasts for 2009 an unemployment rate of 7.7% and of 8.1% for 2010.

Inflation is expected to have increased from 2.3% in 2007 to 2.8% in 2008 due to higher wage growth and lagged effects from higher energy and food prices. This development might put some strain on households' disposable income. However, the Commission expects inflation to drop to 0.8% in 2009 and to 1.4% in 2010.

In 2007[104], the at-risk-of-poverty rate amounted to 15% (men: 14%; women: 16%)[105]. This is slightly below the European average (EU25: 16%). National data suggest that it had been rising steadily since 2000 but that this trend was broken in 2007.

Life expectancy is relatively high. The demographic old-age dependency ratio amounted, in 2008, to 30.3 and is expected to increase to 46.2 by 2030 and to 56.4 by 2050. Healthy life years have also been increasing (rising from 60 years in 1995 to 65 in 2003).

In 2006, expenditure on social protection amounted to 28.7% of GDP, which is above the EU27 average (25.8%). 12.2 % of GDP was spent on pensions, 8% on sickness/health care, 1.7% on disability and 0.8% on housing and social inclusion benefits. The amount spent on families and children (3.1% of GDP) is significantly higher than the EU27 average (2.1%).

[102] According to national data, in December 2008 unemployment rates varied between 4% in Southern Germany (Bavaria) and 13.5% in the North-East (Mecklenburg-Vorpommern).

[103] National data, microcensus 2005.

[104] The 2007 German SILC data are to be considered as provisional. The validity of any comparison with previously published data is limited.

[105] Source: EU-SILC (2007); income year 2006.

2. OVERALL STRATEGIC APPROACH

The 2008 – 2010 NSR aims for a socially inclusive society offering opportunities for every citizen to participate in economic and societal life. It follows up and builds on the 2006 – 2008 NSR, with the relevant challenges, the underlying approach to tackling them and the key priorities remaining largely unchanged.

Recent reforms, covering both employment and minimum resources policies, aim to activate people, striking a balance between the rights and obligations of benefit recipients. In parallel, Germany has pursued a policy of modernising its social protection system with a view to ensuring financial sustainability and curbing the increase on non-wage labour costs. The focus has shifted from reforming the pension sector towards health and long-term care. In addition, family policy has moved up the political agenda. New measures to boost child care facilities, a new benefit to facilitate reconciliation between work and family life and a new allowance for low-income families with children with a low income have been implemented. More generally, in response to Germany's poor performance in the first PISA study, a debate is ongoing on how to improve child care, education and training systems in order to fight the transmission of poverty, increase social mobility and enhance the social inclusion of persons with a migration background.

Support for persons with a migration background[106] has been mainstreamed within the strategy. Various measures have been taken in the field of employment policy and in the area of education and training, such as vocational training or language courses.

Germany is responding to the effects of the financial crisis with a number of measures[107]: the resources available to the public employment service are being increased (1000 additional placement officers are being hired) to ensure that those who become unemployed will be offered intensive coaching; the duration for receiving short-time working allowance (*Kurzarbeitergeld*) is being extended from 6 to 18 months.

The strategies under the Lisbon process and the social OMC have been designed in a consistent way. Progress on the labour market is crucial for the integration of people within economic life and society and to finance social protection systems. In general, a high share of the unemployed are at risk of poverty (51% in 2007) but their absolute number has fallen considerably (in the years 2006 and 2007 by more than a million).

The NSR sets few, yet ambitious targets. These call for boosting child care facilities, the employment rate among older workers and training for young people, creating employment for disabled people, and cutting the ratio of school drop-outs, and securing the level of the contribution rate in the statutory pension scheme as well as its replacement rate before taxes.

The government involved the regions (*Länder*), the social partners and key stake-holders in the preparation of the NSR.

[106] According to the definition used by the German government, a "person with migration background" meets at least one of the following criteria: 1. the person was not born in the Federal Republic of Germany and has immigrated into Germany after 1949; 2. the person does not have the German citizenship or has been naturalized; 3. the person has at least one parent that meets the first or second criterion

[107] Furthermore, a second financial stimulus package is under preparation; it includes one-off bonus of 100 euro for every child in 2009; additional 2 bn euro (for 2009 and 2010) for further training and skills' upgrading for short-time and low-skilled workers; as of July 2009 the recipients of the second stage of unemployment benefit will receive a higher children allowance for children between 6 and 13.

During the period 2007–2013, the ESF allocation for Germany amounts to €9.4bn. In comparison to the period 1999–2006, the policy focus has shifted to education and training. Increasing attention is being devoted to young people, migrants and people furthest from the labour market. Germany will spend 35% of its allocation on 'Improved Human capital' and 31% on 'Enhanced Access to Employment and Social Inclusion of Disadvantaged Persons'.

Equality between women and men is addressed within the overall approach, with the focus on the gender pay gap and the reconciliation of work and family life. Within the overall approach, disabled people are mainly taken into account in employment policy, where they represent an important target group. Other issues that are highly relevant from a social inclusion standpoint, such as housing or transport, are not regarded as urgent challenges.

3. SOCIAL INCLUSION

3.1 Key trends

While vulnerable groups have benefited from recent progress in the labour market, they still face important problems: long-term unemployment fell from 5.4% in 2004 to 4.7% in 2007 but is higher than the EU27 average (3.1%). Unemployment constitutes an important challenge among low-skilled workers (amounting to 17%, a figure exceeded in only four other member States) and among non-nationals (16.2% — EU27 average: 12.1%). In 2007, the employment rate of people born in another EU country (68.2%) was almost as high as that for people born in the country (70.9%), but was considerably lower for persons born outside the EU27 (49.6%). Youth unemployment — which was 15.5% in 2005 — fell to 11.9%, below the EU27 average (15.4%).

In 2007, the risk of poverty (15%) was one percentage point below the European average. Women faced a higher risk (16%) than men (14%), as well as older people (17%); again, the risk for women in this age group was higher (20%) than for men (14%). For children aged 0 – 17 the at-poverty-risk was one percentage point lower than the general rate. However, according to national data[108] for 2005, the poverty risk for people with a migration background is much higher (28.2%) than for others (11.6%).

A major determinant is economic status. While the overall share of people living in jobless households decreased from 11% in 2005 to 9.5% in 2007, 51% of unemployed households, 39% of jobless households without dependent children and 60% of jobless households with dependent children are at risk of poverty. The in-work-poverty-risk is 7% (one percentage point below the European average). Data on unemployment and low wage traps suggest that disincentives to work are still considerable, in particular for lone parents.

Another important factor is household composition: households consisting of one person display a higher poverty risk (men: 25%; women: 29%) as well as single-parent households with at least one dependent child (34%). For a household consisting of two adults and one child, the poverty risk drops from 60% (when both adults are inactive) to 13% when one person is in fulltime employment and to 6% when both are in employment.

[108] Annex to "7. Bericht der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration über die Lage der Ausländerinnen und Ausländer in Deutschland", December 2007. The data are based on the "Mikrozensus 2005"; the data are not comparable to SILC data.

One cause for concern is that, according to national data, the at-poverty-risk has been steadily increasing between 2000 and 2006. However, the trend came to an end in 2007. While these figures show that the recent progress in terms of growth and jobs has had a significant impact on poverty, the question is of how poverty will develop in a context of negative growth.

The impact of social transfers in fighting poverty is sizeable. These transfers reduce the poverty-risk from 25% to 15%. For children, they halve the risk from 30% to 14%. The net income of social assistance recipients amounts on average to 90% of the poverty threshold in the case of a single household, to 120% in the case of a lone parent with 2 children and to 110% in the case of a couple with 2 children.

Unemployment among persons that do not have German citizenship decreased by 12.8% from December 2006 to December 2007.

The early school-leaving rate is slightly under the EU average, but still far from the 2010 target of 10%. It declined from 14.9% in 2000 to 12.7% in 2007. The rate of low reading achievers also decreased from 22.6% in 2000 to 20% in 2006.[109] The inclusion of immigrants and their children remains a challenge.

3.2 Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Germany has achieved good progress in terms of ensuring that the labour market reforms support the long-term unemployed and people furthest from the labour market. It has furthermore adopted a large number of measures to support specific target groups, such as younger people or older workers. However, the situation of low-skilled workers remains unsatisfactory.

Germany has started to address the challenge of breaking the inter-generational transmission of poverty as well as ensuring the active social inclusion of persons with a migration background. Children and young people are a clear priority for Germany, with strategies being developed to overcome issues such as child poverty, early school-leaving and youth unemployment. However, agreeing a consistent policy among the various actors remains a challenge. The social inclusion of young persons with a migration background needs to be improved. Furthermore, the strong relationship between educational achievement and social background has to be addressed.

3.3 Key challenges and priorities

The key challenges and priorities are largely those identified in the 2006–2008 NSR. A cornerstone of the overall strategy is labour market reform, which aims to reduce unemployment and increase employment.

Besides vulnerable groups such as the long-term unemployed, the 2008–2010 NSR focuses on (1) people facing multiple obstacles to (re)entering the labour market and improving their education and training opportunities; (2) the integration of migrants within economic and social life; (3) the fight against poverty among families and children, in particular the transmission of poverty, through improved access to education and (4) the disabled.

[109] German National Strategy Report, p. 50; source: OECD (Pisa-study)

3.4 Policy measures

Germany has set up or strengthened existing measures to provide targeted support to vulnerable groups. Many are linked to the labour market, such as a number of new wage subsidies: '*JobPerspektive'*, for people facing multiple problems on the labour market; '*Kommunal-Kombi'*, to support the long-term unemployed; measures for young people (*Qualifizierungszuschuss* and *Eingliederungszuschuss*). One programme has been set up to help prepare for vocational training (*Einstiegsqualifizierung*). The government has also launched an initiative aiming to create 100 000 additional places for apprenticeships by 2010 ('*Jugend — Ausbildung und Arbeit'*), which is supported by a new subsidy for employers (*Ausbildungsbonus*). '*Perspektive 50plus'*, which aims to support older workers among the long-term unemployed, is being continued.

To facilitate the integration of disabled people within the labour market, the government has launched the programme '*job — Jobs ohne Barrieren*' (co-financed by the ESF). Furthermore, the programme 'Job4000' will run until 2013 with the aim of creating 4 000 new jobs for people with severe disabilities.

In January 2007 the government introduced a new parental benefit (*Elterngeld*), following the child allowance (*Kinderzuschlag*) in 2005, for low-wage earners. A new law was adopted in September 2008. Child care facilities will be increased by 2013 to cater for 35% of all children below 3.[110] In October 2008, the government approved a bill to increase child tax allowance from 1 January 2009 (*Kinderfreibetrag*).

These measures also form part of a wider strategy to improve education: in January 2008 the government adopted an initiative to improve skills, qualifications and education (*Qualifizierungsinitative*). It comprises a number of measures ranging from supporting life-long learning to vocational re-training, such as the IZBB programme (*Zukunft Bildung und Betreuung*), which is investing €4bn in all-day-schools over the period 2003–2009 to give targeted support to pupils facing particular difficulties. Another programme launched in 2008 helps young people to acquire a formal vocational qualification ('*Perspektive Berufsabschluss'*).

The NSR highlights the importance of the "national plan for integration", also from inclusion perspective. The plan contains 400 measures to support persons with a migration background. One key element is to promote proficiency in German.

3.5 Governance

The NSR was drafted in cooperation with the regions (*Länder*), the social partners and key stake-holders. In 2001, the 'Permanent Council of Advisors for Social Integration' was set up to assist in drawing up the National Action Plans. Furthermore, the government has continued the dialogue with relevant stakeholders through a series of seminars ('Forteil').

4. PENSIONS

4.1 Key trends

The German pension system continues to rely to a large extent on its statutory pension scheme. It is a general pay-as-you-go, earnings-related scheme that covers about 80% of employed persons. Major reforms have been implemented since 1992 which (1) revise the pension adjustment formula (in particular the 'sustainability factor', which is geared to

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110 The actual coverage varies between the regions; in average, the coverage was 22.7% in 2007.

changes in the ratio between contribution payers and pension recipients), (2) increase gradually the retirement age, with actuarial reductions in the case of retirement before that age and (3) introduce mechanisms to take into account child care. Some of these reforms, in particular the modification of the pension formula, will lead to lower pension levels in the social pension insurance scheme.

To offset this reduction, a new state-subsidised, fully funded voluntary direct-contribution scheme ('Riester-Rente') was set up in 2002. This is a privately managed capital-funded scheme. The contributions are strongly state-supported. The scheme is supported by bonuses (independent of wages) and by the fact that contributions are tax deductible. As bonuses are independent of wages, the support for low-income groups is rather strong. In addition, a special child bonus makes the Riester-Rente particularly attractive to those who have children.

In 2006 it was decided to increase the pensionable age from the current 65 to 67 in 2029. The increase will be phased in gradually, starting in 2012, the first generation to be affected being those born in 1947. Early exit paths are being closed with a fairly short transition period.

In 2008, the government decided to suspend a certain part of the pension adjustment formula - the so called 'Riester-Treppe' - for 2008 and 2009. When indexing statutory pensions, the Riester-Treppe takes into account employees' increasing expenditure for their supplementary old-age provision. Thus, its suspension allows for a higher increase in pension benefits. Under the formula, the pension adjustment would have amounted to 0.46% in 2008. The actual increase was 1.1%. However, the suspension in 2008 and 2009 will be made up from 2012. This implies that pension adjustments in 2012 and 2013 will be lower.

At present, the level of pension expenditure is high but decreasing: according to ESSPROS data, pension expenditure was 13.4% of GDP in 2003 but 12.2% in 2006 (EU27 average: 11.9%). The reason is that the share of expenditure on early retirement, invalidity and survivors' pensions decreased. In January 2007, the contribution rate for the statutory pension scheme was increased from 19.5% to 19.9%.

The high level of overall expenditure corresponds to the good income position of older people: in 2007, the relative median income of people aged above 65 in relation to the age group 0 – 64 amounted to 86% (89% for men and 84% for women) – compared with the EU25 average of 84% (87% for men/82% for women). It is also reflected in the figure for the poverty risk for men (14%) which is one percentage point below the average for all age groups and 2 percentage points below the European average for the poverty risk among older men. The poverty rate for older women in Germany (20%) is higher than for older men but 2 percentage points lower than the European average. The aggregate replacement rate was 45% in 2007, for men 47% and for women 48% (EU25 average: 49%).

4.2 Key challenges and priorities

The challenge posed by demographic developments persists: the population aged between 20 and 64 is expected to decrease by 9.6 million by 2050. The number of people older than 64 is expected to increase by 7.6 million, while their life expectancy also continues to increase. As a result, the old-age dependency ratio — 27.8 in 2005 — is expected to increase to 56.4 by 2050. The pension dependency ratio was 74 in 2004, but is projected to increase to 98 by 2030 and to 117 in 2050.

The various pension reforms represent a balanced policy response in terms of sustainability and adequacy: the projected increase of 1.7 percentage points of GDP by 2050 is a fairly limited increase when compared with other European countries (public pension expenditure is projected to increase to 13.1% of GDP by 2050, as against 11.4% in 2004) — albeit at a high level. The theoretical replacement rate for the statutory scheme is projected to decrease by 9 percentage points, but this reduction is expected to be offset by the new voluntary scheme. Taking into account the effect of taxation in the future, the theoretical replacement rate in 2046 is forecast to be one percentage point higher than in 2006.

Germany has addressed the challenges identified in the 2007 Joint Report. Good progress has been made with a view to achieving longer working lives, participation in supplementary pensions has been further strengthened and its take-up has accelerated in recent years.

However, there is a risk that the high unemployment rates and high share of long-term unemployed among present cohorts of contributors will lead to low entitlements for a significant part of future pensioners and to a higher rates of old-age poverty.

The “Riester-pension” is likely to offset the decreasing replacement levels to some extent. The coverage of the "Riester-pension" and of the occupational schemes has been increasing continuously and, therefore, the German government is confident that both will ultimately play their role to ensure adequacy. However, the new scheme remains voluntary and therefore the further development should be monitored.

Concerns about maintaining the purchasing power of benefits may generate arguments for increasing pensions more quickly than the adjustment formula would allow. If such concerns continue to be met through ad hoc interventions in the way the formula operates, the credibility of the formula and its role in ensuring financial sustainability may be undermined.

In conclusion, the German pension system is a financially stable system that provides a high replacement ratio. It is rather successful in fighting old-age poverty, in particular in Eastern Germany. Periodic review mechanisms are in place for close monitoring of adequacy and financial sustainability as well as the reliable operation of schemes.

4.3 More people in work and working longer

The general employment rate was 69.4 in 2007 and is likely to have reached the Lisbon target in 2008. The employment rate for older workers has been increasing steadily for a couple of years: while it amounted to 37.7% in 1998, it rose to 45.4% in 2005 and 51.5% in 2007, thus reaching the Lisbon target. The government now aims to attain an employment rate of 55% in 2010. The effective labour market exit age in 2007 was 62 years (EU27: 61.2 years), compared with 60.6 years in 2000. Paths to early retirement are in the process of being closed.

The decision to increase the pensionable age contributes to ensuring financial sustainability and sends an important signal to workers and employers. Older workers will have to stay longer on the labour market to earn full pension entitlements. The government has taken measures to improve the situation and prospects of older workers (aged 55 – 64) on the labour market but the issue warrants continued attention. For people with low income and shorter careers the incentives to work longer will also depend on the future role of minimum income provision (*Grundsicherung*, cf. 4.5 below).

4.4 Privately managed pension provision

Occupational pensions of the book reserve type have been prevalent in the private sector for years. Recently developments and public discussion have centred on the new voluntary scheme introduced in 2002. The number of contracts for a "Riester-Rente" rose from 6.2 million in 2006, to 11 million in March 2008. So far little is known about the benefit levels of supplementary (occupational and private) pensions. However, projections suggest that the pension level – when taking into account social contributions but not taxation – will remain stable in the long run. Whether disposable income from this supplementary scheme will be able to compensate for the decline in benefit levels in the PAYG scheme remains to be seen.

4.5 Minimum income provision for older people

The German pension system does not provide a minimum pension (i.e. a benefit financed by pension insurance). In 2003 a tax-financed and means-tested allowance (‘*Grundsicherung im Alter’*) was introduced as a form of social assistance benefit for older persons with insufficient pension entitlements; it is currently drawn by only 2% of the population above 65.

However, future pension generations will find it more difficult to build up pension entitlements above the level of social assistance. For those with below-average earnings during working life, an even larger number of contributory years will be required to receive a pension above the social assistance level. In view of the labour market situation in the recent past (long spells of unemployment) and the higher age of retirement, the at-risk-of-poverty rate may well increase in the future and the *Grundsicherung* may therefore gain a bigger role.

4.6 Information and transparency

Germany has set up a comprehensive monitoring and reporting system that can be expected to achieve the necessary transparency (e.g.: annual report presented by the government on the financial prospects for the next 15 years; assessment of this report by the experts of the ‘Social Council’; a second report on old-age security to be published during every government term). When the reports show that the contribution rate needed for the desired replacement rate approaches certain thresholds, the government is obliged to submit a bill with counter-measures to parliament.

Information is also provided to individuals: every insured person above 27 years receives information every year on the projected amount of their future pension. Furthermore, a new initiative was launched in 2007: advisors working for the statutory insurance scheme inform citizens about old-age provision in adult education sessions (*Volkshochschulen*).

5. HEALTH AND LONG-TERM CARE

5.1 Healthcare

5.1.1 Health status and description of the system

The health care system is characterised by federalism and delegation to self-administered non-governmental bodies, which are the main actors in the system of social insurance: the health funds (HF) and their association on the purchaser side, and the physicians’ and dentists’ associations on the provider side. Hospitals are, on the other hand, represented by private-law organisations. The Ministry of Health proposes health legislation, supervises the non-governmental bodies and performs various functions in the field of licensing and supervision.
The health care system underwent major reforms in 2004 and 2007. The second reform entered into force on 1 April 2007 and has largely been implemented. It aims to: (1) ensure that every citizen has access to the system; (2) improve quality; (3) increase efficiency

through higher transparency and more intensive competition; (4) extend the ability of insured persons to choose between different tariffs; (5) cut red tape, and (6) introduce a new financing mix.

The reform comprises a broad range of measures, including:

– Increasing competition within the statutory scheme by allowing contracts to be concluded between health funds and service providers and by introducing the possibility for insured person to choose between tariffs;

– Introducing a single contribution rate and a new health care fund (*Gesundheitsfonds*), which starts operating in January 2009, with an annually increasing contribution from the general budget to the new fund until 2016;

– Changing the overall structure of the system by introducing the possibility to merge health funds and allow them to become insolvent;

– Overhauling the remuneration system for doctors;

– Obliging private health insurance schemes to offer a 'basic tariff' (from January 2009 onwards) and making old-age reserves partly portable.

While the German health care system performs well in terms of access and quality, the level of expenditure is very high. The recent reform sets out to address, among other things, the efficiency of the system and its long-term sustainability; it aims to equalise differences in the distribution of financial burdens by introducing a uniform contribution rate. However, it is uncertain whether these aims will be met. In particular, it needs to be monitored whether the new fund will contribute to increasing efficiency, containing costs and avoiding risk selection.

5.1.2 Accessibility

89.6% of the population belong to the statutory health insurance scheme (SHI) and 10.2% have private health insurance (PHI). In the first quarter of 2007, 0.3% of legal residents were not insured. The 2007 reform introduced a legal responsibility to have an insurance policy, starting from 1 April 2007 for people formerly insured in social health insurance and from 1 January 2009 for people who were formerly privately insured. All those who have lost their private insurance can apply to be affiliated, on the basis of the basic tariff, to any private insurance scheme.

In comparison to other countries, the level of co-payments is low (and generally limited to 2% of annual household income and to 1% for chronically ill persons).

Although the ratio of practising physicians per 1000 inhabitants is relatively high (3.5 vs. an OECD average of 3.1), problems have been reported concerning the geographical distribution of physicians, especially general practitioners in the new *Länder* and some rural areas. The 2008–2010 NSR addresses the issue by referring to a number of measures taken, without indicating the progress made. It needs to be monitored whether these measures are effective and sufficient.

5.1.3 Quality

The quality of health care has a high priority in Germany. Care providers, for instance, are legally obliged to implement quality management systems. Moreover, physicians are obliged to pursue continuing medical education. The Institute for Quality and Efficiency (IQWiG), which was established in 2004, performs health technology assessments for drugs and procedures. In addition, many hospitals acquire quality certificates on a voluntary basis to prove that they meet specific quality standards.

The Joint Federal Committee (*Gemeinsamer Bundesausschuss*) decided in May 2007 to extend quality management in hospitals. The 2007 reform has strengthened quality control mechanisms by giving the Joint Committee a more robust mandate.

The electronic health insurance card — seen as another tool to ensure quality — has entered its pilot phase (it is currently being tested in seven *Länder*). However, the NSR does not state when the card will be in use in the entire country.

5.1.4 Sustainability

Spending on health care in Germany is rather high: according to OECD Health Data 2008, Germany spent 10.6% of its 2006 GDP on health, following a steadily increasing trend (in 1990 it amounted to 8.3% of GDP). This was the fourth highest rate among OECD members and the second highest within the EU. Total health expenditure per capita is $3371 on a purchasing power parity basis. This was only the 10th highest rate among OECD members.

The bulk of total health care expenditure comes from the public sector (almost 76.9% in 2006), but the trend is decreasing: in 1992 it amounted to 81.5%. Public expenditure on health care amounted to 6% of GDP in 2004 (EU25: 6.4%) and is projected to reach 6.9% in 2030 and 7.2% in 2050, which would still be below the EU25 average (7.9%). The increase of 1.2 percentage points will also be below average (EU25: 1.6).

The recent reform introduced considerable changes to the financing system. Beginning in 2009, a uniform contribution rate will enter into force. Contributions will be centrally pooled in the new national health fund (*Gesundheitsfonds*), which will allocate resources to each health fund based on a risk-adjusted capitation formula. The new capitation formula will, in addition to gender and age, take into account morbidity from up to 80 chronic and/or serious illnesses.

Like other countries, Germany might face a long-term risk in terms of human resources in the health-care sector. By 2012 more than 40 000 doctors[111] will retire. However, the number of practicing physicians in Germany is well above the OECD average and growing each year. Furthermore, the attractiveness of the profession among students is still very high.

5.2 Long-term care

5.2.1 Description of the system

Social long-term care insurance was introduced in 1995. It is mandatory, covering the risk of needing permanent help, care and support, and comprises public and private schemes. The benefits in both schemes are the same. The level of grants is based on the degree of need for care, which is assessed by the Medical Board of the health insurance funds — irrespective of age, income or wealth. The insurance has been designed in such a way that it covers a large part of the costs linked to long-term care, but not all.

[111] Estimate by the Kassenärztliche Bundesvereinigung.

The system underwent a reform on 1 July 2008 to improve and extend, among other things, the benefits offered while increasing the contribution rate by 0.25 percentage points to 1.95%.

5.2.2 Accessibility

The entire population is covered by either the statutory scheme or a private scheme. The individual regions (*Länder*) can decide to establish long-term care centres (*Pflegestützpunkte*)[112]. The task of these centres is to improve the networking and interaction between local services (including services for the elderly and social welfare agencies etc) under one common roof, and especially to inform patients and their relatives in health and care matters. They must be independent and offer comprehensive counselling. They should be local and easily accessible.

As pointed out in the 2007 Joint Report, there is a debate in Germany on how to ensure access in the future, including specific contributions that long-term care insurance can or should make towards the total cost of care, notably in cases of intensive care needs.

5.2.3 Quality

Although the quality of care has steadily improved in recent years, findings of quality control reports still show that improvements are necessary in many respects. The government acknowledges the need to further strengthen and diversify measures in this field.

Different measures have been taken to strengthen quality: an important innovation under the Long-term Care Development Act is the expansion of quality assurance. The approved care institutions are obliged to take measures to maintain their quality and implement a quality management regime. The development and implementation of National Care Standards has become obligatory by law. In addition, outpatient and inpatient care facilities will be audited every year without prior notice. The quality performance of care facilities and the results of the external auditing carried out by the Medical Board of Health Insurance funds will be accessible to the public from 2009 onwards. In addition, the professional regulations have been changed to improve training in the care professions.

5.2.4 Long-term sustainability

Long-term care insurance is financed through social security contributions. Their rate was increased on 1 July 2008 from 1.7% to 1.95%. According to the NSR, this is sufficient to finance the system, in view of the demographic development, until 2015. The NSR leaves the question open as to how the government intends to address long-term sustainability. However, it refers to an estimate by official advisors to the government (*Sachverständigenrat*) according to which the contribution rate will amount to 2.5% in 2050. The recent reform has not addressed concerns regarding the long-term financial sustainability of the system, for example, through the introduction of supplementary funded elements as referred to in the 2006 – 2008 NSR.[113] The task remains to present a concept to ensure the long-term sustainability of the long-term care system.

[112] Cf § 92 c of the Long-term Care Development Act (*Pflege-Weiterentwicklungsgesetz*).

[113] National Strategy Report 2006 – 2008, chapter 4.3.4.

6. CHALLENGES AHEAD

- To ensure effective support for the long-term unemployed and people furthest from the labour market, in particular the low-skilled, low-wage earners and persons with a migration background, in an increasingly difficult economic context.

- To break the inter-generational transmission of poverty by increasing educational opportunities at all levels for disadvantaged groups.

- To ensure the adequacy and the long-term sustainability of pensions, notably by continuing to promote the participation in supplementary pension provision while reviewing whether progress made is sufficient and allowing the pension adjustment formula to play its role.

- To monitor the effect of the recent health care reform with a view to financial sustainability and, if necessary, to take further measures to keep expenditure growth under control and strengthen efficiency in the health sector.

- To monitor the effectiveness of the measures taken to address the geographical distribution of physicians and, if necessary, to take further measures to address the issue.

- To further improve the quality of care delivered in the long-term care sector while developing a concept to ensure the long-term sustainability of the system.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,2	118,5	2000	65,6	72,9	58,1	46,1	37,6	2000	7,2	6,0	8,7	8,5
2005	0,8	116,9	2005p	66,0	71,3	60,6	42,2	45,4	2005p	10,7	11,3	10,1	15,5
2008f	1,3	112,4	2007	69,4	74,7	64,0	45,3	51,5	2007	8,4	8,5	8,3	11,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth (2003 instead of 2006) Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	73,3	79,7	14,7	18,5	60,0	64,3	5,3	1995	10,1	81,6	9,7		-
2000	75,1	81,2	15,7	19,4	63,2	64,6	4,4	2000	10,3	79,7	11,2	2005	n.a.
2006	77,2	82,4	17,2	20,5	65,0	64,7	3,8	2006	10,6	76,9	13,2	2006	n.a.

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | **Age-related projection of expenditure (AWG)**

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care**
1995	28,3	42,7	30,9	8,8	8,2	1,9	7,4	2004	30,3	23,7	11,4	6,0	1,0
2000	29,3	43,3	29,5	7,9	11,3	1,7	6,5	2010	31,2	-1,2	-0,9	0,3	0,0
2006	28,7	44,3	29,1	6,3	11,1	3,0	6,2	2030	46,2	-1,0	0,9	0,9	0,4
								2050	56,4	2,7	1,7	1,2	1,0

**: including administrative costs; **: under the assumption that benefits are adjusted in l*

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate** Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	15p	14p	15p	17p	24p	21p	26p	19p	5p	2005	12b
male	14p	-	14p	14p	25p	-	28p	19p	-	2006	15
femal	16p	-	16p	20p	23p	-	24p	19p	-	2007	14p

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	8.9	9.7	8.9	10.5
2004	10.9	11.1	10.8	11.4
2007	9.6	9.5	9.1	9.9

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	3.7	3	4.6
2004	5.4	4.8	6.1
2007	4.7	4.8	4.7

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	14.9	14.6	15.2
2004	12.1	12.2	11.9
2007	12.7	13.4	11.9

**: excluding students; **: Provisional data. Comparability with previous years are limited.; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0.86p	0.89	0.84		0.45p	0.47p	0.48p

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
1	2	-9	DB	11	DC	NA	70	19.5	NA	4

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Estonia

1. SITUATION AND KEY TRENDS

In 2007, GDP growth in Estonia remained high, reaching 6.3% (2006: 10.4%, EU: 2.9%). GDP per capita rose to 68% of the EU average. At the same time, inflation was almost twice as high as the EU average (EE: 6.7%, EU: 2.3%). However, recent developments show signs of recession. According to European Commission interim forecast of January 2009 the GDB growth is predicted to be -2.4% and inflation 10.6% in 2008.

The employment rate rose to 69.4% (EU: 65.4%) in 2007 and improvements were recorded both for young people (34.5%) and older workers (60%). The employment rate for both women (65.9%) and men (73.2%) was above the EU average with the exception of youth employment. The unemployment rate was 4.7% in 2007 (5.4% for men and 3.9% for women), which is lower than the EU average of 7.1% (6.6% for men and 7.8% for women). In the light of recent economic developments, the unemployment rate is expected to grow to 7% and the employment rate to fall by 2.5 percentage points by 2009, according to the Bank of Estonia's autumn forecast. Youth unemployment dropped to 10% and long-term unemployment decreased to 2.3% in 2007.

The ethnic minorities constitute almost 31% of the Estonian population, half of them holding Estonian citizenship. The unemployment rate for non-Estonians was approximately twice as high as for Estonians in 2007, and the difference for long-term unemployment was even higher. This fact has a strong correlation with regional disparities, unemployment being higher in the north-east of Estonia, where the percentage of non-Estonians is the highest. The main economic sectors in this region are basic and textile industries, which have suffered worst from difficult economic and financial circumstances.

The gender pay gap was very high at 25% in 2005, compared with the EU average of 15%. Women traditionally dominate in fields of activity and professions that are not very highly valued in society (for instance in education as kindergarten or primary teachers or in the welfare services as social workers).

Against a background of strong economic performance and improvement in the labour market, the at-risk-of-poverty rate increased to 19% in 2007, increasing 1 percentage point from 2006. In 2007, the at-risk-of-poverty rate was 18% for children and 33% for the elderly (compared with 20% in 2005).

The Estonian population is one of the fastest declining populations in Europe despite the rise in birth rates (1.64 in 2007). In 2006, life expectancy at birth was 67.4 years for men (13.2 years remaining life expectancy at 65) and 78.6 for women (18.3 years remaining life expectancy at 65). Healthy life years at birth were 49.4 for men and 53.7 for women. Despite positive trends in recent years, the indicators are still among the lowest in the EU. The old-age dependency ratio increased to 25.1% in 2007 and is projected to be 34.42% by 2030. Infant mortality is still high and increased to 5% in 2007.

In 2006, gross social protection expenditure decreased to 12.4% of GDP and is expected to fall by 0.6 percentage points over the period 2004-2010 and by 2.7 percentage points from 2004 to 2050, although the projections do not include long-term care[114]. Social protection expenditure is one of the lowest the EU (EU25: 27%[115]).

2. OVERALL STRATEGIC APPROACH

Estonia's overall overarching objective is rapid, sustainable and socially and regionally balanced economic development. The key areas for enhancing social protection and social inclusion are competitive education, participation in work life and good health. The social protection system should be designed to provide adequate support to cover social risks. The integrated approach to delivering benefits and services for people in need ensures the accessibility and quality of the help needed. The NSR consolidates the objectives and planned actions from strategic documents in different fields.

The main strategic areas in 2008-2010 are as follows: increasing employment; preventing long-term unemployment and inactivity; supporting families with children to avoid or eliminate poverty and social exclusion; supporting the active participation of the disabled and older persons; increasing the efficiency of social protection and providing incentives and services to support working, independent coping and participation in social life; creating equal opportunities for acquiring quality education in accordance with abilities; improving health indicators and extending quality lifetime; improving the quality and availability of medical and nursing care.

The goals of the NSR for social protection and social inclusion are in line with the Lisbon and Sustainable Development Strategies. Both strategies support improving the skills of the labour force, increasing the flexibility of the labour market and improving the quality of working life. NSR activities are financed under the State Budget Strategy for 2009-2012 and the National Strategic Reference Framework for the use of the Structural Funds for 2007-2013. For many social inclusion measures, use is made of programmes co-financed by the ESF (increase in qualified labour force, development of career systems etc).

For the preparation of the report, a steering committee was set up with representatives of ministries, major non-profit associations and European umbrella organisations. The report has been approved by the government.

3. SOCIAL INCLUSION

3.1. Key trends

In 2007, the at-risk-of-poverty rate was 19% (17% for men and 22% for women), and has increased one percentage point compared to 2006. The rate was 18% for children and 33% for the elderly, with 21% of men and 39% of women aged 65 or more. Thus the rate for elderly is much higher than for the rest of the population. The most vulnerable are single parents, the unemployed and those above 65 years of age living in one-person households, especially women. In 2007, the relative median at-risk-of-poverty gap was at 20%, lower that the EU average. Social transfers (excluding pensions) decreased poverty by 6 percentage points. For children and the elderly, social transfers reduced the at-risk-of-poverty rate by 10 and 3

[114] Source: 'The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050)' Report prepared by the Economic Policy Committee and the European Commission.

[115] Provisional value.

percentage points, respectively. The share of children living in jobless households increased slightly in 2007 to 7.2% (6.9% in 2006) while the proportion of adults (18-59 years old) decreased to 6.0%, by 0.6 percentage points from 2006. The in-work poverty rate was the same as the EU25 average, 8% in 2006 (6% for men and 9% for women) and remained the same in 2007. The number of early school-leavers increased to 14.3% in 2007 while youth educational attainment (80.9%) was higher than the EU average (78.1%).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

For *the prevention and alleviation of long-term unemployment and exclusion from the labour market,* the new Employment Services and Benefits Act (which entered into force in January 2006) emphasised the importance of an individual and needs-based approach in employment services to ensure a more effective labour market policy. Attention was given to improving administrative capacity and promoting the services of the Labour Market Board among the inactive in order to increase employment rates. Active employment measures were made more attractive by providing access to heath insurance and increasing the daily unemployment allowance rate to €2.1. Long-term unemployment decreased from 5% in 2004 to 2.3% in 2007 and activity rates increased by 2.7 percentage points during the same period. As a new initiative, state funding has been introduced for in-service training of the workforce in accordance with the principles of lifelong learning, as an important element of in-work support. The level of lifelong learning has increased slightly to 7% but is still below the EU average of 9.5%. The purpose of the new Employment Contracts Act is to make the labour market more flexible while maintaining the security of employees, as only 8.2% are employed part-time. The registration of all so-called ‘near-accidents’ should improve occupational heath and accident prevention.

For *the prevention and alleviation of poverty and the social exclusion of families with children,* the duration of parental benefit was extended to 575 days, while several amendments to the ‘State Family Benefits Act’ introduced or increased various benefits for families with children and for foster care. The at-risk-of-poverty rate for children decreased by 1 percentage points between 2005 and 2006. The conditions for the payment of disability allowances were changed in accordance with the severity of a disability by the new Social Benefits for Disabled Persons Act, while for compensation for additional work-related costs was introduced to increase the employment rate of the disabled.

3.3. Key challenges and priorities

In view of the social situation in Estonia, the four policy objectives chosen to address poverty and social exclusion carry forward and extend the priorities selected in the 2006-2008 NSR and the challenges identified in 2007 Joint Report on SPSI by devoting attention to children, the disabled and the elderly.

The approach is sufficiently multi-dimensional, with quite a good balance between existing and new policy measures and also between prevention and alleviation. In contrast, the gender dimension has not been adequately taken into account — the gender pay gap (which is one of the highest in the EU) and the high share of single women among the elderly. Insufficient attention is given to the ethnic aspect of social inclusion and regional differences.

3.4. Policy measures

For the period 2008-2010 four priorities have been set: $

Prevention of long-term unemployment and inactivity and bringing the unemployed and inactive people into employment. The focus is on the situation in the labour market: extending the target group of active employment services to include the inactive population; development of the career services system; facilitating labour market entry for persons released from custodial institutions; training of the unemployed to become home and community care workers; the purchase of nursing care services; support for active employment measures and their testing; and increasing awareness of flexible forms of work. While adequate income support (increase in unemployment allowance, access to health insurance) was emphasised in the previous period, the 2008-2010 NSR focuses on a combination of active employment measures with access to services. Nevertheless, no special attention is given to ethnic minorities. (Regardless of the measures, the unemployment rate is projected to increase).

Targets for 2010: Employment rate — 70% (2007: 69.4%); unemployment rate — 5.5% (2007: 4.7%); long-term unemployment rate — 2% (2007: 2.3%); activity rate — 73.8% (2007: 72.9%); employment rate of older people — 63.5% (2007: 60%); employment rate of women — 68.3% (2007: 65.9%).

Prevention and alleviation of poverty and social exclusion in families with children. As the family and child benefit system is now established, the main measures focus on the development of services to support families raising children and help bring parents to the labour market through: the advancement of parental education; support for parents and provision of welfare services based on need; providing equal opportunities for obtaining quality education; support for the participation of parents in the labour market; and carrying out surveys and analyses concerning children.

Targets for 2010: Share of children aged 0-15 living below the absolute poverty line — 6.2% (2007: 9.4%); share of children aged 0-15 living below the relative poverty line — 16.8% (2007: 18%); share of households with children on subsistence benefit — 30.1% (2007: 32%); number of children without parental care and in need of assistance (registered for the first time, per 10 000) — 54 children aged 0-17 per year (2007: 60); average number of children per child protection official — 1350 (2007: 1630); young people who are not learning, have acquired only basic education or have a lower education level — 10% (2007: 14.6%); share of 15-year-old children with low reading skills — 20% reduction (2007: 13.7%); employment gap of parents with small children — 35% (2006: 38.5%).

Supporting the active participation of the disabled in social and working life. Active inclusion of the disabled is an important challenge for Estonia. The main measures to improve self-realisation and independence of the disabled include: development of services to support the rehabilitation and independent coping of disabled persons; providing income support and employment opportunities for disabled persons; promoting the education of disabled persons; and conducting surveys and analyses on disabled persons. On the other hand, the social economy, social enterprises or sheltered employment as a source of work for disabled people are not mentioned.

Targets for 2010: Employment rate of persons (age group 15-64) with restricted capacity for work due to long-term illness — 38.5% (2006: 32.6%); disabled persons on 24-hour welfare services as a percentage of all adults with disabilities — 6.2% (2007: 6.4%)

Prevention of the social exclusion of the elderly and supporting active and dignified aging. Estonia has a relatively high share of elderly people and also a high employment rate of older people (55-64 years of age), but at the same time a high relative poverty rate among older people, particularly women. The main measures planned in the NSR for the prevention of social exclusion include: increasing employment opportunities for older people; developing a network of care institutions for the elderly; raising the qualifications of staff in the care institutions for the elderly; and developing a sustainable financing system for the old-age care system. However, the measures do not take adequate account of the gender dimension and ethnic aspects. Despite these measures, the poverty rate of persons over 65 is projected to increase.

Targets for 2010: Employment rate of older people — 63.5% (2007: 60%), health-related restrictions on daily activities among persons aged 65 or above — 33% (2007: 35.1% of the population over 65 years did not report any restrictions on their daily activities due to health reasons); persons over 65 on 24-hour care services as a percentage of the total population of the same age — 1.8% (2007: 1.72%); percentage of elderly people living under the absolute poverty line — 3.7% (2007: 3.8%); at-risk-of-poverty rate for persons over 65 — 35% (2007: 33%); households with retired members on subsistence benefits as a percentage of all households with retired members — 1.7% (2007: 2%).

3.5. Governance

For the preparation of the report, a steering committee was set up with representatives of ministries, major non-profit associations and European umbrella organisations. There is no evidence of debate in the media or political discussions. Arrangements to ensure the mobilisation and involvement of all relevant actors are in place, though insufficient attention is given to the involvement of people experiencing poverty.

Thematic roundtables and workshops of representatives of the government, local governments and NGOs will ensure monitoring of the implementation of the new measures. Third-sector organisations will be invited to participate. All ministries will be responsible for monitoring and evaluation of their respective action plans with the Ministry of Social Affairs, which is responsible for the implementation of the report as a whole. In addition, every sector will be responsible for the involvement of stakeholders. The arrangements to monitor and evaluate the overall implementation of the inclusion part are in place and commonly agreed EU indicators, supplemented by national indicators, have been identified for monitoring progress.

4. PENSIONS

4.1. Key trends

Since the previous reporting period no major changes in the Estonian pension system have been introduced. During 1999-2002 a pension reform took place, resulting in a statutory PAYG defined-benefit pension scheme, a statutory mandatory funded defined-contribution scheme and voluntary private pensions. The state PAYG system is financed from 20% (or 16% for members of the mandatory funded pillar) of the social tax, paid by employers, and is moving from a flat-rate pension scheme to a more earnings-related scheme. The statutory defined-contribution system is financed from 4% of the social tax (paid by employers) and 2% of gross wages (paid by employees), and is mandatory for persons born in 1983 or later. Those born before 1983 and in the labour market can join the second pillar on a voluntary basis. The multi-pillar pension system is based on the requirement that income at pensionable age should be drawn from several different sources with different legal, organisational and

funding principles. However, a closer relationship between pension, work and remuneration poses a risk that people with lower incomes or short professional careers may not have sufficient resources to ensure a decent subsistence at pensionable age. The large wage gap between different groups (e.g. men and women) will ultimately translate into an income gap in retirement as well.

The pension reform provides for an increase in the statutory retirement age and its gradual equalisation for men and women (to 63 years) by 2016. Currently, the retirement age is 60 for women and 63 for men. There is a possibility for retirement 3 years earlier if the person has a work record of at least 15 years, indicating a rather short average contributory period given the demographic situation.

The average old-age pension was raised twice over the period 2000-2007 to €200 a month, but is still rather low.

4.2. Key challenges and priorities

State pension insurance, which is partly financed by the central government, has been in deficit over the previous years (except for 2007) and will remain so for the period 2008-2011. The Government has put additional resources into the pension insurance reserves. Although the reserves are fairly substantial, the financial sustainability of the Estonian pension insurance system is weak, in view of the 2008 requirements. Likewise, the positive effect of the mandatory funded pillar on the pension insurance balance will not be seen for decades. In the meantime, the additional need for funds may amount to tens of billions in EEK.

Pension expenditure in Estonia was 6.0% of GDP in 2006 (EU25: 12.0%[116]). Public pension expenditure is projected to decrease from 6.7% in 2004 to 4.2% in 2050, as a result of the diversion of part of social security pension contributions into privately funded schemes. Total pension expenditure is projected to decrease from 6.7% of GDP in 2004 to 6.6% in 2050.

Under the new regulations, pension increases will be more in line with the increase in social tax, as 20% of the value of the index is based on the annual increase in the consumer price index and 80% on the annual increase in that part of social tax related to pension insurance, instead of 50% previously. This change should increase pension adequacy without jeopardising the sustainability of the system. The solidarity element in the state pension was increased by increasing the proportion of the basic pension amount. Given the current gravity of the economic situation in Estonia, the change could lead to a further deficit in the PAYG system.

In 2007 the aggregate replacement ratio was 47% (40% for men and 57% for women). According to projections of the theoretical replacement rates, an increase in net retirement income as a ratio of work income at the point of retirement is expected by 11 percentage points between 2006 and 2046 for a worker retiring at age 65. This is due mostly to the calculated rates of return on the statutory funded scheme, covering younger workers.

4.3. More people in work and working longer

Generally, the financial incentives for working after retirement age are good in Estonia, as pension can be drawn in combination with salary. As a result, Estonia's indicators for the employment of older people are higher than the EU average. The employment rate was 41.4%

[116] Provisional value.

for 60–64 year-olds (EU: 28.1%) and 58.5% for 55–64 year-olds in 2006 (EU: 43.6%). The effective retirement age was 62.6 years (EU: 61.2), whereas life expectancy at birth was 67.4 years for men and 78.6 years for women.

At the same time, about half of pensioners retire before statutory retirement age by taking up early retirement pension, special pensions and pensions under favourable conditions, indicating a need to look further at early exit pathways for older workers.

Preventing the social exclusion of the elderly and supporting active and dignified ageing is one of the priorities in the social inclusion part of the report, with measures for increasing employment among older people and promoting flexible forms of work.

4.4. Privately managed pension provision

The compulsory funded defined-contribution scheme was introduced in 2002 by diverting a proportion of contributions from the statutory PAYG scheme into private funds. The scheme is mandatory for those born from 1983, with the possibility for the others to opt in. Following recent modifications, the investment limits for real estate and real estate funds have been increased from 10% to 40% and for venture capital funds from 30% to 50%.

The first benefits will be paid as from 2009. The recently adopted legislation covers the regulation of annuity contracts, programmed withdrawals, lump sum payments from pension funds and stricter regulation of administration fees. The law also provides for an increase in the equity investment limit for so-called ‘progressive’ (higher risk) pension funds from 50 to 75%, which increases the risk at a time of crisis on the financial markets.

Voluntary private pension schemes were introduced in 1998. Participation in such schemes can take two different forms: pension insurance policies offered by licensed private insurance companies or units of pension funds managed by private asset managers. However, participation is low despite tax incentives (voluntary contributions are deductible from taxable income) covering around 8% of labour force.

4.5. Minimum income provision for older people

The relative standard of living for older people decreased to 69% (72% for men and 68% for women) in 2006 compared to 73% in 2003 for the general population. The relative income share for those aged 65 and older was 69%, lower than the EU average (EU25: 85%) in 2005. The risk of poverty for people aged 65 and older increased from 20% in 2005 to 33% in 2007 (36% before social transfers), women having the highest risk. Over the period 2000 to 2007, the share of persons over 65 with an income below the relative poverty line doubled, with a particularly high increase during 2004-2006. The minimum pension (which is below the poverty level) covers the minimum food basket, but has persistently been below the national minimum cost of living as well as the relative poverty line.

4.6. Information and transparency

The transparency of the system is good, especially given the high levels of internet usage among the public and the availability of most information and transactions via electronic channels. The report contains no specific information on the role of social partners and other stakeholders regarding pensions and how they are involved in the decision-making process.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Estonian Health Insurance Fund (EHIF) purchases and reimburses care for about 96% of the population, based on residence and group membership (e.g. the unemployed, children, pensioners, full-time carers). Provision is decentralised and mostly public. Residents register with primary health care (PHC) doctors, who play a gate-keeping role for specialist and hospital care. Specialist care is provided in health centres, hospital out-patient departments and specialists' own practices. In-patient care is provided in regional, central and local hospitals (mostly municipal or state). The system is financed through an earmarked payroll tax on employees and the self-employed and through taxation.

In 2006, life expectancy at birth was 67.4 years for men and 78.6 for women, among the lowest in the EU despite the positive trends of recent years. The gap between men and women is 11 years, which has remained approximately the same since 1996. In 2006, healthy life years came to 49.4 years for men and 53.7 for women. There is a significant difference between healthy life years and life expectancy at birth. This implies that many elderly persons are restricted in their daily activities for the last two decades of their life. There are also socio-economic health inequalities: women with a higher education live 13 years longer than men with a basic education.
The health behaviour of young people has deteriorated remarkably from the mid-1990s. The share of young people and adults who smoke, consume alcohol, use illicit drugs and are overweight is growing, and the level of injury continues to be high among young people. There is a high death rate from traffic accidents, cardiovascular diseases and cancer, while the incidence of newly reported HIV and TB infections is also high. These are deemed preventable to a large extent.

The government has approved the Public Health Development Plan for 2009-2020 with the strategic objective of continuously improving the health status of the population. Among the priorities are increasing the population growth rate, raising average life expectancy (at birth for men to 75 and for women to 84 by 2020) and healthy life expectancy (at birth for men to 60 and for women to 65 by 2020), while reducing socio-economic health inequalities

5.1.2. Accessibility

According to national data, 96% of the population were covered by public health insurance in 2007. Insured persons are charged for some services (including adult dental care). Out-of-pocket payments formed 21.3% of total health expenditure in 2004. Self-reported unmet need for medical care was 7.3% in 2006 (12.2% for dental care) compared with the EU average of 3.1% (5% for dental care). The figure for the poorest socio-economic groups is 4.5 greater than for the better-off (9 x for dental care), with richer households having better access than poorer households.

According to the authorities, the availability of family physicians is good, with 99.8% of the population able to make an appointment within 3 days, while the availability of certain special

medical services (both ambulatory and in-patient) is problematic. On the other hand, according to a longitudinal survey, the share of patients who had to wait for an appointment with a specialist doctor for over one month increased from 14% in 2003 to 25% in 2007, and the share of patients who had to wait for an appointment with their family doctor for three or more days increased from 18% in 2003 to 22% in 2007. Ongoing efforts are being made to shorten and prioritise the waiting lists for specialised care. Additional resources are being allocated to services with the longest waiting lists, while central waiting lists have been established for some services for people with urgent needs. The free primary health care counselling phone was launched in 2005, but there is still a lack of awareness.

There are also considerable geographical differences in access to PHC. Access to family doctor services is better in rural areas than in the capital city of Tallinn. The authorities want to ensure that PHC is available close to the place of residence.

Uninsured persons are entitled to receive emergency care paid by the state. In 2007, health insurance was introduced for all unemployed persons participating in active labour market measures. The government wants to ensure the equal availability of PHC and planned special medical care to everybody on a voluntary basis from local governments.

5.1.3. Quality

Longitudinal national surveys carried out jointly by the EHIF and the Ministry of Social Affairs show a positive trend in the development of patient-centredness in the health care system. The quality of medical care received was assessed as ‘good’ or ‘rather good’ by 69% in 2007, while 23% considered it ‘bad’ or ‘rather bad’.

A development plan has been drawn up to ensure a more purposeful development of primary health services by supplementing current services with others (such as nursing care) and creating cooperation networks. The main objective is to facilitate access close to home.

Quality standards based on best practice and guidelines for in-patient and ambulatory nursing-care services and modern treatment for rehabilitation have been prepared. The operating licence issued by the Health Care Board ensures the conditions for providing quality services. The EHIF in cooperation with experts carries out quality audits. To measure the quality of hospital services, the EHIF together with the WHO have been developing a system of quality indicators.

An eHealth project has been launched, the aim being to create an Estonian-wide digital documentation system by the end of 2008.

Patients are free to select both the family physician and the person providing specialised medical care. In recent years, patient associations have been included in the preparation of some strategies and in the composition of certain national committees.

5.1.4. Sustainability

Total health care expenditure in 2005 was 5% of GDP (PPP $846 per capita) and is one of the lowest in the EU (exceeding only Bulgaria and Romania). In 2004, the share of public expenditure was 76% of total health care expenditure, and has decreased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 1.1% of GDP by 2050, still well below the EU average.

The reform of the health care system to reduce the number of hospital beds for acute treatment is not proceeding at the recommended pace. To ensure continuous optimisation of the hospital network, fully available and functional first-stage, nursing and rehabilitation care is needed.

The plan for supplementary measures commenced in 2005 with the control and optimisation of health insurance costs (cost-based prices and 'diagnosis-related groups' — DRGs) and an increase in the health insurance tax base (increase in the minimum social tax rate to the minimum wage level in 2009). Extending the groups of persons subject to social tax is also under consideration. As an incentive, family physicians can collect remunerable bonus points by monitoring the chronically ill and conducting preventive interventions. One important priority is disease prevention and health promotion to improve the public state of health.

After Estonia's accession to the EU, the mobility of health care professionals has become a problem.

5.2. Long-term care

5.2.1. Description of the system

No major changes have been made to the long-term care system from the previous reporting period. The health care system provides medical care, nursing care in institutions or hospitals, geriatric assessment, home PHC and home nursing care. These services are paid for by the EHIF. The welfare system provides care in institutions, day care centres, home care, housing services (e.g. house alterations, cleaning, food) and other social services. The municipalities are responsible for providing these services or purchasing them from state and local agencies and the private sector. Care-givers receive an allowance to reimburse care costs or alleviate their care burden. A social worker, together with the family doctor or a geriatric team, considers and chooses between forms of care based on the person's needs and financial situation.

With the growing ageing trend, the most vulnerable group is the over-65s in one-person households, whose relative poverty risk is the highest. As healthy life years are only 3.4 years for those over 65, they are also the most disabled. Consequently, long-term care is a major issue. As the report notes, not enough resources have been devoted to either health care or long-term care to improve the situation sufficiently.

5.2.2. Accessibility

Total long-term expenditure was 0.15% of GDP in 2005. Although slightly increasing, it is still among the lowest in the EU. As the provision of home care services and community social services for the elderly is the responsibility of the local municipalities, the accessibility and quality of these services varies greatly.

The most acute problem in nursing care is its insufficient availability caused by a lack of financing, particularly for domestic services. A strategy for integrated services for the elderly has been developed to solve the lack of available health and nursing services for the elderly requiring daily nursing care by creating centres to provide both nursing and medical care (hitherto separated).

5.2.3. *Quality*

Enhancing the quality of nursing and rehabilitation services for patients leaving active treatment, but also for the elderly and chronically ill, is one of the priorities for health and long-term care. In order to improve the availability of nursing care services, a development plan for a nursing care network and a concept for integrated long-term care are being implemented, which aims to cover needs by 2015.

5.2.4. *Long-term sustainability*

The present economic situation, with the steep fall in economic growth in 2008 in Estonia, will reduce the overall budget, which will also have an effect on the budget for social expenditure. This might in turn have a substantial effect on long-term care, which is mainly the responsibility of local governments. The financial base for local governments might decrease significantly and the rather high level of out-of-pocket expenses in long-term care (55% own contribution to costs) might lead to an increase in the burden of these costs for the population. The network for the provision of services complementing long-term institutionalised care is very small and would not be able to expand in the coming years. Ultimately, this will increase the social expenditure costs for households.

6. CHALLENGES AHEAD

- To continue increasing labour market participation among at-risk groups, through a combination of properly financed active labour market policies and promoting flexible forms of work.
- To reduce the high risk of poverty among families with children.
- To reduce the high risk of poverty among the elderly through an integrative, active inclusion policy (active ageing).
- To secure the long-term financial sustainability of the pension system so as to be able to provide more adequate pensions in future.
- To ensure that the current economic context and possible public sector expenditure cuts do not affect healthcare access, in view of the low health status of the population and the low overall expenditure; to use the current situation as an opportunity to improve the value for money in the system notably through stronger use of primary care, better coordination of services and promotion and prevention strategies to improving health status. In the medium run, to continue to address the geographical and socio-economic disparities in access, improve the quality of services and address human resources issues
- To arrive at an integrated and functioning model of long-term care for the elderly and cushion the financial impact of the crisis on this sector.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	9,6	44,6	2000	60,4	64,3	56,9	28,3	46,3	2000	12,8	13,8	11,8	23,9
2005	9,2	61,1	2005	64,4	67,0	62,1	29,1	56,1	2005	7,9	8,8	7,1	15,9
2008*f*	-2,4	64,8	2007	69,4	73,2	65,9	34,5	60,0	2007	4,7	5,4	3,9	10,0

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth: Male	Life expectancy at birth: Female	Life expectancy at 65: Male	Life expectancy at 65: Female	Healthy life expectancy at birth: Male	Healthy life expectancy at birth: Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	61,5	74,3	12,0	16,1	n.a.	n.a.	14,9	1995	n.a.	n.a.	n.a.		-
2000	65,5	76,2	12,8	17,0	n.a.	n.a.	8,4	2000	5,3	77,5	19,9	2005	6,6
2006	67,4	78,6	13,2	18,3	49,4	53,7	5,0	2006**	5,0	76,9	20,5	2006	7,3

s: Eurostat estimate; p: provisional; **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	14,0	45,3	32,1	1,3	11,9	2,7	6,6
2006	12,4	45,2	31,2	0,9	12,1	1,0	9,5

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
2004	25,2	17,1	6,7	5,4	n.a.
2010	25,0	-0,6	0,1	0,4	n.a.
2030	34,4	-2,3	-1,9	0,8	n.a.
2050	47,2	-2,7	-2,5	1,1	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate: Total	Children 0-17	18-64	65+	Poverty risk gap: Total	Children 0-17	18-64	65+	Income inequalities: S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	19	18	16	33	20.0p	26.0p	26.0p	14.0p	5.5p	2005	18
male	17	-	15	21	24.0p	-	29.0p	14.0p	-	2006	12
female	22	-	17	39	19.0p	-	23.0p	14.0p	-	2007	8

	People living in jobless households: Children Total	% of people aged 18-59*: Total	Male	Female
2001	11,2	11	10,9	11,1
2004	9,6	9,5	10,2	8,7
2007	7,2	6	6,1	5,9

	Long Term unemployment rate (% of people aged 15-64): Total	Male	Female
2000	5,9	6,7	5
2004	5	5,6	4,4
2007	2,3	2,9	1,7

	Early school-leavers (% of people aged 18-24): Total	Male	Female
2000	14,2	16,3	12.1u
2004	13,7	20,5	n.a.
2007	14,3	21	n.a.

**: excluding students; i: change in methodology; b: break in series* *u - data lack reliability due to low sample size*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,65	0,68	0,63	***Aggregate replacement ratio***	0,47	0,4	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046) Net: Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	*Assumptions* Coverage rate (%): Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
11	9	9	DB/DC	/	-	100	/	22	-	-0,1

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)* *p - provisional value*

Ireland

1. SITUATION AND KEY TRENDS

2006 and 2007 saw GDP growth of 5.7% and 6% respectively, compared to an EU average of 3.1% and 2.9%. However, a dramatic deterioration in the Irish economy during 2008, driven by a collapse in the domestic housing market and exacerbated by the financial crisis, means the Commission services' January 2009 economic forecast has estimated that real GDP will contract by 2% in 2008 and 5% in 2009.

The employment rate increased to 69.1% in 2007 before contracting slightly in 2008 with a further contraction of -4% expected in 2009. The female employment rate stood at 60.6% in 2007 while the rate for older workers increased to 53.8%. Unemployment remained stable in 2006 and 2007, at 4.5% and 4.6% respectively, but is estimated by the Commission to have averaged 6.5% in 2008 and to increase further to 9.7% in 2009. Youth unemployment increased from 8.6% in 2006 to 9.2% in 2007 and it is likely that it increased further in 2008. In 2007, 18% of the population were at risk of poverty (down from 21% in 2004), compared to an EU average of 16%. The number of children at-risk-of-poverty was the same as the EU average at 19% while 29% of those over 65 were at risk of poverty, compared to an EU average of 19%. While only 6% of employed persons were at-risk-of-poverty in 2007, the rate for those who were unemployed was 43%.

Expenditure on social protection in Ireland remained static at 18.2% of GDP between 2004 and 2007, significantly behind the EU average of 27%. This difference can be partly accounted for by the significant growth in GDP in Ireland during this period and the fact that Ireland spends proportionally less on old age due to its lower age profile and reliance on private pension provision.

Life expectancy at birth for Irish people increased to 79.7 years in 2006 (from 77.2 in 2001), with an expectancy of 77.3 for men and 82.1 for women. Life expectancy at age 65 was 18.6 in 2006, up from 18 years in 2004. Infant mortality rates have dropped to 3.7 in 2006 from 5.1 in 2003 and 6.2 in 2000. Ireland had the lowest dependency ratio in the EU in 2008 at 16.3 compared to the EU average of 25.4. Although this rate has decreased slightly from 16.4 in 2004, it is expected to rise significantly to 43.6 in 2060 (albeit still below the EU average) as a result of the projected rapid ageing of the population in the coming decades.

420 000 people, or 10% of the population, classified themselves as being of non-Irish nationality in 2006, up from 5.8% in 2002, and made up approximately 16.3% of the labour force. Although inward migration[117] is still occurring in Ireland, the NSR noted a 50% decrease in March 2008 compared to a year earlier while overall inward migration for 2008 is expected to be 60% less than in 2007. The report also states that non-Irish nationals face a higher risk of poverty (23.5%) than Irish nationals (16.6%).

2. OVERALL STRATEGIC APPROACH

The strategy adopted draws much of its focus from pre-existing plans, especially the National Action Plan for Social Inclusion, 2007 – 2016, which represents Ireland's integrated approach to social protection and social inclusion policy. The NSR incorporates a number of high level goals from the national action plan, including the adoption of a specific poverty related target.

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[117] Ireland uses the term 'migration' in its national report to describe the movement of both intra-Community workers and non-EU nationals.

The report was formulated before the publication of *Budget 2009,* following which the full impact of the recent economic downturn on public finances started to emerge. The budget was aimed at achieving fiscal stability while maintaining capital expenditure on critical infrastructure and protecting those who are most vulnerable. Within that context, it contained a number of changes which will have an impact on the actions outlined in the NSR including additional expenditure in priority areas, particularly social welfare and capital expenditure in the areas of health and education, coupled with cuts in other areas, such as to the capital childcare programme, the abolition of the automatic right for those aged over 70 to a medical card, and the placing of a limit on the number of language support teachers in schools. However, the economic situation in Ireland has deteriorated further since *Budget 2009* was announced and further significant cuts in public expenditure (including the public sector payroll bill) have been signalled by the Government for 2009 and 2010.

Ireland has adopted similar priority areas for achieving the three overarching objectives as in 2005, while some new initiatives that will contribute to the objectives are also mentioned, such as additional childcare places and a new national sustainable development strategy (in the context of linking to the EU's Sustainable Development Strategy). Otherwise, many of the actions described are similar to 2005 reflecting, the long-term nature of the priorities identified.

There is little description in the report of how the ESF can contribute to achieving the overarching objectives. Notwithstanding this, an ESF-funded *Equality for Women* measure has been announced since the publication of the NSR, and this will also address the issue of gender mainstreaming. In relation to governance, no specific consultation process was engaged in prior to the preparation of this report although there was an extensive consultation process in advance of the national strategies and plans, introduced in 2007, on which the report is largely based, and there was also significant consultation on the *Green Paper on Pensions*.

3. SOCIAL INCLUSION

3.1. Key trends

The at-risk-of-poverty rate in Ireland fell from 21% to 18% between 2004 and 2007, just above the EU average of 16%. However, when the poverty rate is anchored at a fixed moment in time (2005), the at-risk-of-poverty rate drops to 12% (compared to EU average of 14%), reflecting the significantly above-inflation rise in median incomes during this period. The rate for older people in 2007 was 29% (compared to an EU average of 19%), down from 40% in 2004. The rate for children also decreased between 2004 and 2007, falling from 22% to 19%, the same as the EU average. Lone parents continued to have a higher than average rate at 40% in 2007 (compared to an EU average of 34%) although this fell significantly from 56% in 2004. Two-adult families, on the other hand, had at-risk-of-poverty rates below the EU average in 2007 for one, two and three-child units of 10%, 12% and 20% respectively. According to national EU SILC figures, the rate for people with disabilities fell to 37% in 2007 from 51.7% in 2003.

The relative at-risk-of-poverty gap decreased from 20.3% in 2005 to 16.4% in 2006 but rose slightly to 18% in 2007, though this remained below the EU average of 22%. The Gini co-efficient reduced slightly to 31% in 2007, just above the EU average of 30%, while the ratio of income distribution was the same as the EU average at 4.8. The role of social transfers can be seen in the fact that 33% of the population were at risk of poverty in 2007 before social transfers, compared to 18% after. This 15 percentage point reduction in the at-risk-of-poverty rate compares to a 9-point reduction across the EU.

Illustrating the important role played by employment, 6% of employed people over the age of 18 were at risk of poverty (compared to 8% in EU) in 2007, compared to 43% for those not in employment (42% in the EU). 11.5% of children and 7.9% of adults lived in a jobless household in 2007, compared to 10.4% and 8.8% respectively in 2001.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Some progress in relation to *child poverty* has been made. There was a decrease in the at-risk-of-poverty rate, and the provision of childcare places and additional grant-aid assistance to schools to address educational disadvantage were singled out as contributing to this. Despite this progress, however, Ireland still has some distance to travel in meeting its own targets and it remains to be seen whether further progress will be hampered by expenditure cuts in this area.

Given the importance of employment, child poverty is also linked to *access to quality work and learning opportunities*. While the employment rate continued to rise for most of the period covered, this did not apply equally to disadvantaged groups such as lone parents and people with disabilities. Progress in increasing employment for these groups is dependent on implementing planned reforms to encourage participation in education, training and employment and these will, in turn, depend on putting in place the necessary supports, especially childcare and retention of secondary benefits, particularly the medical card, for people with disabilities. Improvements in the quality of employment will also depend on the full implementation of the National Skills Strategy, especially in relation to lifelong learning.
Progress in relation to employment is also linked to progress in improving *access to services*. The report details developments across a range of services, many of which are targeted at disadvantaged areas and groups. Further analysis of the impact of these developments is hampered by a lack of data. In relation to the *social inclusion of migrants*, there have been a number of developments, such as the establishment of the Office of the Minister for Integration and the publication of an integration strategy. However, analysis of progress is hampered by the lack of data on migration in Ireland. The economic downturn is also having an impact on the nature of the migration challenge in Ireland as the number of people entering Ireland for employment slows and the number of immigrants who find themselves without employment increases.

3.3. Key challenges and priorities

Ireland has identified the same broad policy objectives in 2008 as in 2005, reflecting the long-term orientation of the policies and progress to be made. They are:

- Child poverty;
- Access to quality work and learning opportunities (activation measures), with a focus on lone parents and people with disabilities;

– Social inclusion of immigrants;

– Access to quality services, with a focus on the Homeless.

3.4. Policy measures

Child Poverty: The main target is to reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating it by 2016. Although not a specific child-related target nor framed using the at-risk-of-poverty measure[118], the inclusion of an overall target is a positive step. The report sets out an integrated strategy which includes a range of actions and targets covering early childhood development and care, improving health and education outcomes and income support. In many cases implementation is already under way or at an advanced planning stage. However, whether these measures are fully implemented will depend to a great extent on the resources allocated in these changed economic circumstances. Specific targets have been set in relation to the childcare strategy and child income support against which progress can be measured. Details of funding are given for childcare investment and income support, including both universal and targeted supports, but not for the other policy areas covered.

Access to Quality Work and Learning Opportunities: The main aim is to target 50,000 people and reduce by 20% the number depending on long-term social welfare payments for their total income by 2016.

The main policy measures to achieve this target are active engagement with the unemployed/inactive and improving access to learning opportunities. Priority will be given to preparing people with disabilities and lone parents for education, training or employment opportunities while those workers with low skills will also be targeted. Specific quantitative targets are set for employment and training of people with disabilities and also for access to lifelong learning opportunities such as *youth reach* and *back to education* places. Despite increased income thresholds for receipt of *family income supplement* and proposals to reform the *one parent family payment*, there is a need for further progress on removing tax- and welfare-related disincentives to employment and recently commissioned research on financial disincentives for social welfare claimants of working age may help to address this. Making further progress on all of the above areas is inextricably linked to progress on other priorities, including access to services, especially childcare and other supports. The recent significant rise in unemployment in Ireland will also pose additional challenges to those outlined in the NSR, especially in terms of financial and human resources, and it remains to be seen whether this will affect the roll-out of activation measures for other inactive groups.

Social Inclusion of Migrants: No targets are mentioned in relation to this objective and policy measures will be focused on: facilitating participation in employment, education supports, and follow-up on the National Action Plan against Racism.

The measures outlined in the report are more strategic than before, exemplified by the appointment of an Office and Minister for Integration. This is an innovative response and has been listed by Ireland as an example of good practice. A more strategic approach by relevant Departments is also evident, in particular the Department of Education and Science. The economic downturn may also affect the nature of the challenge in relation to migration, given evidence that the number of migrants entering Ireland is falling while those who remain are being disproportionally affected by the general rise in unemployment (the proportion of non-

[118] Consistent poverty is a nationally developed indicator which measures a combination of monetary risk of poverty and material deprivation. It is the indicator used for poverty-related targets but is not comparable across the EU.

Irish nationals claiming unemployment benefit increasing from 12% in January 2007 to 18.7% in December 2008). The lack of reference to targets for this priority is apparent, as is the lack of data available on which to base them (which is linked to a difficulty in including migrants in large scale surveys due to small sample size).

Access to Quality Services: No target is given for this priority although there is a list of comprehensive measures covering areas such as education, employment, health care, housing, homelessness and income support, which are targeted at the most vulnerable groups. The targeting of health-related actions at disadvantaged groups and areas is also apparent, for example, with the National Intercultural Health Strategy which has been listed as a best practice measure. Special attention has been given to homelessness – an area in which the report indicates progress in relation to reducing numbers (although non-government organisations working in this area dispute this). Achieving the target of eliminating long-term occupancy of emergency accommodation by 2010 will be critical in this regard. A new homelessness strategy has been developed to help achieve this but an implementation plan is now a priority. Access to employment services could become more of an issue as unemployment continues to increase, particularly for the 16 -24 cohort which has been most affected by rising unemployment.

The issue of gender is specifically addressed under this priority, with reference to the National Women's Strategy. Again, some financial allocations are included, and a breakdown of funding under the NAPinclusion and the social inclusion chapter of the NDP is given in the Annex.

3.5. Governance

While the decision not to engage in a separate consultation process in advance of this NSR received some adverse publicity in Ireland, the report details an extensive consultation process undertaken in 2005, which subsequently informed the social partnership negotiations, the NDP and the 2007 National Action Plan – upon which the current NSR is largely based. In addition, extensive consultation is planned for the European Year for combating poverty and social exclusion (2010). Despite this, there is uncertainty as to the extent to which stakeholders are involved in an 'ongoing structured dialogue in all stages of the policy-making process', although the role of the social partners in the *Towards 2016* steering group is mentioned. Ongoing involvement of people experiencing poverty, or groups representing them, which are outside the social partnership structure, occurs in the annual Social Inclusion Forum.

Overall coordination of implementation and monitoring of social inclusion policy is achieved via the cabinet committee on social inclusion, chaired by the Taoiseach (Prime Minister), and a senior official group which reports to it. The Office for Social Inclusion, which will shortly be merged with the Combat Poverty Agency, is responsible for day-to-day monitoring and reporting on the implementation of these various strategies and reports to the cabinet committee. Some social inclusion policy competence has been devolved to local authorities but coordination of this is less structured than at national level.

4. PENSIONS

4.1 Key trends

The pension system in Ireland has two main components; the state-run social welfare system, on the one hand, and an occupational or private pension system, on the other. Reform of the pension system is largely on hold pending the publication of a new framework for pension policy, due by the end of 2008. This framework will build upon the 2007 *Green Paper on Pensions* and the subsequent extensive public consultation.

Recent changes to the pension system consisted primarily of improvements to pension rates, which increased by 16.7% in the 2005–2008 period. State pension increases are not index linked but the Government has committed to raising the level of the state pension to €300 per week by 2012, a level which would bring the rate to approximately 40% of Gross Average Industrial Earnings (GAIE). However, this target is likely to be impacted by the current budgetary situation, with an increase of just over 3% announced for the contributory pension in 2009. Recent increases resulted in the aggregate replacement ratio in Ireland increasing to 0.47 in 2006; just below the EU average of 0.49.

While all people over 65 in Ireland have public pension coverage, this is not considered sufficient to guarantee an adequate income in retirement. Instead, Government policy envisages supplementary pension cover for 70% of those at work between 30 and 65 years of age by 2013. According to the latest figures the level was 61% in 2008, up slightly from 59% in 2002. The lack of progress in meeting these targets is a key issue to be addressed in any new pension framework. Nationality is also a factor determining pension coverage; the proportion of Irish nationals aged 20–69 with private pension coverage increased to 58% in 2008 (from 53% in 2002), the equivalent rate for non-Irish nationals decreased from 34% to 28% in 2008. The disparity in coverage between the employed and self-employed has narrowed slightly, with 56% of employed persons and 46% of self-employed persons being covered in 2008, compared to 53% and 41% in 2002.

Pensions receive favourable tax treatment in Ireland, mainly to encourage private and occupational provision. Pension contributions (up to a limit of €150 000) and investment returns are tax exempt and, although tax is nominally payable when the pension is in payment, this is subject to an allowance of €20 000 per annum for a single person aged over 65, or €40 000 for a couple.

4.2. Key challenges and priorities

The 2007 Joint Report highlighted the need for Ireland to maintain pension adequacy while widening coverage and maintaining sustainability.

In relation to adequacy, recent increases mean rates of public pension provision have continued to grow in real terms. The average income of pensioners is now 34% of GAIE and the government has committed to maintaining this growth until at least 2012. These rate increases have contributed to a reduction in the number of pensioners considered *at-risk-of poverty* (as detailed below). However, the report does not mention the adequacy of private pension provision which is especially topical given recent economic developments and the impact these could have on private pensions, especially DC pensions.

It is recognised that increasing adequacy can lead to further challenges in relation to sustainability and this issue, along with coverage, has seen little progress since 2005. The October 2007 *Green Paper on Pensions* was published with the objective of stimulating

debate on the future development of pensions in Ireland and identified the ageing of the population and the sustainability of the public system as two of the most pressing issues to be addressed. The demographic challenge is exemplified by the fact that the current dependency ratio of 16.3 is estimated by the EU Commission to increase to 43.6 by 2060. This, together with the commitment to increase pension rates to address adequacy issues, will have consequences for the financial sustainability of the system, with public expenditure on pensions projected by the EU Commission to rise by 6.4 percentage points from 4.7% of GDP in 2004 to 11.1% in 2050[119]. While the Government continues to pre-fund this liability through the pensions reserve fund (with a market value of €16.4billion or 8.8% of GDP as at 30 December 2008), it is estimated this will only contribute about 3% of GNP annually towards pension provision from 2050. The impact of the unprecedented falls in stock market performance could also affect the value of the NPRF. Ireland is also making slow progress in meeting its own targets for supplementary pension coverage.

4.3. More people in work and working longer

Future changes in the population structure in Ireland imply that there is a mismatch between the spending demand facing the public pension system and its ability to meet these demands. Measures being considered to address this include increasing the share of the population at work and increasing the retirement age.

Ireland had an employment rate of 69% in 2007 while it exceeded the EU targets for both older and female workers with rates of 54.3% and 60.7% respectively. Despite the recent increases in these rates, there is room for further improvement but this will depend on, firstly, putting in place the necessary supports such as childcare for increased female participation and, secondly, improving skills and learning opportunities for older workers. Measures adopted by Ireland in that regard have been to extend the employment action plan to the 55-64 age group and developing a systematic programme of engagement to deal with those currently at the margins of the labour market.

In addition to increasing participation rates, increasing the retirement age would allow for contributions over a longer period and could, therefore, contribute to a considerable easing of spending pressures. Although the average labour market exit age in Ireland was 64.1 in 2006, considerably above the EU average of 61, measures have been taken to increase this further, for example by abolishing the pre-retirement allowance, raising the minimum retirement age in the public service to 65 from 60 and introducing a €200 earnings disregard for those in receipt of a means-tested state pension who wish to remain in employment after age 65.

4.4. Privately managed pension provision

It is estimated that 70% of the workforce in Ireland over 30 will require supplementary pension provision by 2013 if adequacy is to be ensured (the state pension should be adequate for the remaining 30%). In 2008 it was estimated that 61% of people working aged 30–65 had such supplementary cover.

A recent trend has been for employers to opt for defined contribution (DC), as opposed to defined benefit (DB), occupational pension schemes. It is estimated that the ratio of DB to DC schemes fell from 4.5:1 in 1996 to 2:1 in 2008, mainly because of the strict funding and accounting standards that apply to DB schemes in Ireland. The danger of this trend is that the risk is effectively transferred from the employer to the employee. This risk becomes particularly apparent in the current economic climate where there is a very real danger that the

[119] ECFIN-EPC Report, 2006. Revised figures are due to be released by the Commission in Spring 2009.

value of DC schemes will not be enough to guarantee an adequate income. Some reports have suggested that managed pension funds fell by as much as 33% in 2008. The potential impact of such a fall in value particularly affects workers who are due to retire in the near future, as there will be less time for any improved market performance to make up for previous losses.

However, there is also a risk to the significant number of DB schemes identified in the Green Paper as not meeting the funding standard, a situation which is likely to have worsened further since then. While such shortfalls might not be problematic in other circumstances, there is evidence that the current economic climate is placing great strain on the ability of employers to meet such shortfalls and, ultimately, on their ability to stay solvent.

4.5. Minimum income provision for older people

The adequacy of income for pensioners was identified as a challenge for Ireland in the 2007 Joint Report. The response of the Irish Government has been to continue its policy of above inflation increases in the basic rate. As a result, between 2005 and 2007 this rose by 16.7% in real terms, compared to a rise in inflation and GAIE of 9% and 8% respectively.

These increases have almost certainly had an impact on the trend in poverty rates for older people. For example, the number of those aged over 65 considered at-risk-of-poverty has declined from 41% in 2003 to 29% in 2007. Although this is still above the EU average, the gap has narrowed from 23% in 2003 to 10% in 2006. However, females continue to face a higher risk of poverty (33%) than men (24%).

4.6. Information and transparency

The Pensions Board provides information to the general public on pension provision and conducts publicity campaigns to increase awareness of the need for supplementary provision. Both trustees and employers are obliged by law to provide pension holders with a wide range of personal and scheme information including annual reports and audited accounts. Recent changes mean trustees will be obliged to issue annual benefit statements to scheme members. Moreover, the consultation process recently engaged in and the way in which it is feeding into the development of a framework for pension policy, via the publication of a report detailing the submissions received and the options for further action, is a good example of transparent policy making.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The health service in Ireland is a mix of public and private institutions and operates on the basis of residency. A medical card gives full eligibility for all GP, A&E, in-patient, out-patient, prescribed drugs, dental, ophthalmic and maternity services. Those without a medical card are eligible for some services, including in-patient and out-patient services in public hospitals. Primary health care (PHC) is delivered primarily via health centres and GPs. The health service is mainly financed through general taxation and private health insurance covers 47.6% of the population. The Department of Health and Children is responsible for the development of strategic policy while the Health Service Executive (HSE) is responsible for the management and delivery of services.

The *National Health Strategy, Quality and Fairness: a Health System for You*, launched in 2001, provides overall strategic direction. A reform programme was launched in 2003 to deliver on the goals of the strategy, primarily by reorganising and reforming the health service

Since the last report the main developments reported on include PHC and families, cancer control, acute hospitals, older people, and disability and mental health. The Offices of the Minister for Children and Youth Affairs, Disability and Mental Health and Older People have been set up to give policy direction to the respective policy areas. Some progress has been made on transferring activity from hospitals to community-based settings through expanded PHC, although much work remains to be done in that regard. A National Cancer Control Programme has been implemented, involving significant realignment of services across the country.

Life expectancy in 2006 was 79.7, up from 76.6 in 2000. The gender difference 2006 was 4.8 years (77.3 for males and 82.1 for females), a slight decrease from the 5.2 years recorded in 2000. Perinatal mortality rates were 7.9 in 2004 compared to an EU average of 6.4.

5.1.2. Accessibility

Limited progress has been made since the previous report in relation to accessibility. The proportion of the population in receipt of the medical card has remained static at 32.2%. The proportion of private income paid for health care was 21.7% in 2007. The lack of attention paid to health inequalities in the report, in terms of actions taken or improved outcomes, is striking given the concern expressed in the 2007 Joint Report concerning the substantial health inequalities that exist.

The Department of Health has committed to bringing forward a legislative framework in 2008 which will set out clear statutory provisions on eligibility and entitlement to the medical card, while improvements have also been made to assessment procedures. The government has also committed, during its lifetime, to indexing income thresholds to average earnings and allowing people with disabilities who enter employment to retain their medical card past the current limit of 3 years. However, no progress has been made on these commitments yet. A recent government decision means that the over-70 age group will no longer have automatic entitlement to the medical card but will instead have to undergo a means test.

In relation to disability and mental health, Part 2 of the Disability Act, which concerns the automatic entitlement of people with a disability to an assessment of need, came into effect from 2007 for children under 5. It is intended that these assessments will be rolled out to other children (to age 18) by 2010.

Improving acute hospital services is also a priority and additional capital funding has been invested in this area, although firm commitments in terms of targets and time-lines are not given. The National Treatment Purchase Fund, which aims to treat patients who have been longest on in-patient waiting lists, has been further expanded with a budget of €100m in 2008, from €5m in 2002. In relation to PHC, there is an overall commitment for 500 primary care teams by 2011. Progress is, however, slow and only 87 teams have been set up, although funding for additional teams in 2008 has been provided. The overall target is being reviewed in 2008.

5.1.3. Quality

The development of PHC, with access to services in the community, is one of the main measures envisaged to improve quality. Other planned developments include a policy framework for the management of chronic disease, a cancer control strategy, the continued development of mental health services, and a pre-hospital emergency care council.
In order to better inform the public, a health information strategy continues to be implemented while a Health Information Bill is also being drafted. A strategy for service user involvement in the health service has also been launched, including goals and actions for ensuring that service user/provider partnership is established. A statutory complaints procedure and a 'whistle blowing' safeguard also protect patients' interests.
Finally, a Health Information and Quality Authority was established in 2007. The aim of this body is to promote the delivery of high-quality health and personal social services by setting and monitoring standards for service delivery and by undertaking special investigations on patient safety issues.

5.1.4. Sustainability

According to the OECD, total health expenditure per capita increased from $796 in 1990 to $3 082 in 2006, representing an increase from 6.1% of GDP to 7.5%. The EU Commission (ECFIN-EPC, 2006) has calculated public expenditure at 5.3% of GDP in 2004, below the EU average of 6.4%, and estimated that it would increase to 7.3% by 2050 (compared to an EU average of 7.9%).

The scale of recent increases in expenditure on the health sector will be difficult to sustain, particularly in current economic conditions and given the improvements in services the government has committed to, not to mention the long-term issue of the ageing of the population. This was recognised by the Minister for Finance in a recent speech in parliament where he pledged to secure savings on health sector payroll, partly through the introduction of a voluntary early retirement scheme. It remains to be seen what effect this will have on costs in the future.

In relation to personnel issues, a significant development which could have a positive impact on efficiency was the agreement of a new employment contract with medical consultants which provides that a proportion of consultants will not have any fees from private practice while others who do engage in private practice are obliged to have at least 80% public patients.

5.2. Long-term care

5.2.1 Description of the system

The long-term care system in Ireland includes, alongside primary and hospital care: home nursing, home help and care attendants, day centres, grants to adapt homes, therapy and rehabilitation, day hospitals, public residential care and private nursing homes. Access is based on need. Care in public facilities incurs a set charge while a means-tested grant is given to patients to pay for private nursing home care. Financial assistance for carers is available via the carer's benefit and carer's allowance schemes and the respite care grant. Care in the community is the authorities' preferred option with the aim of allowing people remain at home in accordance with their wishes. Healthy ageing (promotion and prevention at older ages) is also a stated aim. The ageing of the population and its effects on sustainability is considered one of the biggest challenges facing the Irish system.

5.2.2. *Accessibility*

Ireland is addressing the accessibility and affordability of long-term care through the *Fair Deal* initiative. Under this system, where a person is diagnosed as being in need of long-term care, an assessment will be made of their ability to contribute to the cost of that care and the state will meet the remainder of the cost. This personal contribution will be no more than 80% of their disposable income but may also include 5% of their assets, including up to 15% of the value of a private residence. A choice can be made between any approved private or public nursing home. The legislation for this scheme was published in October 2008 and is expected to be implemented in 2009. Geographical disparities in the supply of long-term care are reported outside the NSR.

5.2.3 *Quality*

The improvement of home care packages, including the services of nurses and therapists, is mentioned in the report although it appears that no additional funding has been provided in this area for 2009 and no details are given on the availability or coverage of such packages. The implementation of draft standards for all public and private nursing homes will begin following their consideration by the Department of Health and Children.

5.2.4 *Long-term sustainability*

The report offers no analysis of the costs of long term care although it does acknowledge that the financial model to support any new arrangements must be financially sustainable and that further data collection and evaluation is required. The Department has committed to progressing this work later in 2008. The EU Commission (ECFIN-EPC, 2006) has estimated that the cost of providing long-term care will increase from 0.6% of GDP in 2004 to 1.2% in 2050.

6. CHALLENGES AHEAD

- To continue to invest in services in tandem with welfare reforms in order to address inequalities and further reduce the risk of poverty, especially for disadvantaged groups. Continued priority should be placed on childcare, especially in relation to affordability, including for those in employment.

- To continue to address the high risk of poverty and low employment rates of certain disadvantaged groups through targeted activation and training measures as well as though tax and welfare policies that encourage such groups to take up employment.

- Given the recent rise in those claiming unemployment benefits, to monitor the adequacy of the welfare system in meeting the income support needs of this group and ensure personalised responses and timely transfer to appropriate active labour market programmes.

- To quickly adopt a pensions framework policy which will ensure pension security, adequacy and sustainability, taking account of the impact the current economic downturn is having on private pension provision.

- To make progress on tackling issues of financial and geographical access to health care, in particular through the full implementation of the planned primary health strategy and home care packages on a nationwide basis, and also in relation to the rationalisation of medical card eligibility.

- To address the sustainability of the health care system through a more efficient use of resources in general and in tackling persistent health inequalities.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**
2000	9,2	131,0
2005	6,4	144,1
2008f	-2,0	140,1

Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64
2000	65,2	76,3	53,9	48,1	45,1
2005	67,6	76,9	58,3	48,7	51,6
2007	69,1	77,4	60,6	49,9	53,8

Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	4,3	4,3	4,2	6,8
2005	4,3	4,6	4,0	8,6
2007	4,6	5,0	4,2	9,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2005 instead of 2006)		Infant mortality rate
	Male	Female	Male	Female	Male	Female	
1995	72,8	78,3	13,5	17,2	63,2	n.a.	6,4
2000	74,0	79,2	14,6	18,0	63,3	66,9	6,2
2006	77,3	82,1	16,8	20,2	63.3b	65b	3,7

WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	6,7	71,9	13,5		-
2000	6,3	73,5	10,9	2005	2,0
2006	7,5	78,3	12,4	2006	1,9

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	18,8	26,5	36,2	15,3	12,0	5,2	4,8
2000	13,9	25,4	41,4	9,6	13,7	4,5	5,3
2006	18,2	27,4	41,1	7,6	14,7	3,8	5,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
2005	16,3	15,5	4,7	5,3	0,6
2010	16,7	-0,1	0,5	0,2	0,0
2030	24,6	3,3	3,1	1,1	0,1
2050	40,4	7,8	6,4	2,0	0,6

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20
Total	18	19	15	29	18	19	20	10	**4,8**
male	16	-	14	24	18	-	20	10	-
femal	19	-	16	33	17	-	20	10	-

Anchored at-risk of poverty	Total - fixed 2005 threshold
2005	20
2006	
2007	12

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	10,4	8,8	7,4	10,2
2004	11,8	8,6	7,2	10,1
2007	11,5	7,9	6,7	9,3

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	1,6	2	1
2004	1,6	2	1
2007	1,4	1,8	0,9

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	N/A		
2004	12,9	16,1	9,7
2007	11,5	14,2	8,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female
Relative income of 65+	0,69		

SILC 2007	Total	Male	Female
Aggregate replacement ratio	0,47	0,41	0,53

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-11	-10	-2	DB	-9	DC	100	55	9,5	10-15	6,4

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Greece

1. SITUATION AND KEY TRENDS

Real GDP growth was high (over 4% on average between 2001 and 2007), outstripping the EU-27 average (2.1% between 2001 and 2007). Sustained economic growth is reflected in GDP per capita expressed in purchasing power standards (PPS), which steadily improved to 97.2% of the EU average in 2008). The employment rate is rising, especially for women, but is still below the EU average at 61.4% in 2007 (EU-27: 65.4%), and exceptionally low for young people and for women (47.9% in 2007, EU-27: 58.3%).

The unemployment rate in Greece (8.3% in 2007) remains higher than that for the EU-27 as a whole. The latest data for 2008 show a further decrease in unemployment stemming mainly from a decrease in the unemployment rate for women (from 12.8% in 2007 to 10.9% in the second trimester 2008). Unemployment continues to affect mainly young people and women, together with vulnerable population groups (e.g. people with disabilities). The long-term unemployment remains high, at 4.1% in 2007 (EU-27: 3.1%) with a significant gender imbalance: 2.2% for men, 7.0% for women (EU-27:3.3). As a result of the global financial crisis, there is an indication of a potential increase of the unemployment rate for 2009. Economic activity, primarily in the tourism sector, is expected to slow down due to lower external demand.

Social protection expenditure stood at 23.6% of GDP in 2006, below the EU average. The share of social protection expenditure not spent on pensions continued to increase in 2008, to 17.9% of GDP from 17.3% in 2007; the Government's aim is to reach 18.4% by 2010. The at-risk-of-poverty rate remains high, at 20% against the EU average of 16% in 2007, and affects men and women proportionally. The risk of poverty for older people (aged 65 and over), although declining, is still high (23% in 2007 as against 28% in 2005; EU-27: 16% in 2007). In 2007, 7.9% of poor people lacked access to health care. The child poverty rate stood at 23% in Greece in 2007 (EU-27: 19%).

Foreign nationals (outside EU-27) are less hit by unemployment (7.5% compared to a total unemployment rate of 8.3% in 2007) but they are affected by a greater risk of poverty linked to undeclared and uninsured work.

2. OVERALL STRATEGIC APPROACH

In recent years, efforts have been made to improve the social protection system and specifically to respond to the needs of vulnerable social groups at risk of social exclusion and poverty. The NSR for 2008–2010 follows the rationale of the 2006–2008 NSR, and takes into consideration the input on social inclusion, on pensions, and on health and long-term care. It identifies three strategic directions: (1) reinforcement of policy coordination, implementation, monitoring and evaluation, and of participation by interested parties, (2) ensuring a decent socioeconomic living standard for vulnerable groups through: (a) upgrading their skills and integrating them into the labour market and (b) providing income and other support, and (3) ensuring high-quality social services for all, especially by modernising education, health, social security and welfare systems.

The strategic approach and the key challenges identified appear to go in the right direction. However, implementation needs to be accelerated. Efforts are being made to tackle social cohesion, e.g. by improving the functioning of the National Social Cohesion Fund to reduce poverty. ESF co-financing will be sought for many of the proposed interventions. Administrative and governance measures may improve the sustainability of the pension system but improving its fairness remains a challenge.

Health and long-term care systems are in need of greater attention, especially to quality assurance, rationalisation of spending (tackling the lack of coordination of both public and private providers) and ongoing assessment of services and needs.

3. SOCIAL INCLUSION

3.1. Key trends

Efforts to improve and extend the social protection system are evident but almost half of social expenditure is devoted to old age and survivors' pensions. The impact of social transfers on reducing the risk of poverty in Greece remains one of the lowest in the EU: this is one of the main challenges of the social protection system. In 2006, the impact of social transfers (excluding pensions) on reducing the at-risk-of-poverty rate in Greece was 2.0 percentage points (23.6% before social transfers (other than pensions) and 21% after social transfers), against an impact of 10 percentage points EU-wide (26% before and 16% after social transfers). The at-risk-of-poverty rate remains high (20% in 2007 against 16% for the EU-27). The percentage of jobless households remains low and is decreasing slightly, whereas in-work poverty is very high (14%), much higher than the EU-25 average (8% in 2006). Moreover, the child poverty rate stood at 23% (EU-27: 19%). Furthermore, in 2006, 7.9% of poor people in Greece (6.2% for the EU-25) were unable to access health care due to financial difficulties.

The proportion of people with low educational attainment, in 2007, was 24.8% among 25–34-year-olds (EU-27: 20.7%), but the gap was much higher for the 65+ population (81-.9%, EU-27: 63.8%). The percentage of low-achieving 15-year-olds in reading literacy was one of the highest in the EU, at 27.7% (2006) against 19.8% (2003). The rate of early school-leavers in Greece is slightly above the EU average, at 14.7% in 2007. Lifelong learning participation is one of the lowest in the EU and is progressing slowly.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Overall, Greece has made progress in social inclusion. The latest report states that 'the progress achieved is obvious in many respects, though some of the challenges remain'. The report gives the number of beneficiaries and the number of structures set up under the various measures and programmes, but no indication as to whether the participants ultimately found a job or whether the work of supportive social welfare structures facilitated the transition to employment for vulnerable groups.

Analytical references are made to a number of challenges which must be further addressed (i.e. strengthening employment, decreasing the high poverty rates of the working poor, older unemployed people, one-parent families and children, increasing access for people with disabilities and the social inclusion of immigrants, etc.). Although these challenges are dealt with under the corresponding policy priorities, no specific quantified targets are set for them in the Report, with the exception of objectives set for increasing women's employment, decreasing the poverty and child poverty rates and decreasing the school drop-out rate.

3.3. Key challenges and priorities

The recently (2008) established National Social Cohesion Fund is the most important policy initiative on poverty and social inclusion in Greece. The Fund aims to provide monetary support to the most vulnerable groups to reduce poverty considerably in the next five years. No major initiatives such as 'make work pay' or 'welfare to work' policies or 'minimum income guaranteed' schemes have been introduced.
The report identifies four priorities: (i) increasing employment and the attractiveness of work, especially for women, young people, the long-term unemployed and vulnerable groups; (ii) tackling the disadvantaged position of certain people and groups with regard to education and training; (iii) reinforcing the family with emphasis on the wellbeing of children and support for the elderly; and (iv) promoting the social inclusion of people with disabilities, immigrants, and people or groups who are socially vulnerable owing to their cultural characteristics. Although the priorities point in the right direction, further efforts are needed to make existing policies more efficient. The Report recognises the need to fill the knowledge gaps as regards statistical and administrative data for those groups. Some newly established institutions are expected to fill some of these gaps.

3.4. Policy measures

Policy interventions are similar to those that have been implemented in recent years, such as: upgrading Public Employment Services (to transform the OAED's services into one-stop-shops); targeted active labour market policies for women, young people, vulnerable groups and older people (active ageing); and equality between the sexes / combating discrimination. Evaluations and impact assessments of the action taken are not yet available. The main challenges under the priority 'Strengthening employment especially for women, young people, long-term unemployed and vulnerable groups' have been identified, but new interventions that would improve efficiency are not evident. The quantitative objectives of these policies are to increase the total employment rate from 61.4% (2007) to 64.1% by 2010 and to 65% by 2013, the women's employment rate from 47.9% (2007) to 52% by 2013, the participation rate of registered unemployed persons aged 15–24 in active labour market measures to 100% by 2013, the percentage of long-term unemployed people participating in active labour market measures to 25% by 2013, and the percentage of vulnerable groups benefiting from active labour market measures from 9% in 2006 to 15% in 2013.

Progress on education and training has accelerated and specific measures are being introduced to deal with illiteracy, lifelong learning participation and school failure. Public investment in education and training is one of the lowest in the EU. The outlook for 2009 is 3.069% and the national target (set in 2004) of 5% by 2008 has now been put back to 2013. The target of reducing early school-leaving to 10% by 2010 (from 14.7% in 2007) has also been put back, to 2013. The number of 'all-day' schools is falling and appears to be insufficient.

Reinforcing the family, with emphasis on the wellbeing of children and support for the elderly, is also a priority. The report recognises the high inactivity rates among people of working age, which partly suggest both that work is particularly unattractive and that the inactive have a particularly low capacity for work. Yet very few activation measures are proposed to facilitate their return to the labour market; greater efforts could be made. Regarding services to children and families in difficulty, no new interventions are planned. Most of the actions envisaged are a continuation of existing measures such as employment projects, psycho-social support, income support, childcare services and the programme 'help at home' for elderly people, co-financed by the ESF, to reconcile family responsibilities with the working life. Formal childcare provision for children aged 0-3 is very low and far off the Barcelona target (7%; EU target: 33%). There is an urgent need to increase provision and raise the quality of early childhood education and care.

Promoting the social inclusion of people with disabilities, immigrants, and people and groups who are socially vulnerable owing to their cultural and other characteristics is the fourth priority covered by the report. The interventions planned are based on a combination of new measures especially to promote integrated policies, together with existing measures such as integrated programmes for Roma people and for immigrants (e.g. the 'ESTIA' programme) and action to support health and social solidarity services. More efforts are needed to introduce targeted measures such as strengthening administrative capacity, raising awareness of immigration issues, certifying the educational and professional qualifications of immigrants, and providing support services to help them benefit more from participation in socioeconomic life.

Despite the continuation of existing activities, in-depth evaluations are needed to review and re-adjust some of the interventions to meet the specific needs of each sub-group and tie in with the different socioeconomic policies.

3.5. Governance

Consultation on the draft report was not based on structured involvement and participation by the various stakeholders, particularly regional and local.

Their involvement over the full policy cycle continues to remain limited.

Monitoring and evaluation mechanisms and arrangements are urgently needed. The report refers to the setting up of the National Council for Social Protection (NCSP), which is a positive step but is still pending.

4. PENSIONS

4.1. Key trends

The Greek pension system is a 'pay-as-you-go' system, although funds are allowed to keep existing surpluses, with pensions provided by a number of funds, which have the status of public bodies and form part of the Greek public sector. The system is highly fragmented and, as a result, the various benefit schemes provided for different occupational categories differ, not only across the funds but often within the funds. Some of the existing funds are primary funds that provide the main pension, and some are supplementary, lump-sum and provident funds. Most primary funds provide health cover in addition to pensions and some funds provide additional benefits such as family benefits. Older workers are insured by at least one primary fund but usually have supplementary coverage (which may be provided by another

fund), while new workers only have one fund. Some workers contribute towards a lump-sum separation payment at the time of retirement. Civil service pensions are paid directly out of the national budget, while many public enterprises and banks have enterprise-specific funds. A second tier consists of occupation-based auxiliary funds which provide supplementary pensions. The primary pension funds typically provide a replacement rate of between 70% and 80%, while the supplementary funds provide a replacement rate of 20%. Thus, the total replacement rate is usually 90% for 35 years of insurance. This is often not the norm, however, as several primary and supplementary pension funds provide more generous benefits.

The statutory retirement age is 65, but some funds are still in the process of adjusting upwards to this standard. As regards contributions, the standard contribution rates for those insured after 1992, for a primary pension, are 6.67% for the employee, 13.3% for the employer and for those insured after 1992, and 10% for the government. Farmers contribute 7% to OGA, which receives an additional 14% from the government. The standard rates for supplementary pensions are 3% for the employee and 3% for the employer. Lump-sum separation benefits are financed exclusively by employees. Some funds (especially those for public enterprises and bank employees) have set higher contribution rates, as have those for workers in heavy and unhealthy professions that typically allow earlier retirement.

In 1996, a means-tested supplementary pension scheme (EKAS) was introduced for those with very low benefits. In 2004, the calculation of pensions stemming from contributions paid to multiple funds was made uniform. Stricter rules were also imposed for civil servants' pensions. Replacement rates were gradually lowered from 80 to 70%, the retirement age for women was increased to 65, and the calculation of benefits shifted from the final salary to the average of the last five years. Finally, in 2008, a new law adjusted the statutory retirement age upwards for certain groups and merged the existing 175 funds to just 13.

'Second-pillar' schemes (occupational pensions) are small in Greece and were prohibited until recently. The Pension Act of 2002 introduced some favourable arrangements for occupational pensions, including exempting contributions from taxable income, and in 2005 three occupational pension schemes for small professional groups were allowed to operate. In order to supervise the occupational pension funds, two bodies have been set up: the Occupational Insurance Division of the Ministry of Employment and Social Protection and the National Actuarial Authority. There is currently no legal provision for voluntary savings via private pension (third-pillar) schemes, although the Monitoring Service for Private Insurance has been funded.

The relative median income ratio for people aged 65 and over relative to the income of the age group 0–65 was 83% in 2007, compared to 79% in 2005. The recent Law 3655 of April 2008 on 'Managerial and Organisational Reform of the System of Social Security' unifies the different funds (primary and supplementary), equalises retirement ages for some insurance funds and introduces limits on early retirement. The new law also aims to improve maternity provision and combat undeclared work and evasion of social security contributions. It provides for a new intergenerational solidarity fund (AKAGE), to be used after 2019 to strengthen the viability of the pension system. Finally, issuing a social security identification number (AMKA) to each insured person, to be used for all transactions with the social security system (employment, health, income transfers), as of 1 June 2009, will contribute to the viability of the system by simplifying administrative procedures and cutting overheads.

4.2. Key challenges and priorities

The main challenges identified in the 2007 Joint Report relate to the sustainability of the pension system and to overcoming its fragmentation. Raising employment rates, especially for women and older workers, and curbing contribution evasion were highlighted as key priorities. Some progress has been made in addressing these challenges but efforts should continue at a faster pace. The 2008 Law is a step in the right direction, i.e. equalising conditions for all employees, but further progress is needed to reduce the variation in replacement rates across funds. The gross replacement rate calculated according to the ISG methodology for Greece in 2006 was 105 (115 for the net replacement rate). The rate is expected to fall by 12 percentage points between 2006 and 2046 (compared to a fall of 7 p.p. for the net replacement rate). This figure hides the great variation in outcomes for different funds and different contributory histories. The net replacement rates must become more uniform for similar careers across all socio-occupational groups.

It will be necessary to monitor progress on institutional changes regarding sustainability. The pension expenditure rate as a percentage of GDP (ESPROS, Eurostat data) in 2006 was 11.9% (EU-27: 11.9%). According to projections, pension expenditure is expected to double to 24.8% of GDP by 2050. Hence more efforts are necessary: in particular it is necessary to improve incentives to work longer and to contribute to social protection throughout one's career, by tightening the link between contributions and benefits and tightening eligibility criteria for early retirement.

4.3. More people in work and working longer

The national standard age of retirement is 65 for men and 60 for women, raised to 65 for women entering the labour force as of 1993, and at this age requiring a minimum of 15 years of contributions. Workers with a contribution record of 37 years can retire on full benefit regardless of age. There are more favourable provisions for people who work in heavy or unhealthy occupations and for parents with dependent or disabled children. The minimum pension requires 15 years of contributions. For people working after age 65 and up to 68, there is a higher accrual of 3.3% per year. Working mothers (insured by IKA) can benefit from an additional six-month maternity leave. Seniority (including non-contributory periods) at retirement for new flows of retirees in 2006 was 25.1 years (27.5 years for men and 20.8 years for women), very low in comparison with other countries.

The employment rate for older workers (aged 55 to 64) is comparatively low (42.4% in 2007), with no clear signs of a strong upward trend despite high economic growth; the employment rate of women aged 55-64 is remarkably low, at 26.9% (EU-27:36%). In 2005, the median effective age of retirement was 61.7 years for men and 58.4 for women.

Recent legislation has attempted to limit the special provisions that allow early retirement before the 'normal' retirement age of 65. Active measures in place as regards ageing include a range of lifelong learning programmes addressed to old-aged workers, subsidies to firms as an incentive to hire male unemployed workers aged 50 years and over (and special programmes for female unemployed workers aged 45 years and over), and earmarked subsidies to firms for hiring unemployed people close to retirement.

4.4. Privately managed pension provision

There are currently five occupational funds operating in Greece, and two more are being set up. No reference is made to private schemes. The percentage of the working population contributing to a personal pension is very low, less than 2%. Voluntary (third-pillar) pensions are mostly provided by the life insurance industry. In life insurance schemes, lump sums are preferred to annuity benefits. In Greece, total premiums added up to 2.14% of GDP in 1999, slightly less in the two years to follow, but then rose, to 2.17% in 2005 (the EU-25 average stood at 8.5% in 2005). Rapid expansion of the life insurance industry has been observed lately.

4.5. Minimum income provision for older people

The elderly (aged 65 and over) face a higher at-risk-of-poverty rate (23% in 2007, EU-27: 19%). Uninsured elderly persons receive pensions from the OGA, but several studies stress the inadequacy of minimum pension benefits, given the high rate of poverty among pensioners and particularly among single elderly women. However, no measure is mentioned in the NSR to address this problem.

4.6. Information and transparency

An IKA pilot project to inform people about insured time covered and contributions paid, in operation since May 2007, could prove a good means of promoting information services. There are no surveys or other sources measuring knowledge/competency with regard to income security in old age (nor is there any information on differences broken down by gender, age, or educational level). The NSR does not refer to any tools for monitoring and analyzing pension developments. As to the involvement of main stakeholders in decision-making, the NSR states that a social dialogue and public consultations with all relevant bodies (mainly political parties and social partners) preceded recent legal developments.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Greek healthcare system is based on the coexistence of the National Health Service (NHS), a compulsory social health insurance, and voluntary private health insurance schemes. Universal coverage of the population is provided by the NHS and a variety of social insurance funds. Primary health care (PHC) is delivered through PHC centres and hospital ambulatory (outpatient) services, secondary and tertiary care in general and specialised hospitals. Major developments from the previous period are: the reduction in the number of Regional Management Health Care Agencies (from 17 to 7); new legislation (Law 3457/2006) on pharmaceuticals, focusing primarily on the use of IT to monitor and coordinate pharmaceuticals consumption and expenditure across the 30 health insurance funds, secondary and tertiary healthcare units; and the enactment of Law 3580 of 2007 on procurement by healthcare units. The public private partnerships (SDIT) for building health and social care units are expected to boost local employment.

PHC is a priority co-financed by the structural funds. The development of an integrated information system for the national healthcare system may contribute to improving access to the system for all socioeconomic groups. Not enough health outcomes indicators are provided. In recent decades, life expectancy at birth has risen, to 77.2 years for men and 81.9 for women

in 2006, which is above the EU-27 average (72.2 for men and 81.9 for women). Concerning inequality, the NSR does not provide data on gender, occupation/working conditions, housing or living conditions.

5.1.2. Accessibility

Access for all and non-discrimination is guaranteed by law but accessibility problems remain, due to geographical disparities and variations in coverage by the social insurance funds and other sources. A mixed system of service delivery by public and private providers characterises both primary and secondary health care. According to household expenditure data, private expenditure in the form of out-of-pocket payments is substantial and has expanded fast. The unmet needs data (unmet needs and self-reported health needs) are a continuous problem. Expenditure on health has increased rapidly over the last two decades: from 5.7% of total household expenditure in 1993/94 to 7.2% in 2004/05 (of this, two thirds concerns direct payments to physicians and the rest drugs expenditure, including co-payments, and hospital care; data from the National Statistical Service). The multiplicity of funding also accounts for the lack of coordination of purchasing policies and system inefficiencies. No reference is made to how the pension reform will affect health insurance.

The NHS is still characterised by inequalities owing to the oversupply of specialists (but undersupply of nurses) mostly concentrated in the large urban centres and by significant direct costs faced by patients in the private sector and in the NHS (under the table payments) Furthermore, there are still waiting lists in public hospitals particularly in urban areas. Regarding health and women, there is no reference to specific measures incorporating a gender dimension or promoting women's health.

5.1.3. Quality

Reference is made to the Health and Welfare Inspectorate in charge of carrying out periodic inspections of health and care units (the emphasis is primarily on physical amenities and operational aspects). These inspections do not assess the outcome of treatment and interventions and a national framework for assessing the efficiency and effectiveness of medical care is needed. There is no national service regulation laying down the performance standards required across sectors (which could also provide a basis for uniform costing of services and provider reimbursement). Given the fragmented character of the NHS, there is discontinuity between ambulatory and secondary care, with defective information transfer and poor medical records. Care coordination remains a problem owing to the lack of national regulations.

The need to upgrade quality by means of accreditation procedures, standardisation, and evaluation procedures is noted in the report and will be part of future planning. A draft bill dealing with quality issues is under preparation but there is no indication of plans/targets or timelines for implementing and devising on uniform quality assessment and improvement mechanisms.

5.1.4. Sustainability

Total health expenditure as a percentage of GDP (9.1% in 2006[120]) is above the EU average[121], while expenditure has stabilised recently. The public share of total health expenditure was 61.6% in 2006, coming from the state budget and social security. The remaining 36.4% of total health expenditure comes from private payments. Private expenditure appears very high and indicates access and service use inequalities. Despite increased total health expenditure, health status indicators have not improved. Modernisation efforts emphasise efficient ICT use, education, and measures promoting electronic government but, without appropriate monitoring of the implementation and evaluation of these plans, there is a risk of overspending and developing some services (private) more than others (public) with potentially difficult consequences for accessibility, due to the lack of effective monitoring/evaluation and a needs-based resource allocation without uniform standards for that allocation. Reference is made in the NSR to recent legislation on procurement to improve the sustainability of the system but documentation regarding expected impacts on expenditure is lacking. Care coordination remains a problem for the sustainability of the system with adverse consequences for vulnerable group accessibility, because of comparatively high private expenditure borne disproportionately by the poor.

5.2. Long-term care

5.2.1. Description of the system

The LTC system is mixed, including direct social service provisions, care needs coverage through insurance funds, tax exemptions and indirect care provision. LTC services include rehabilitation, social care, 'Care at Home', and occupational and empowerment activities managed by public and private institutions. Programmes co-financed by the Structural Funds such as 'all-day' schools, counselling, education and training for the disabled and 'care at home' for the elderly will continue in order to allow working women with dependent family members to adequately cover their working hours. The national strategy aims to improve the 'social' model in place of the 'clinical' model, e.g. deinstitutionalisation of mental patients, mainly developed at local level, and to improve the effectiveness of health and LTC systems by extending the scope of PHC. Improvement of coordination between the systems is needed.

5.2.2. Accessibility

The general aim is to favour care at home for the elderly and contribute to reconciling family life and work for women. Service providers are concentrated in urban centres. Increasing demand for care services, due to changing family patterns and growing female employment rates, combined with demographic ageing and a steadily increasing number of single elderly people, is met by female migrant labour (either as co-residing or day-care minders. The NSR does not provide data on differences in access to care by gender, age, health status, ethnic minorities and geographical location in relation to population needs. It is problematic that increased funds are being allocated without a rational needs assessment. On the coordination of care services with medical and rehabilitation services, the Report states that further development of specialised centres (for disabled and elderly people and other vulnerable groups) will be co-funded by the EU.

[120] OECD Health Data 2008 — Version: June 2008.
[121] EU average of 8.87% and PPP$2376.33 per capita in 2004.

5.2.3. Quality

The Report mentions the development of a 'Quality Charter for Social Services' by the Ministry of Health and Social Solidarity. The aim is to develop methodologies and tools for the evaluation of services, pooling information and promoting coordination. As in the case of health care, reference to quality issues is linked to the operation of the Health and Welfare Inspectorate and to accreditation of non-profit institutions providing long-term care services by the Social Protection and Solidarity Institute supervised by the Ministry. The legislative framework for the accreditation and evaluation of NGOs and voluntary organisations providing LTC is in place. Implementation gaps and insufficient LTC health professionals (rural areas) are a challenge to uniform provision and to the quality of services. Cost-effectiveness assessment or needs assessment by users of the services is needed. Accreditation and procurement are important; however, uniform quality assessment and performance assessment of the new centres and old institutions are needed but are not referred to in the NSRs.

5.2.4. Long-term sustainability

It is difficult to assess total LTC expenditure because of the multiplicity of providers and forms of provision. A large part of LTC is informal and family-provided, and hence hard to assess in cost terms. The mixed financing system of formal long-term care is further complicated by differences in the financing rates, which vary according to the type of care and the provider's legal status. Cost-controlling mechanisms are weak and there is no comprehensive framework for cost evaluation (based on either needs assessment or demographic projections). Coordination between medical and care services, and the many factors involved in measuring quality in social care is lacking. The NSR expresses the intention of the relevant authorities to use all available national, EU and other international resources efficiently in order to meet demand. In addition, an increase in employment of carers, an assessment of the resources made available and the promotion of public-private partnerships (SDIT) is expected to contribute to the improvement and expansion of new care units.

6. CHALLENGES AHEAD

- To promote an active inclusion approach combining active employment measures and the promotion of quality jobs, adequate income support and access to services for all citizens and especially for vulnerable groups. To take concerted action to combat child poverty and promote the wellbeing of children;

- To improve governance, to promote the mobilisation and full participation of all relevant stakeholders, and to increase the effectiveness and efficiency of social expenditure by establishing concrete mechanisms and procedures for overall coordination, monitoring and evaluation of the social policy initiatives under implementation and for impact evaluation and strategic future planning;

- To increase action to tackle poverty among the elderly, and, in particular, meet the need for a uniform safety net against poverty in old age (a safety-net pension based on income and other relevant criteria so as not to create distortions against working at older ages). The National Cohesion Solidarity Fund should take immediate effect to address poverty;

- To address the sustainability of the overall pension system, by continuing to harmonise the conditions across different pension funds, improve administrative efficiency and

governance, and tighten the link between contributions and benefits. To address the adequacy of income for all current pensioners;

- To improve the cost-efficiency and quality of health services, to ensure coordination between care levels and funding arrangements, to establish an effective monitoring and regulation mechanism in the public and private sectors, and to effectively reduce inequalities in access;

- To enhance the provision of long-term care services and to establish mechanisms (uniform quality standards and performance-management tools) for evaluating the quality of the services provided in both the public and private sectors.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	*Employment rate (% of 15-64 population)* 15-64 Total	Male	Female	15-24	55-64	Eurostat	*Unemployment rate (% of labour force)* 15+ Total	Male	Female	15-24
2000	4,5	84,1	**2000**	56,5	71,5	41,7	27,6	39,0	**2000**	11,2	7,4	17,1	29,1
2005	2,9	92,8	**2005**	60,1	74,2	46,1	25,0	41,6	**2005**	9,8	6,1	15,3	26
2008*f*	2,9	94,1	**2007**	61,4	74,9	47,9	-	42,4	**2007**	8,3	5,2	12,8	22,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	*Life expectancy at birth* Male	Female	*Life expectancy at 65* Male	Female	*Healthy life expectancy at birth* Male	Female	*Infant mortality rate (2007 instead of 2006)*	WHO - OECD	*Total health exp %GDP*	*Public health Exp % of THE**	*Out-of-pocket payments % of THE*	EU-SILC	*Unmet need for health care % of pop*
1995	75,0	80,1	15,9	18,2	65,8	69,2	8,1	**1995**	8,6	52,0	n.a.		-
2000	75,5	80,6	16,1	18,4	66,3	66,9	5,9	**2000**	7,8	60,9	37,2	**2005**	4,6
2006	77,2	81,9	17,5	19,4	66.3b	67.9b	3,7	**2006**	9,1	61,6	35.4**	**2006**	5,8

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	*Total expenditure * (% of GDP)*	*Old age and survivors*	*Sickness and health care*	*Unemploy ment*	*Family and children*	*Housing and social exclusion*	*Disability*
1995	19,9	52,1	26,0	4,5	8,8	3,8	4,8
2000	23,5	49,7	26,5	6,2	7,4	5,4	4,8
2006	24,2	51,3	28,7	4,6	6,2	4,5	4,7

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	*(2008) Old age depende ncy ratio Eurostat*	*Expenditure (% of GDP) Level in **2004** and changes* Total social expend.	*Public pension s*	*Health care*	*Long-term care*
2004	27,8	8,9	5,1	5,1	n.a.
2010	28,2	-0,2	n.a.	0,3	n.a.
2030	38,5	0,2	0,8	0,8	n.a.
2050	57,0	1,3	1,7	1,7	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	***At-risk-of-poverty rate*** Total	Children 0-17	18-64	65+	***Poverty risk gap*** Total	Children 0-17	18-64	65+	***Income inequalities*** S80/S20	***Anchored at-risk of poverty***	Total - fixed 2005 threshold
Total	20	23	19	23	26p	29p	26p	24p	**6p**	**2005**	20
male	20	-	18	21	26p	-	25p	24p	-	**2006**	20
femal	21	-	19	25	26p	-	26p	24p	-	**2007**	20

	People living in jobless households Children Total	% of people aged 18-59* Total	Male	Female
2001	5,3	8,8	6,4	11,2
2004	4,5	8,5	6,2	10,7
2007	3,9	8	6	10

	Long Term unemployment rate % of people aged 15-64 Total	Male	Female
2000	6,2	3,6	10,2
2004	5,6	3	9,4
2007	4,1	2,2	7

	Early school-leavers % of people aged 18-24 Total	Male	Female
2000	18,2	22,9	13,6
2004	14,9	18,3	11,6
2007	14,7	18,6	10,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,83	0,88	0,83	***Aggregate replacement ratio***	0,4	0,46	0,42

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046) *Net* Total	*Gross replacement rate* Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	*Assumptions* Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-7	-12	-12	DB	/		NA	/	20	/	

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Spain

1. Situation and key trends

Economic growth has been very dynamic in Spain in recent years, reaching an average GDP growth of 3.7% in 2007 (EU25: 2.9%). However, as a consequence of the global financial turmoil, economic growth rapidly decelerated in 2008 (to 1.2%) and it is projected to contract by 2% in 2009.[122] The low growth in productivity hampers the competitiveness of the economy. Employment prospects reflect the economic and financial situation in general. While in 2007 activity and employment continued to rise, at 71.6% (EU: 70.5%) and 65.6% (EU: 65.4%) respectively, job creation is expected to decline sharply from +3% in 2007 to -0.7% in 2008 and -3.9 in 2009. The previous downward trend in unemployment is also changing rapidly, due to rise from 8.3% in 2007 (EU: 7.1%) to 11.3% in 2008, 16.1% in 2009 and 18.7% in 2010.[123] The long-term unemployment rate of 1.7%[124] in 2007 remains one of the EU's lowest (average is 3.0%). Spain faces very high labour market segmentation as the proportion of fixed-term contracts is twice the EU average (31.7% in 2007, EU average: 14.5%).

Despite the economic growth in recent years, the number of people below the at-risk-of-poverty threshold has remained practically unaltered, (20% in 2007[125], EU average: 16%). Children (24%) and the elderly (28%, 30% of older women) are particularly at risk. Inequality of income is above the EU average (S80/S20 ratio: 5.3 in 2006, EU25: 4.8) and the percentage of working poor was 11% in 2007 (EU: 8%).

The population continues to grow, mainly as a result of migratory flows. In 2007, 15.1% of the population aged 15-64 had a foreign background, of which 4% were EU25 and 11.1% third country nationals. The population aged 15-64 with a foreign background have a higher employment rate (more than 69% for both groups, 65.6% for nationals), although they face a higher risk of job quality. Spain will have to deal with the effects of an ageing society (17% of a total population of more than 46 million is over 65). Although lower than in previous forecasts, the projections show a significant rise in the old-age dependency ratio (24.1% in 2008, 24.4% in 2010 and 58.7% in 2050. Life expectancy at birth remained among the EU's highest in 2006 (men: 77.7, women: 84.4).

Social expenditure as a percentage of GDP continues to be significantly below the EU average (20.9% in 2006[126], EU: 26.9%). Old age and survivor benefits accounted for 8.4% of GDP.[127] Spain has one of the highest rates of early school leavers in the EU (31.0% in 2007, EU average: 15.2%), with significant regional and gender differences.

2. Overall strategic approach

The Spanish SPSI Report builds on two premises: the validity of the challenges and priority objectives identified in the Report 2006-2008 and the need to update and reinforce them, while addressing emerging social needs (resulting from migration flows and an ageing population) to increase social progress, progressively reduce social inequality and prevent

[122] ECFIN Interim forecast, January 2009.
[123] ECFIN Interim forecast, January 2009
[124] 1.96% in 2007, according to national data (Spanish Labour Force Survey).
[125] 19.7% in 2007, according to national data (National Statistic Institute, Living Conditions Survey). To note that, for the first time in 2007, the data computes the ownership of the first residence, which throws significant differences in the at-risk-of-poverty rate for the elderly. .
[126] ESSPROS 2006
[127] ESSPROS 2006

social exclusion. There are clear links between the five NAPincl priority objectives and the strategies on pensions and health and long-term care, and the aim is to coordinate the social protection and social inclusion OMC and the National Reform Programme. The social and labour market objectives and policies are presented as interlinked and mutually reinforcing, combining measures to boost economic activity and employment and to address the needs of vulnerable groups, as well as to boost the equity and efficiency of public expenses. Particular attention is paid to the gender impact of the measures proposed.

The Report was adopted by the Council of Ministers. The drafting process was coordinated jointly by the Ministries of Education, Social Policy and Sport and of Labour and Migration, in close cooperation with the Ministry of Health and Consumer Affairs. The social partners and NGOs were closely involved in preparing the new NAPincl, which also benefited from improved coordination between the various tiers of public administration. The Report on Pensions was presented to the social partners, whose contributions will feed into the social dialogue process during the new negotiation phase of the 'Toledo Pact'.

The Spanish report includes a chapter, under the inclusion part, on the ESF contribution to the objectives of the NSR, through 19 regional and 3 national programmes to address obstacles to general participation in the labour market and social inclusion of the most disadvantaged groups.

In order to tackle the global economic crisis, the government has confirmed that the social policy budget planned for 2009 will be maintained. It also recently adopted a series of ad-hoc measures (not included in the NSR), including schemes to boost economic activity, support to families (e.g. scope to postpone mortgage payments for the unemployed under specific conditions) and support for employment and contracting (i.e. adoption of a temporary Guidance, vocational training and labour insertion Plan, bonuses to boost indefinite contracting of those unemployed with family responsibilities, the promotion of public employment in cooperation with local authorities and an increase in the budget to implement the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency).

3. SOCIAL INCLUSION

3.1. Key trends

One of the main consequences of the global economic and financial turmoil in Spain is the steadily rising unemployment rate, which is likely to seriously affect the proportion of unemployed persons in poverty (37% in 2007)[128] and the share of people living in jobless households (6,2% in 2007) in the months to come.

The general rate of people at risk of poverty remains high (in 2007, 24% before and 20%[129] after social transfers), despite the overall economic and labour market progress in recent years. The elderly (28%)[130] and children (24%) are particularly at risk. The indicators available show that child poverty results from a complex interaction between several factors, including work intensity (a relatively low rate of 5,3% of all children lived in jobless households in 2007, but 71% of these jobless households with dependent children were under the poverty threshold in 2007) and household structure (in 2007, 37% of households with

[128] Population: 16 years and over in unemployment

[129] 19.7% in 2007 according to national data (National Statistic Institute, Living Conditions Survey).

[130] To note that, for the first time in 2007, the data computes the ownership of the first residence, which throws significant differences in the at-risk-of-poverty rate for the elderly.

more than three dependent children were at the risk of poverty). In relation to education, progress has been achieved regarding childcare and the schooling rate, but Spain lags behind on student performance and retains a high early school leaving rate (31.0% in 2007, EU average: 15.2%). Public expenditure on education is lower than the EU average (4.23% of GDP in 2005, EU average: 5.04%).

The working poor accounted for 11% in 2007[131] (EU25: 8%). Definition of working poor is a combination of aspects related to household structure, job quality and unstable flow of income (note the high segmentation in the Spanish labour market, with a very high share of fixed-term contracts, particularly for women, young people, people with a migrant background and people with disabilities).

Societal aspects triggered by the shift in the age structure and by immigration flows are significant. Spain is one of the countries with the highest life expectancy, showing a clear link between the health status and the economic situation of individuals. Worth noting is the health status of specific groups, like the Roma population, who, despite the progress achieved in recent years, still suffer from health problems and chronic illnesses to a greater extent than the population average. The Roma[132] also face problems related to labour market integration and access to housing.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The 2006-2008 NSR identified five priority areas (still valid in the 2008-2010 Strategy), related to access to the labour market, improvement of minimum income, equity and quality of education, social inclusion of immigrants and assistance to persons in a situation of dependency). The Report includes information on the progress made in policy plans and measures regarding each priority, providing key data to support the progress achieved. However, an effective assessment of the impact of the measures and policy actions will take some time, due to the very broad scope of the priority areas.

In line with economic growth, progress in access to the labour market has been consistent in recent years. Implementation of measures such as the Agreement on Growth and Employment and the Law on Equality between Men and Women has specifically helped integrate women and vulnerable groups into the labour market.

The Report gives detailed information on the increase of the statutory minimum wage (paid to 0.73% of full-time employees in 2007) and minimum pensions. Currently at €600, the minimum wage corresponds to approximately 43% of average gross monthly earnings. An increase is expected to positively influence the low-wage trap. The NSR also describes a financial incentive designed to help integrate into the labour market potentially active persons in need.

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[131] Data for 2007, not yet available for all MS, show that the rate of working poor has increased to 11% in Spain.

[132] Non official data estimates the total Roma population in Spain between 650.000 and 700.000 people.

The Report also gives a detailed description of the increase in scholarships in 2007 and the progress concerning access to childcare and pre-schooling. The high early school leaving rate is partially addressed by implementing the Reinforcement, Counselling and Support Programmes, although the NRP target for 2010 (to reduce the rate from the current 31.0% to 15%) seems unattainable. However, some other factors are worth considering, such as the positive effect that rapidly rising unemployment will have on the school drop-out figures for economic reasons.

Implementation of the Strategic Plan for Citizenship and Integration 2007-2010 and the Fund for the Reception and Integration of Immigrants and their Educational Support is also described. It reports a slowdown on implementation of the Law on the promotion of personal autonomy and care for people in a situation of dependency, mainly due to institutional coordination problems. Specific support measures for vulnerable groups are worth noting, such as the National Plan for Awareness-Raising, the Prevention of Gender Violence (2007-2008) and the creation of the State Council of the Roma People.

3.3. Key challenges and priorities

The strategy aims to consolidate progress on social policy, ensuring continuity with the previous NAPincl. The selected priorities entail combining strategies to increase access to secure employment with enabling services and income support to minimise the risk of creating traps. Nevertheless, the objectives are very broad, and positive results will only stem from sustainable and sustained measures and a reinforced coordination between national and regional administrations.

The overall objectives are to: 1) enhance access to the labour market, taking into account the gender perspective, and focusing on potentially active vulnerable groups; 2) guarantee a minimum financial income for all citizens; 3) provide an education policy that makes equity part of access to and quality of the education system; 4) improve social inclusion of people with a migrant background and 5) guarantee equity for people in a situation of dependency.
The report includes an annex on the contribution of the 2007-2013 ESF strategy to social inclusion policy. It focuses in particular on the programme 'Fight against Discrimination', which aims to promote equal treatment, opportunities regarding social inclusion and labour market integration and create a national ESF Social Inclusion Network.

3.4. Policy measures

The report lists a comprehensive set of measures linked to the five overall objectives. Gender issues are also taken into account.

Implementation of the Law on Equality includes measures to promote employment for women (54.7%, EU average: 58.3% in 2007), with specific schemes for women over 45, and to foster the work/private life balance. A specific strategy addressing the integration of people with disabilities into the labour market (2008- 2012) is planned. Implementation of the new system of vocational training and training schemes for disadvantaged groups will continue.

Financial support measures are planned, such as the Active Income for Insertion Programme (designed to support labour market integration of those in financial need) as is a progressive increase in minimum pensions and the minimum inter-professional wage in real terms to increase purchasing power for the least qualified workers. Nevertheless, the effects of these measures could be overshadowed by the new economic situation.

The report describes targeted measures supporting infant education, boosting financial support to students, enhancing success at school at all levels and ages, developing special programmes for immigrant students, increasing the attractiveness of technical and vocational education and preventing early school leaving.

The Strategic Plan for Citizenship and Integration 2007-2010, approved in February 2007, includes twelve areas of action: reception, education, employment, housing, social services, health, infancy and youth, equal treatment, women, participation, raising awareness and co-development. Specific objectives and measures are being identified in each area. Support measures for local entities, public and non-profit organisations are also planned. In light of the new economic situation and rising unemployment, it is worth mentioning the recently established programme for voluntary return of migrants.

Schemes to provide care in rural areas, prevent situations of dependency, support training for family and professional carers, etc., linked to the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency, will be implemented. Measures to boost institutional coordination are also planned.

The NAPincl also includes specific measures designed to boost social inclusion and labour market access for vulnerable groups, such as the elderly, young people, the Roma, returned migrants, prisoners and ex-prisoners, etc.

3.5. Governance

Drafting of the NAPIncl was coordinated by the Ministry of Education, Social Policy and Sport. All stakeholders, including the Economic and Social Council, social partners and NGOs, (through the State Council for Social Action NGOs and the State Council for Roma) were actively involved, and coordination has been improved, both at horizontal level (ministries) and vertical level (regional and local authorities). The Plan was approved by the Council of Ministers.

4. PENSIONS

4.1. Key trends

The Spanish pension system relies on public earnings-related schemes (mandatory) financed by social contributions from workers (4.7% of earnings) and employers (23.6% of earnings). Pensions are calculated on the basis of revenue earned in the last 15 years before retirement and are adjusted annually in line with the consumer price index. Employees can extend their working career beyond the 65-year limit through, for example, part-time contracts or incentives to access retirement beyond 65. Early-retirement is possible from the age of 61 (60 under specific transitory provisions). The relative median income ratio of people aged over 65 in 2007 was 0.76 (EU: 0.82).

Private pension plans are voluntary and cover both individual and occupational pension funds. In 2006 nearly 9.8 million people were covered by private pension plans (8 million people covered by individual plans).

Since the previous full report, the system has continued to show a surplus of well over 1% of GDP, as a consequence of revenues increasing faster than expenditure. This has allowed additional allocations to be made to the Global Reserve Fund introduced in 1997 to deal with future projected financial strain (currently totalling €55.900 million, 5.32% of GDP).

The social security system was recently reformed through several legislative initiatives. Law 40/2007, which establishes longer minimum periods of contributions taking into account only the actual days of contribution, toughens the requirements for early retirement, applies effective controls to avoid fraud in incapacity protection, changes death and survival benefits and introduces new incentives to extend working lives. There is also a move to simplify the Social Security System integrating all schemes in the General Scheme and the Self-employed Scheme, in order to secure enough contributions for adequate pensions[133] . Law 20/2007 brings social protection of self-employed-workers and salaried workers closer. Lastly, Organic Law 3/2007 introduced important social security measures to reconcile work and family lives, including the new paternity benefit.

4.2. Key challenges and priorities

The population increase, as a result of migration flows (4.7 million from 1996), has positively influenced the old-age-dependency ratio and the working-age population (and thus the people registered in the social security system). However this positive effect will not last as migratory flows are projected to stabilise at a lower level and immigrant workers will reach the retirement age. In fact, the old-age dependency ratio for Spain in 2050 is expected to be 58.7%, above the EU25 average.

Measures already adopted and changes made to the system raised the standard of living for pensioners, improved and rationalised certain schemes and the conditions for accessing pension benefits and have encouraged more people to work longer.

The accumulation of funds due to surpluses in the social security system (5.32% of GDP in 2008) is projected to last until 2023, an increase of 8 years compared to the projection made in 2005. From 2023 until 2029 the reserve fund will compensate unbalances on income. Despite this ‘time bonus’, the process of reforms must continue, since public finances will be under great pressure as public pension spending is expected to increase from 8.6% of GDP in 2004 to 15.7% in 2050.

In terms of adequacy, the statutory scheme provides a high replacement rate for low or average wages (about 91% of gross replacement rate and 97% of net replacement rate for a worker retiring at 65 after 40 years of contributions) but it will decrease in the future as the change in gross theoretical replacement rates (2006-2046) for statutory pensions is -9.

On the other hand, the minimum contribution has increased and minimum supplements are progressively being financed from the general budget (100% planned for 2013).

Although sustained economic growth and rising employment during past years has enabled Spain to make significant progress, demographic trends and other challenges are expected to translate into pressure on public finances. Economic and labour market conditions are rapidly deteriorating and all economic indicators point to a further weakening of the economy. Over 2008 there has been a marked jump in unemployment in Spain, which has been even more pronounced for immigrant workers.

Under these circumstances, the importance of further reforms must be stressed as current projections of the pension system — although better than previous projections — could change if the situation worsens. The need to continue the reform process is recognised and the

[133] Law 18/2007, of July 4th, on the integration of self-employed workers from the agricultural scheme in the self-employed Scheme).

Spanish Government and the social partners have already started a new negotiation process within the Toledo Pact to tackle the pending challenges outlined.

4.3. More people in work and working longer

Overall employment increased by almost 10% since 2000, up to 65.6% in 2007, mainly driven by an increase in employment of women (13.4 % since 2000, 54.7% in 2007, still below EU average) and foreign workers. The employment rate of persons aged 55-64 also increased (7.6% since 2000 to 44.6 % in 2007).

The effective labour market exit age in 2007 was 62.1 years, above the EU average. The main pathways of early exit from the labour market are unemployment and early retirement. The share of exits through unemployment can exceed 25% and the share of exits due to long-term sickness or disability is often higher than 25%. The effective average retirement age for new pensioners is 63.6 years.

The average number of contributory years for new retirement public pensions was around 40 for men and 30 for women.

The new law introduces new requirements to qualify for partial retirement, conditions for early retirement, incentives for voluntary postponement of retirement after 65 and criteria for calculating disability pensions. However, the process of strengthening the link between contributions and benefits must continue, as must the increase in the number of contribution years taken into account when calculating the corresponding retirement pension benefit. This benefit is currently calculated according to the amount of contributions made by workers and employers during the 15 years prior to retirement. Moreover, it is important to further facilitate flexible and gradual retirement, as well as further restrictions in early retirement schemes.

4.4. Privately managed pension provision

Supplementary pensions are underdeveloped in Spain. They are optional and designed to supplement public pensions on a voluntary basis. As lump-sum payments represent the largest share of pay-outs in pension schemes, the government has changed the fiscal incentives for pension funds to encourage the use of annuities after retirement, instead of lump sums.

4.5. Minimum income provision for older people

Minimum contributory pensions have income guaranteed by a 'top-up' benefit and amount to €6538/year in 2006 (€7.99.7/year in 2008) for those over 65 years or plus (or €7920 in 2006 / €9222.5 in 2008 for 65+ with a dependant spouse), representing 27% of the total number of pensions (20.2% for the new pensions). Implementation of the measure to increase by 26% the minimum contributory pensions over the period 2004-2008 continues, and now reaches 36% of beneficiaries with a dependent spouse and 28% of single beneficiaries.

Non-contributory pensions and other means-tested welfare pensions act as basic universal provision, covering 11.4% of pensioners.

Recent reforms of minimum and survivor pensions have translated into fewer gender differences in living standards and poverty risk. The increase in minimum pensions has reduced the number of persons on a low income and the share of pensioners who are not eligible for earnings-related pension is decreasing.

Nevertheless, according to 2007 data, the risk of poverty of older people (31% before, 28% after social transfers) is still much higher than for the population as a whole, especially for women (30%), a trend that has gradually increased in recent years. Gender differences in the at-risk-of-poverty rate are even greater for people over 65 in single households (49%, women 52%). Nevertheless, the poverty gap of older people is lower, which highlights the role of minimum benefits to fight poverty among older people. Reducing gender differences in living standards and poverty risks of old people is an objective that needs to be pursued.

4.6. Information and transparency

In terms of transparency and information for citizens, workers are being offered substantial information on their pension rights, in particular via the social security website, which is continuously updated.

Reform of the pension system in Spain is based on social dialogue. The Toledo Pact is the product of the political and social consensus on reforming the social security system. There is a joint commitment to regularly monitor and evaluate the progress made on reforming the pension system.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The National Health System (NHS), defined as a mix of central government and regional government services, provides universal coverage. It is a decentralised system under which 17 autonomous regions run healthcare services, the Ministry of Health monitors and ensures the equity of the system and the Interterritorial Council of the NHS (ICNHS) has a coordination role. Primary health care (PHC) is publicly managed and delivered in health centres. Patients register with a general practitioner (GP). GPs refer patients to specialists, who refer them to hospital care. Outpatient ambulatory centres provide outpatient specialist care, and in-patient care is provided in hospitals which are publicly owned. It is a tax-based system, free at the point of access. Co-payments apply to pharmaceuticals except for retired and disabled people. Patients can choose their GP within their area of residence. Private voluntary supplementary insurance covers 4.7% of the population. Civil servants can choose from three publicly funded mutual funds (70% state funding and 30% contributions) and either public or private provision. In June 2008 a major Pact for Health was signed by the Ministry of Health and all autonomous regions in the Inter-territorial Council with the aim of reinforcing the NHS. This agreement addresses crucial issues, such as improving human resources policy; creating a common portfolio of services; designating services and reference units; rationalising healthcare spending; establishing a common vaccination calendar; fixing a maximum waiting-time guarantee; increasing the quality and facilitating innovation in health services; facilitating universal access to palliative care; boosting preventive care and implementing policies to counter illicit drug consumption.

5.1.2. Accessibility

The Spanish population is almost universally covered (98.3% in 2006) by the NHS. Though care is free at point of access except for pharmaceuticals, data show that private, notably out-of-pocket expenditure is high (21.5% of total expenditure in 2006), which is closely related to extensive waiting lists. Spain is one of the EU countries with the least inequality in access to

health care for all income levels. Since 2000, illegal immigrants have also been granted access by simply entering their names in a municipal census. However, it is important to highlight that, whilst decentralisation can ensure more adaptability to local needs, to some extent it has also resulted in regional differences in provision. To prevent such disparities, the Spanish Government approved a new decree in September 2006 which established a portfolio of common standardised services for the NHS countrywide and will use social cohesion funds to compensate some regions. Moreover, the Ministry of Health will boost primary health care by implementing the Strategic Framework for the Improvement of Primary Health Care, which will be in force over a six-year period (2007-2012). A new law on Sustainable Development in Rural Areas was also approved in December 2007, which lays down measures to improve primary health care in rural areas, such as better access to modern technologies and improvement in urgent and emergency care. Schemes to facilitate the full cover of immigrants by the NHS, part of the Strategic Plan for Citizenship and Integration 2007-2010, are also being carried out.

5.1.3. Quality

According to the bi-annual national health surveys, the Spanish NHS scores high in terms of efficacy, efficiency and equity in access. A quality plan for the NHS was drawn up to guarantee maximum levels of quality in health care in all regions on an equal basis. It involves developing strategies with all stakeholders (e.g. staff and patients) to ensure clinical excellence. Strategies include greater use of ICT. In 2007, the Spanish authorities revised a former plan to gather and monitor data on effectiveness. The main concern is the length of the waiting time for surgery and specialist care, which is partly due to having one of lowest number of beds — 338 per 100 000 inhabitants in 2005 in the EU. In June 2007, 9.33 and 37.7 patients per 1000 people awaited surgery and specialist care respectively. The Ministry of Health therefore set criteria indicators and a minimum basic and common national requirement for waiting time lists for specialists, diagnostic and therapeutic tests and surgery. Several measures have been carried out to address waiting lists: paying extra hours or fees-for-service to public health professionals within their own public institutions; contracting out services to private institutions, financed publicly and contracting out services to other public institutions with shorter waiting lists.

5.1.4. Sustainability

Total healthcare expenditure (8.4% of GDP and 2458 US$ PPP per capita in 2006) has grown more or less constantly over the past decade. Total public expenditure on health in 2006 corresponds to 71.2% of total health care expenditure[134]. Several measures to rationalise spending have been adopted or planned by the autonomous regions, e.g. rational criteria for purchasing management; policies ensuring quality and rational use of medicines; mechanisms to promote responsible demand and encourage healthy lifestyles; improved access to the best scientific information available; consolidation of plans to make the most up-to-date medical tools available to healthcare professionals; additional support for the Evaluation Agencies of Healthcare Technologies; improvement of resources and decision-making capacity in primary health care; development of Information and Communication Technologies ICT and other rationalisation measures.

[134] Source: OECD and WHO data

5.2. Long-term care

5.2.1. Description of the system

Traditionally the family had the main role in care giving, but socio-demographic changes are making the provision of long-term care services an ever more pressing concern for the authorities. Demand for long-term care has increased in Spain as a result of the growing number of people over 65 years of age, the higher survival rate of the chronically ill, changes in the structure of families and the entry of women into the labour market. Hence, various laws have extended the range of services in this area over the past decade. They now include: PHC at home, day centres, temporary stays in residential homes, residential homes, telecare and financial aid to dependents and carers. A new Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency was approved in December 2006. This new Law created the Autonomy and Dependency Care System (SAAD), designed to increase coverage to all people in a situation of dependency (from disabled children to adults to the dependent elderly, some 1 300 000 people) by 2015 through a large boost in provision. The SAAD aims to ensure equal access by using a common dependency scale and defining a standard catalogue of services (wide range of home care, assistance and adjustment, day centres, night centres and residential care). It also aims to improve the integration of health and social services. Services may be supplied by public or private providers agreed by the public Administration and each region organises service supply. Financial benefits will be granted and family carers will enter the social security system and attend training courses when they are caregivers. User charges are to be based on income and income brackets. The government recognises that this process will take some time and effort to accomplish. Since the Law entered into force, the central government has approved implementing regulations, previously agreed in the Territorial Council as the central operational body. A dependency evaluation scale, a minimum level of protection guaranteed by central government, and the amounts of financial benefits were laid down last year. The intergovernmental cooperation framework was also approved, together with the central government budget allocation criteria to finance autonomous regions. Services to help people in a dependent situation are mostly carried out by autonomous regions but are financed fifty-fifty by central and regional governments.

5.2.2. Accessibility

The Law provides for progressive implementation until 2015 when it will be implemented in full. The target is that by this date, all Spanish dependants will be universally covered. This ambitious new System of Dependency and Care (SAAD) has begun to be implemented, although it shows regional disparities and delays. During the first year in which the Law was in force, 72% of beneficiaries covered were aged over 65, nearly half of whom were over 80 years old. As of July 2008, 536 342 people had requested to be accredited as dependent and 326 015 have already been recognised as beneficiaries (high and severe dependence degree).

5.2.3. Quality

To boost quality, an accreditation of centres, services and entities working in the field is required. By the end of 2008 the Territorial Council is expected to have adopted the common accreditation criteria, which cover equipment and material as well as human resources, to be applied by all the autonomous regions. In July 2008, a Special Commission for the improvement of quality within SAAD was created. However, public and political debate in recent months has revolved around regional disparities in access. In this context, a crucial aspect covered by the Law is patient involvement in monitoring long-term care.

5.2.4. Long-term sustainability

The services provided by the Law on Dependency are financed by the Central State, the autonomous regions and by co-payments from users proportional to income and patrimony. For 2007-2008, State contributions totalled €1 271 million. The 2009 Central State budget will include €1158 million under this heading, which represents 33% more than 2007. The new Plan for Improving Economy and Employment recently approved by the government reinforces the budget with an additional €400 million. Funding totalled about 0.57% of GDP in 2005 (before the Law on dependency came into force), and expenditure is now expected to increase by 1% of GDP by 2015. Authorities have noted that implementation of the Law will create 300 000 new jobs. However, family care is still the predominant and most accepted form of care both by carers and care recipients. In this respect, there are strong ties of intergenerational solidarity between family members with regard to care tasks. Informal carers in Spain are predominantly married women, housewives aged about 50 years with primary education. It is worth mentioning that families face substantial out-of-pocket payments for contracting care from private providers and/or informal home care workers (unqualified, immigrants), due to the low level of coverage of public services.

6. CHALLENGES AHEAD

- To break the intergenerational transmission of poverty, in particular by reducing the high rate of early school leavers. Although several measures implementing the Education Law address this issue, achieving the 2010 target will require substantial and comprehensive efforts.

- To intensify efforts to promote the active inclusion of vulnerable groups, such as the elderly, immigrants, young people, the Roma population and people with disabilities, with a gender-based approach, in light of the expected effects of the financial downturn and rising unemployment.

- To monitor the sustainability of the pension system in view of the economic downturn, further strengthen the link between contributions and benefits and improve incentives to work longer.

- To enhance the provision of long-term care and to counter regional disparities.

- To shorten waiting times for care services provided by the NHS.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	5,0	97,3	2000	56,3	71,2	41,3	32,5	37,0	2000	11,1	7,9	16,0	24,3
2005	3,6	102,0	2005	63.3b	75.2b	51.2b	38.3b	43.1b	2005	9,2	7,1	12,2	19,7
2008f	1,2	101,7	2007	65,6	76,2	54,7	39,1	44,6	2007	8,3	6,4	10,9	18,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	74,3	81,5	16,0	19,8	64,2	67,7	5,5	1995	7,4	72,2	23,5		-
2000	75,7	82,4	16,5	20,4	66,5	69,3	4,4	2000	7,2	71,6	23,6	2005	1,2
2006	77,7	84,4	17,9	22,0	63.7b	63.3b	3,7	2006	8,4	71,2	21,5	2006	0,6

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits / **Age-related projection of expenditure (AWG)**

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	21,6	43,9	28,6	16,5	2,0	1,6	7,4	2004	24,1	20,1	8,6	6,1	0,5
2000	20,3	44,7	29,4	11,6	4,9	1,4	7,9	2010	24,4	-0,4	0,3	0,2	0,0
2006	20,9	41,3	31,2	12,5	5,7	2,0	7,3	2030	34,3	3,3	3,3	1,2	0,0
								2050	58,7	8,5	7,1	2,2	0,3

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	20	24	16	28	24	25	27	21	5,3	2005	20
male	19	-	15	26	24	-	27	21	-	2006	18
female	21	-	17	30	24	-	27	20	-	2007	17

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	6,4	7,4	6,6	8,3
2004	6,3	7,3	6,7	7,9
2007	5,3	6,2	5,8	6,7

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	3,7	2,3	6
2004	3,4	2,2	5,1
2007	1,7	1,1	2,5

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	29,1	34,7	23,4
2004	31,7	38,5	24,6
2007	31,0	36,1	25,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,76	0,77	0,76	***Aggregate replacement ratio***	0,47	0,52	0,48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
-12	-9	-9	DB	/	-	89	/	28,3	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

France

1. SITUATION AND KEY TRENDS

GDP growth, which is lower than the Community average, reached 2.2% in 2007, with a forecasted 0.7% for 2008 and –1.8% for 2009. The rising employment rate was 64.6% in 2007, but remains low for young people (31.5%) and older people (38.3%). In 2007, the female employment rate (60%) reached the Lisbon objective. However, employment growth in recent years conceals an increase in lower-quality jobs: temping and fixed-term contracts accounted for 10.6% of paid employment in 2006 and the working poor accounted for 6.4%[135]. The unemployment rate was 8.3% in 2007, but the regular downward trend observed since 2005 was interrupted in the middle of 2008. Estimated at 7.8% in 2008, the unemployment rate could rise to 9.8% in 2009 as a result of the economic crisis. The female unemployment rate (8.9%) is over one point higher than that for men, and young people are particularly hard hit (19.4%). Long-term unemployment has fallen slightly, with levels of 4% in 2006 and 3.6% in 2007. The risk of poverty concerns 13% of the population (2007). Social protection expenditure represents 31.1% of GDP (2006), with expenditure on pensions accounting for the highest share (44.3% of the total), followed by health expenditure (29.9% excluding invalidity). The French population is still characterised by a high fertility rate (two children per woman in 2006). The demographic dependency ratio (between those aged over 65 and those aged 15 to 64) is set to increase from 25.8% in 2010 to 46.4% in 2050. Due to the lack of statistical data broken down by ethnicity and geographical origin, the report does not offer a specific analysis of minorities.

2. OVERALL STRATEGIC APPROACH

Following directly on from the previous report, the French authorities underline the convergence between the European objectives and the French model, which is based on the aim of high-quality, full employment and greater territorial cohesion. Their strategy is based on the three main general objectives of the open coordination method. The first thrust focuses on the aim of financial consolidation of the general social protection regime, with more employment for older people and the recovery of the health insurance system in parallel with a policy centred on better access to healthcare, prevention and efficiency. The French strategy also features the aim to improve small pensions, the issue of dependency and the three sections of the social inclusion strategy (return to employment for those with the poorest job prospects, social and occupational integration of young people, and housing). The interaction between the strengthening of social cohesion and the development of growth and employment is assured through measures to promote the active inclusion and employment of older people, and through the effects of family policy on population growth (however, the role of certain provisions concerning withdrawal from the labour market, aimed particularly at low-skilled women, should be noted). No explicit reference is made to the positive consequences of the strategy for growth and employment in terms of social cohesion, pensions and health, and the links with the sustainable development strategy are not explained. The report underlines the importance of governance. The strategy pays little attention to the gender dimension, and not enough detail is given on each specific measure and from the transversal point of view, particularly in the section on social inclusion. The issue of disability is mainly covered from the perspective of long-term care.

[135] 2006 national figures

3. Social inclusion

3.1. Key trends

13% of the population was living below the poverty threshold in 2007. The stabilisation of this percentage since 2001 conceals the rising severity of poverty. 14% of women and 16% of children are affected. The rate is much higher for people living alone (18% for women), single-parent families (27%) and the unemployed (33%). The poverty rate before transfers (excluding pensions) is 26%, 24% for those aged 18 to 64, and 36% for children. Net income from social assistance amounts to 80% of the poverty threshold for a person living alone and a single parent with two children (70% for a couple with two children). Numbers drawing the "*revenu minimum d'insertion*" (RMI, minimum guaranteed income) dropped by 5.2% from June 2007 to June 2008, and the 12-month exit rate has increased slightly since 2004 (27.7% in 2006). Nevertheless, the percentage of people continuing to receive the RMI is rising (46% have been receiving it for over three years). In 2007, 10% of adults were living in a jobless household (11.1% of women and 8.7% of children). Two categories are very exposed to unemployment: the 15-24 age bracket (19.4% in 2007), and the foreign population[136] (14% of men and 18% of women). School failure has not decreased in comparison to 2005 (12.7% of young people and 14.6% of boys in 2007) and 33.5% of people aged 25 to 64 have a low educational level of attainment (18.3% of the 25-34 age bracket).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The report includes the results of numerous measures concerning the return to employment, the integration of young people and housing and, where appropriate, presents conclusions concerning the necessary adjustments. It also mentions developments during the period in question, in particular the "*Grenelle de l'insertion*" (Grenelle agreement on occupational integration) process, and the *revenu de solidarité active* (RSA, active solidarity income) and *contrat unique d'insertion* (single integration contract) experiments. While there has been substantial growth in the construction of social housing, around 70% of the increase since 2000 is accounted for by intermediate social housing for rent, with housing for more extreme social cases representing only 8% of the financed volume. Furthermore, reconstruction of the housing supply is outweighed by demolitions.

3.3. Key challenges and priorities

The stability of the poverty rate, the high level of unemployment, the number of poor workers, social integration difficulties and the social housing deficit justify the carry-over of previous objectives. The three priorities, which match the challenges identified in the 2007 Joint Report, thus target access and the return to employment for those with the poorest job prospects, the social and occupational integration of young people, particularly those living in depressed areas and who belong to visible minorities, and social housing (covering the problem of housing unfit for habitation). The greater emphasis laid on employment does not cause the poor quality and precarity of many jobs to be disregarded; however, it tends to limit the multidimensional approach (for instance, little attention is paid to the reduction of social inequalities linked to health). No estimate is made of the overall effort by the State to pursue social inclusion policies, nor is any reference made to the contribution of the ESF. Yet social cohesion and the fight against discrimination constitute a substantial component of the ESF Country Operational Programme for regional competitiveness and employment (39% of the total appropriation of 4.494 billion euros). Furthermore 28% of the ESF budget is dedicated to

[136] National figures based on the following definition: people born as foreigners abroad and residing in France.

improving access to employment for jobseekers, focusing in particular on the most fragile population groups. The discussions envisaged in the previous phase to set target figures in the fight against poverty gave rise in 2007 to the stated aim to reduce the time-anchored poverty rate by one third by 2012. A consolidated scoreboard is proposed with supplementary indicators and a breakdown by age, the objectives for which are currently being discussed. There are two gender-related indicators concerning the rate of poverty among women aged 75 and over, and the female rate of employment.

3.4. Policy measures

Under the first priority (encouraging the return to employment for those with the poorest job prospects), the RSA, which replaces the RMI and the single-parent allowance, is the key measure in the active inclusion strategy. It was generalised after a relatively short experimental phase and must guarantee recipients of minimum welfare benefits an increase in income if they return to employment and ensure additional resources for poor workers. Care must be taken to prevent certain beneficiaries from settling in precarious, low-quality employment. The report briefly mentions the active inclusion policy targeting the disabled (action plan launched in 2008). The other thrusts concern developing support, merging the national employment agency (the ANPE) and the unemployment insurance bodies in order to achieve more effective protection, particularly for vulnerable population groups, reforming vocational training to improve the connection between employment and training, improving and balancing training provision for the least qualified, and strengthening the transparency and governance of the system. A new simplification of subsidised contracts (with stronger support) and the modernisation of integration through economic activity (in order to make integration possibilities more relevant to the needs of people in difficulty) are announced, and aid for the creation of businesses has been increased. To offset the effects of the economic downturn, there are plans to re-launch subsidised contracts, bringing their number to 330 000 for 2009, an increase of almost one third. Various supplementary measures are set out, in particular the involvement of the business community, reflection on the mobility of jobseekers, priority access to crèche facilities for the children of anyone following an occupational integration pathway (not only the beneficiaries of minimum welfare benefits), the development of personal microcredit, and experiments to combat illiteracy. Actions are planned against ethnic discrimination (diversity label for employers, mentoring).

The second priority, namely the social and occupational integration of young people, must be backed by measures aiming to make schools more open to the world of work (reform of professional qualifications, prevention of interruptions in learning) and improve provisions for young people leaving school with no qualifications (school support, second-chance schools, centres run by the *Établissement public d'insertion de la défense*). Young people from disadvantaged areas benefit from specific measures (individualised support plans complemented by material aid, recruitment commitments by large businesses and professional federations, and stepping up the fight against school failure). This framework allows for frequent recourse to experimentation. A third section deals with young immigrants or young people from immigrant backgrounds and their families. Overall, actions already in existence have been renewed or developed, but the problems of fragmentation, lack of clarity and, consequently, of efficiency in numerous measures, have not been fully solved.

In view of the ongoing imbalance between supply and demand, developing the supply of social housing and the renovation of housing form the third priority. Policy in this field is based on the Act of 2007 establishing the enforceable right to housing and the draft Act on action for housing and the fight against exclusion. The main thrusts are the development of social housing and tackling the problem of housing unfit for habitation and entail an area-by-area assessment and a special effort in deficit zones, in particular Île-de-France. A number of measures aim to make it easier for people to find housing and stay in it. Action has been stepped up with regard to housing unfit for habitation and the most rundown areas of social housing are being renovated. Provision is made for the development of adapted accommodation and the improvement of accommodation arrangements for highly vulnerable population groups under the objective to ensure a move towards ordinary housing. The issue of travellers (residential sites, suitable accommodation) is also covered.

3.5. Governance

The INAP was preceded by work conducted mainly by the *Conseil national des politiques de lutte contre la pauvreté et l'exclusion sociale* (National Council for policies to combat poverty and social exclusion) and in the context of the "*Grenelle de l'insertion*". This participative six-month process, aimed at giving new impetus to integration policies, is overseen by a multiparty monitoring committee. Apart from this initiative, progress in the field of governance is presented to the general public and the local authorities from the angle of the general revision of public policies and greater attention to the process in the parliamentary context. In the triple "consultation, dialogue and experimentation" stage before generalisation, emphasis is laid on social trials and assessment. The statistical annex, which is very comprehensive, presents in particular the scoreboard used to monitor changes in poverty in relation to the presidential commitment to reduce time-anchored poverty by one third by 2012. Reference is made to the establishment of targets for the supplementary indicators. However, the coordination of policies fragmented between national level and regional or local levels remains a major challenge. Little attention is paid to the dovetailing of policies, or to links between the various sections of the OMC (open method of coordination) and with the National Reform Programme (NRP). Nevertheless, the links between the OMC and the NRP are pointed out in relation to the occupational integration of those with the poorest job prospects.

4. PENSIONS

4.1. Key trends

The average age of exit from the labour market is 58.7 for men and 59.1 for women. Since 2003, the average retirement age has fallen and settled at 60.7 for men, in particular owing to early retirements following a long career. The aggregate replacement rate is 58% (with a significant difference between men, 61%, and women, 54%). The median standard of living for retired persons, taking account of income from assets and imputed rent, is 5% lower than for employed persons. In 2008, pensions were upgraded and the indexing mechanism was revised to take better account of changes in inflation. The reform initiated in 2003 (the Fillon Act) has preserved the structure of the system, based essentially on the statutory pay-as-you-go systems, through an endeavour to ensure its financial sustainability and more equal treatment between the different systems, with the State undertaking to offset the risks of social exclusion. It relates to the demographic transition expected between the years 2005 and 2050 (with the retirement of the post-Second World War baby boomers). The Act establishes the principle of an increase in the insurance period in proportion with the rise in life expectancy, and provides for a meeting every four years to examine the situation on the basis of economic,

social, demographic and financial data. The conclusion of the first four-yearly meeting in 2008 proved to be less favourable in the short and medium terms than had initially been forecast, with a deficit in the basic scheme of 4.6 billion euros in 2007 (probably 5.6 billion in 2008), half due to the success of early retirement following a long career (more than 400 000 beneficiaries since 2004). The deficit is expected to be greater than planned until 2015, mainly owing to the modest effects of the 2003 reform and of the subsequent measures on employment rates (mitigated success of the progressive retirement and of the employment/pension combination, and failure of pension bonuses to provide an incentive). However, the comparison of forecasts concerning the financial requirements of the retirement system between 2001 and 2007 shows a 50% reduction in the overall deficit expected in 2040. Long-term projections are more favourable than those for 2005 owing to a higher fertility rate, a better migration balance and a slower rise in life expectancy. The need for financing is expected to be 1.7% in 2050 with a demographic dependency ratio for retirements (52% in 2004) of 69% (and not 78%).

4.2. Key challenges and priorities

Pension expenditure represented 13.1% of GDP in 2007, with a forecast of 14.8% for 2050. The theoretical net rate of replacement should progress from 79.7% in 2006 to 62.2% in 2046 for a male employee retiring at the age of 65 after a full-time career on an average salary. This is one of the most significant changes among the Member States[137]. According to long-term forecasts, if the labour market does not become more accessible for older people, France will face the double challenge of adequacy (a drop in the theoretical net rates of replacement) and financial viability (a rise in expenditure in relation to GDP). Combating youth unemployment and achieving increased employment rates, particularly for older people, therefore offer the only solution. Two major reforms were initiated in 2007 primarily to align the special schemes with those of the public administration by 2012, particularly as regards the length of the insurance period. Although the financial impact is negligible on account of the small percentage of the labour force concerned (2%), this development helps to create a fair and harmonised system. The meeting of 2008 also focused on the following issues: increased period of insurance, the situation of those on small pensions, the management of retirement ages and keeping older people in employment. In addition to the effective application of the Act of 2003 with, by 2012, the duration of insurance being taken up to 41 years, the firm establishment of the early retirement provision after a long career and financial restructuring of the various branches of social security, a decision was made to step up action to encourage the employment of older workers. There is to be a progress report in 2010. In the context of the current economic slowdown, measures to increase the employment of older people which are under way or have already been confirmed will probably not suffice to achieve the Lisbon objective of an employment rate of 50% for older people in 2010. Given the current-account deficits of the general insurance scheme, the employment of older people will be crucial to long-term financial viability.

4.3. More people in work and working longer

The employment rate for people aged 55 to 64, which has been increasing slightly since 2003, reached 38.3% in 2007 (40.5% for men, and a very low 15.7% for people aged 60 to 64). The improvement in the overall rate is mainly due to the rise in female employment among the post-war generations. The average period of contribution is 35 years and 9 months (40 years for men and 31 years and 9 months for women). The statutory retirement age (60 years) is

[137] It should be underlined that, unlike the AWG projections, the ISG projections assume a continuing reduction in the value of the point for the AGIRC and ARRCO supplementary insurance schemes.

relatively low. As entry to the labour market is often late, there is a conflict between the statutory retirement age and the minimum period of insurance. The national old-age pension fund has simulated the effects of a progressive increase of up to two years in the statutory retirement age for paid employees under the general scheme: the result would be a drop in the deficit from 13 to 8 billion euros in 2020. A number of statutory provisions for early retirement still exist. At the end of 2006, 700 000 people benefited from these, including 417 000 unemployed people aged 55 and over exempt from searching for employment. However, there has been a clear decrease in the proportion of people aged 55 to 59 since 2000, not including early retirement on account of a long career. Given the success of this measure, the period entitling contributors to a pension was raised to 43 years for 2009. The measures to encourage the employment of older people taken since 2003 have had modest results and a decision was made to reinforce them: a progressive increase in the minimum age for exemption from the search for employment (60 years in 2011), an increase in the pension bonus, the liberalisation and simplification of the employment/retirement combination, the discontinuation of automatic retirements and of age limits in the private sector, and reflection on this subject in the public sector. A parliamentary amendment in the context of the legislative debate on the social security budget has raised the age at which an employer can oblige an employee to retire from 65 to 70. Compulsory negotiations on the employment of older people are planned for industries and businesses, with a target figure for increasing employment among people aged 55 to 64 and a penalty in the form of an additional pension contribution in the event of failure. On the other hand, negotiations between the social partners failed to reach a successful conclusion on early retirement from employment of an arduous nature. As most workers declared that they were unsatisfied with their working conditions, this issue must also be tackled in the bid to lengthen working life. No measures have been taken to address the chequered pattern of the career paths of women and younger age groups.

4.4. Privately managed pension provision

In the private sector, schemes are established by sectoral or corporate collective agreement, or even on the employer's initiative, financed on a shared basis or by the employer and often with compulsory membership. For workers who are self-employed or come under special schemes, these schemes are offered by a professional organisation or association, with optional membership and financing by the members. The reform of 2003 authorised individual retirement plans. These schemes attract tax concessions and social benefits and are managed in accordance with directives on insurance to secure the rights of the beneficiaries. Although there has been some progress since 2003, these provisions are still of minor significance in France.

4.5. Minimum income provision for older people

The poverty risk rate for people aged over 65 (13%) was one point higher in 2007 than the rate for people aged 18 to 64; the gap widens after 75 years (16% for women). Two main mechanisms aim to guarantee a minimum income for the elderly. The minimum old-age pension ensures a minimum income for those aged 65 and over, on a means-test basis and subject to place of residence, with no employment conditions (599 000 beneficiaries in 2006 for a monthly amount of 633 euros for a single person, a level relatively close to the poverty threshold at 50% of the median standard of living but higher overall taking account of imputed rent). It is to undergo a 25% revaluation by 2012 in relation to 2007 in order to support the poorest pensioners. The aim of the second measure, namely the minimum contribution, is to increase the pensions of those who have completed a low-salary career or take their pension after the age of 65 (only 40% have had a full career). It concerned 4.4

million people in 2004 (over 40% of private-sector pensioners). It amounts to 584 euros per month (638 euros for a full career), plus any amounts payable from supplementary pension schemes. In both cases, women are in the majority at over 60%. The government has carried over to 2008 the objective of a net rate of replacement of 85% of the SMIC (minimum wage) after a complete full-time career with contributions paid on the basis of the SMIC. Account is taken of random events in a recipient's working life (periods of unemployment, illness, early retirement validated without penalty) and whether they had children. Various tax and health measures and long-term care also contribute to the standard of living of older people.

4.6. Information and transparency

Access to information, perceived as a priority which could help beneficiaries to reconsider their age of retirement, led in 2007 to pension estimates being sent to those insured under the compulsory schemes. This information will be generalised from 2011. Since 2000, public debate has been fuelled by a standing body, the *Conseil d'orientation des retraites* (Pensions Advisory Council), which represents the main stakeholders. Its reports, which are public, have paved the way for the recent reforms.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Life expectancy at birth is high, with a pronounced difference between men (77.3 years in 2006) and women (84.4 years), almost two and three points respectively above the European average. Life expectancy for people in good health is 62 years for men and 64.3 years for women (2005), and life expectancy at 65 years is 18.2 years and 22.6 years respectively. Infant mortality is falling steadily (3.8/1000 in 2006). The French system, which is underpinned by solidarity and universality, covers the entire population mainly on a professional basis and, since 2000, subsidiarily on a residential basis. The basic insurance schemes, which are financed by social contributions and taxes, cover around 75% of expenditure, with better coverage of long-term illnesses (100% coverage for reimbursable procedures and services, within the limits of the social security rates, therefore excluding additional charges – in particular the hospital charge – and fees which exceed the set amounts). 85% of the population has a supplementary insurance scheme of an either professional or personal nature; the underprivileged benefit from free supplementary sickness insurance (CMUC), but 7.7% of the population has no supplementary insurance. The basic principle is to reimburse insured persons, but direct billing ("*tiers payant*") to the sickness insurance funds or supplementary insurance funds is possible, and is the rule for hospitalisation.

5.1.2. Accessibility

Access to healthcare is a growing problem from a financial and geographical point of view. Since the 1990s, governments have limited reimbursement, leaving the supplementary insurance funds to cover 12.9% of expenditure, with 9.1% still to be paid by insured persons (2005). The CMUC covers 100% of health expenditure without advance payment for those on low incomes (7.4% of the population). For those on incomes slightly higher than the eligibility conditions for the CMUC, assistance to pay for supplementary insurance is provided in the form of tax credit. Although the rate of failure to receive care for financial reasons has been decreasing since 2004 (from 4.7% to 3.7% of the population in 2006),

considerable contrasts still exist between social groups as regards access to care, particularly eye and dental treatment (less well covered by the compulsory schemes), and access to specialists, who account for most cases of the set fees being exceeded. The social gradient of health inequalities is significant and despite efforts to ensure cover and incentives to take out supplementary insurance, a heightened access problem for low-income groups can be observed, with certain practitioners refusing to treat patients under the CMUC (41% of specialists and 39% of dentists in 2006). Geographical disparities in care provision owing to practitioners' freedom to select their place of practice constitute a further source of inequality and trigger measures which are still not enough to encourage practitioners to establish their practice or create groups of health professionals in deficit zones. This situation may deteriorate due to the foreseeable fall in the number of active doctors and the growing demand for care due to the ageing population. Furthermore, in some areas, virtually all practitioners exceed the rates set for fees. However, the medical profession opposes the introduction of geographical regulation.

5.1.3. Quality

The main missions of the *Haute autorité de santé* are (High Authority for Health) to assess the medical service provided in terms of treatments, products and services, develop recommendations for good professional practices and ensure the provision of high-quality care by professionals through the accreditation procedure of health establishments. The *Agence française de sécurité sanitaire des produits de santé* (French Health Products Safety Agency) monitors the quality of products, from their production to the surveillance of risks after they are placed on the market. The formalisation of health strategies using thematic plans (cancer, chronic illnesses, rare illnesses, environmental factors, risk behaviours and addictive behaviours) and targeted programmes (Alzheimer’s, diabetes, nosocomial infections, palliative care, emergencies, smoking, nutrition) help to improve quality standards. Efforts to ensure coordination by appointing a reference doctor to guide patients over the age of 16 in their health choices constitute a means of improving quality (and regulating expenditure). The selected doctor can be a general practitioner or a specialist, and may be free to set their own fees, and the patient can change doctors subject to a prior declaration. In contrast, the future computerisation of medical records to facilitate medical monitoring, opposed by the Ethics Committee, is uncertain.

5.1.4. Sustainability

The discrepancy between income and expenditure remains the main challenge despite the decrease in the deficit between 2006 (5.9 billion euros) and 2007 (4.6 billion euros). However, it is expected to rise again in 2008 and 2009. National health expenditure represented 11.2% of GDP in 2005 (8.9% for the publicly-funded part), i.e. 3 374 dollars per inhabitant measured in PPP. In 2007, expenditure increased by 4.2% in comparison to 2006. Since 2004, the financial accountability of insured persons has been reinforced, which for certain categories of people can negatively affect access to care, with a fixed financial contribution per procedure which is not reimbursed by supplementary insurance schemes (capped at 50 euros per year for consultations and 50 euros for other procedures – people under the age of 18, pregnant women and CMUC beneficiaries are exempt). Cost control is also based on the medicine-based management of expenditure, with an assessment of the "medical service provided" adjusting the rate of cover, the revision of the nomenclature of technical procedures, endeavours to manage prescriptions by promoting the correct use of healthcare, the regular revision of medicine prices and the promotion of generic medicines. The medical agreement of 2005 set the target of saving one billion euros, particularly in fields where consumption is very high (psychotropic substances, antibiotics); an amendment in 2006

changed the target to 1.4 billion euros. There is no coercive regulation through the control of medical practices based on proof, nor are there any measures to tackle the dramatic increase in charges exceeding the statutory fee over the last ten years. As regards the overall development of healthcare, the structuring of primary care should be improved, refocusing on the out-patient sector and with improved connections between non-hospital care and hospitals to ensure the continuity of healthcare and avoid unjustified use of hospital structures.

5.2. Long-term care

5.2.1. Description of the system

The system is based on double insurance coverage. Sickness insurance finances the care provided by residential homes for disabled or dependent residents, long-term care units in hospital services for patients who cannot live independently and nursing care for people at home. This care is covered directly by the sickness insurance scheme under the "*tiers payant*" system. Accommodation is charged to the person or covered by social security if their means are insufficient. In addition to this, two mechanisms which are mainly financed by the State and the local authorities offer grants (depending on income and dependence levels) to meet the expenses incurred by a loss of independence at home or in residential care: the *prestation de compensation du handicap* (disability compensation benefit), and the *allocation personnalisée d'autonomie* (personalised independence allowance, APA) for dependent elderly persons. Old-age pension insurance funds also pay out household benefits as part a social welfare provision. The development of home assistance comes at a cost (excluding APA cover) in the form of tax and welfare benefits. Elderly or disabled people also use the ordinary care system, as do other insured persons, and represent a considerable drain on public funds.

5.2.2. Accessibility

The reforms in progress aim to increase residential care facilities for disabled and elderly people, although not fast enough to cover needs and keep pace with the growing numbers of dependent elderly people. The accommodation costs for people in care exceed their personal income in 80% of cases. The remaining amount charged to the dependent elderly person is high (25% on average for home and residential care taken together), thus creating inequalities of access to long-term care. Consideration is being given to reforming prices and aggregating tax benefits and aids.

5.2.3. Quality

The focus here is on improving the medical supervision of establishments and the qualifications of paid workers, and on support for family carers (introduction in 2007 of a one-year period of unpaid family support leave, and an increase in day care and temporary residential facilities as part of the Alzheimer's plan). The problem of qualifications and quality of home-care services still remains. Furthermore, better account must be taken of the diverse needs of dependent people staying at home, in particular as regards technical assistance and the conversion of accommodation.

5.2.4. Long-term sustainability

The increase in the public cost of long-term care has led to more resources being allocated to the *Caisse nationale de solidarité pour l'autonomie* (solidarity contribution of 0.3% paid from wages by an additional, unpaid day's work, additional contribution of 0.3% to social security contributions deducted from certain income from assets and investments). The number of people over the age of 60 (12.8 million in 2007) is expected to reach 20.9 million in 2035 and 22.3 million in 2050. The number aged over 75 is expected to double over this period. The number of dependent elderly people should increase by 40% by 2040 as a result of this demographic trend. This is dealt with in a number of ways: encouraging the use of private insurance, redirecting aid to those on lower and average incomes by taking account of assets when deciding on entitlement to cover for long-term care, creating a fifth branch of the welfare system in order to standardise the financing and governance system, and reassigning surplus from the family section to dependence. The plans to decompartmentalise the medical and welfare sectors through the creation of regional health agencies should increase the number of places. Lastly, the promotion of jobs in the welfare sector must be encouraged (400 000 jobs to be filled by 2015), with emphasis on quality and working conditions. This poses a double social challenge, as the workforce in this sector is largely female, and is characterised by fragmented work of an involuntarily part-time nature and low qualification and remuneration levels.

6. CHALLENGES AHEAD

- To promote active inclusion, in particular access and lasting return to the labour market of persons who are furthest removed from it, paying particular attention to the effective occupational and socio-economic integration of young people and visible minorities, and also with a view to ensuring territorial cohesion.

- To overcome the housing crisis, especially in the hardest-hit urban areas.

- To ensure pension adequacy and financial viability by reinforcing the measures to encourage the employment of older workers.

- To consolidate the financial viability of the health system by further pursuing the reforms aimed at improving coordination and rationalisation of care while preserving broad access and correcting geographical disparities.

- For long-term care, to coordinate the various funding bodies, in order to guarantee the long-term solvency of the system and reduce the remaining cost payable by individuals, thereby ensuring greater equality of access.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**
2000	3,9	115,3
2005	1,9	110,8
2008*f*	0,7	105,7

Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64
2000	62,1	69,2	55,2	28,6	30,0
2005	63,1	68,8	57,6	30,7	38,0
2007	64,6	69,3	60,0	31,5	38,3

Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	9,1	7,6	10,9	20,1
2005	9,7	8,8	10,7	22,7
2007	8,3	7,8	8,9	19,4

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth – Male	Life expectancy at birth – Female	Life expectancy at 65 – Male	Life expectancy at 65 – Female	Healthy life expectancy at birth – Male	Healthy life expectancy at birth – Female	Infant mortality rate
1995	73,9	81,8	16,1	20,6	60,0	62,4	
2000	75,3	83,0	16,8	21,4	60,1	63,2	4,5
2006	77,3	84,4	18,2	22,6	62.7b	64.1b	3,8

WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE
1995	9,9	79,7	7,6
2000	9,6	79,4	7,1
2006	11,1	79,7	6,7

EU-SILC	Unmet need for health care % of pop
	-
2005	1,7
2006	1,5

s: Eurostat estimate; p: provisional; b: break in series

**THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	30,3	43,5	28,3	7,9	10,0	4,5	5,9
2000	29,5	44,4	28,8	7,2	9,1	4,7	5,9
2006	31,1	44,3	29,9	6,9	8,6	4,3	6,1

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	25,3	26,7	12,8	7,7	0,0
2010	25,8	0,0	0,1	0,3	n.a.
2030	39,0	1,9	1,5	1,2	n.a.
2050	44,7	2,9	2,0	1,8	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate: Total	Children 0-17	18-64	65+	Poverty risk gap: Total	Children 0-17	18-64	65+	Income inequalities: S80/S20
Total	13	16	12	13	17	15	17	19	3,8
male	12	-	11	12	17	-	18	19	-
femal	14	-	13	14	16	-	17	19	-

Anchored at-risk of poverty	Total - fixed 2005 threshold
2005	13
2006	13
2007	13

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	9,2	10,3	8,9	11,6
2004	9,6	10,8	9,5	12,1
2007	8,7	10,0	9,0	11,1

	Long Term unemployment rate (% of people aged 15-64): Total	Male	Female
2000	2,9	2,4	3,6
2004	3,9	3,5	4,3
2007	3,3	3,1	3,6

	Early school-leavers (% of people aged 18-24): Total	Male	Female
2000	13,5	15	12
2004	14,2	16,1	12,3
2007	12,7	14,6	10,9

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female
Relative income of 65+	0,9	0,93	0,89

SILC 2007	Total	Male	Female
Aggregate replacement ratio	0,61	0,61	0,54

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net – Total	Gross replacement rate – Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions – Coverage rate (%): Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions – Estimate of current (2002)	Assumption
-18	-16	-16	DB	/		100	/	20	/	

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Italy

1. SITUATION AND KEY TRENDS

A slight improvement was recorded on the labour market, with an increase in employment from 58.4% (2006) (57.6 2005 data of the summary sheet) to 58.7% (2007), but with a significant gender gap (70.7% for men vs. 46.6% for women). In the same period, unemployment decreased from 6.8% (7.7 2005 data of the summary sheet) to 6.1%. The general activity rate fell by 0.2 percentage points to 62.5% in 2007. This is still well below the Lisbon target, and the gender gap is substantial: 50.7% for women (it was 50.8% in 2006) and 74.4% for men.

Despite the recent increase, the employment rate for older workers (aged 55-64) was 33.8% in 2007 (45.1% for men and 23% for women), far below the Lisbon target of 50%. Overall youth employment is 24.7% (29.6% for men, 19.5% for women). Unemployment indicators have continued to post a year-on-year decrease, falling from 10.1% in 2000 to 6.1% in 2007, with a significant gender gap (4.9% men, 7.9% women). The breakdown by age group shows 20.3% for those aged 15-24 and 2.4% for those aged 55-64 respectively. Due to the impact of the crisis in the labour market, no net job creation is projected for 2009. Unemployment is due to reach 6.7% in 2008 and 8.2% in 2009.

In 2007, Italy's at-risk-of-poverty rate was 20%, 1% more than in 2004. The breakdown is 21% for women and 18% for men respectively; by age group, 25% for children aged 0-17 and 22% for people aged over 65.

Significant gender gaps and regional imbalances still characterise the Italian labour market, as does the persistently high presence of irregular jobs and the increase in flexible jobs, especially for younger generations. 65% of Italian poor households and 68% of poor people are concentrated in the South. The poverty risk is higher for children in large families living in the South (36.7%) compared to the national average (27.1%)[138].

In 2006, Italy spent 26.6% of its GDP on social protection. This expenditure primarily targeted old age and survivors[139] (60.5%), sickness and health care (26.8%), while unemployment, housing and social inclusion measures are chronically underdeveloped. Due to ageing and a low fertility rate (1.35 in 2006), Italy is expected to face major adverse demographic pressure over the coming decades. The old-age dependency ratio (30.5% in 2008) is expected to reach 59.2% by 2050, with social expenditure expected to rise by 1.8%.
Life expectancy at birth (2004: 77.9 for men and 83.8 years for women), and healthy life expectancy (2005: 65.8 for men and 67.0 for women — provisional values) are high and above the EU average. Infant mortality, at 3.8 per 1000 in 2007, is slightly below the EU average.

Immigrants in Italy constituted 5.8% of the total population in 2007 (51% women, and 49% men), up from 2.3% in 2001.

[138] ISTAT reports in the document '*la povertà relativa in Italia nel 2007' ;* 4 November 2008'

[139] It should be noted, however, that in Italy benefits such as the TFR (trattamento di fine rapporto, sort of firm-based compulsory saving scheme) are classified under the old age function, but partly come under unemployment expenditure. These benefits represent some 5% of total social benefits.

The Italian government adopted a number of measures aimed at bringing some relief to families and businesses most directly affected by the crisis, while trying to accelerate public investment. Measures to support disposable income of households and restore consumer confidence include a one-off cash transfer to low-income households, extensions of unemployment benefit payments to atypical workers, tax relief on performance-related pay and tariff freezes for some utilities. The total cost of these measures is around 0.25% of GDP in 2009. In addition, a monthly €40 "social card", already foreseen in the 2009 budget law, supports low-income households purchase certain goods and services as from the fourth quarter of 2008.

2. OVERALL STRATEGIC APPROACH

The report highlights the importance of ensuring the long-term sustainability of public finances, while promoting stronger economic growth. Therefore the strategic priority is to reduce public spending, eliminate waste of resources and redirect public spending to those who need it most. A second priority is to raise employment rates of women, young people, and older workers given the need to substantially increase employment to ensure sustainability of the public system and increase individual freedom of choice. A third priority is to promote family-friendly policies, with both more purchasing power and better reconciliation of work and family life. Finally, there is an accent on the regional dimension, focussed on the decentralisation of competencies through the reform of the welfare system that will be implemented in parallel with fiscal federalism.

Recent political changes led to certain measures under the 2006-2008 priorities set by the previous government being discontinued. The 2006-2008 NSRSPSI priority number 4 “reducing regional disparities”, is essentially confirmed as part of the horizontal approach and through the reference to the Lisbon National Reform Programme, where the regional dimension and disparities are widely addressed, along with an in-depth on the use of Structural and National Funds within the National Strategic Reference Framework (NSRF) 2007-2013. Regional gaps are still very evident in Italy, with southern regions lagging behind in areas such as education, employment, health care and access to health and care services.

The draft report is more akin to an explanatory document than a programming document. With some exceptions in the chapter on social inclusion, it does not set any targets, quantitative indicators or deadlines. This is partly do with the fact that a new *White Paper* on the future of welfare in Italy will be presented soon. It follows the consultation launched by the Minister of Labour, Health and Social Policies last summer through the *Green Paper* and will identify a new model of welfare, with specific priorities, measures and means to reach the objectives.

Social inclusion priorities cover (1) the homeless and those living in extreme poverty, (2) families in difficult conditions, (3) child poverty, and (4) immigrants, Roma and Sinti. Concerning the generalised gender gaps, the NSR recognises that this is an issue in Italy but the policies proposed do not seem to fully address the existing challenge.

The objective on ‘governance’ is explicitly mentioned and the draft underlines the need for more coordination between national, regional and local authorities through a permanent agency. An important role will be given to all stakeholders in implementing the various policies and measures. Except for social inclusion supported by concrete data, more details are needed to better explain the link to the Lisbon strategy. The importance of the Structural Funds in implementing social inclusion policies and reducing regional disparities is highlighted. The document refers to the Structural Funds and to the need to coordinate

measures between the various tiers of government and management, particularly given the number of operational programmes (24 co-financed by the European Social Fund). It also refers to the National Strategic Reference Framework (NSRF) and the importance given to social inclusion, as a macro-objective of the NSRF. The final aim is to improve living conditions and access to services for all citizens.

3. SOCIAL INCLUSION

3.1. Key trends

The deceleration of the inflation provides some relief to low-income households but the risk of job losses and, to a lesser extent, consumer credit restraint will affect households and individuals living conditions. The total at-risk-of-poverty rate after social transfers in 2007 is 20%, but as high as 25% for children under 18 years of age. The number of children in jobless households has declined steadily over recent years, down to 5.9% in 2007 (2.9% less than in 1999). The number of people in jobless households fell over the same period to 9.2% in 2007. The incidence of poverty is overwhelmingly concentrated in the South and affects mainly large households, households whose head is unemployed, and women or men with low educational levels. In general, women are more at risk of poverty, and the gap increases with age.

The percentage of early school leavers, although decreasing, is still high and well above the EU average (19.3% in 2007), with a substantial gender gap (15.9% for women and 22.6% for men). The poor performance in terms of educational attainment and employment signals the difficulties young people experience in the transition from school to work. This is reflected in the concentration of unemployment among young people (the unemployment rate for people younger than 24 years is 20.3% compared with a rate of 4.9% for people aged 24 or more).

It should be noted that the rate of fixed-term contracts is close to 45% for new employees.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The objectives of the draft 2008-2010 report differs from the priorities of the 2006-2008 report, as the political change led to modify some measures and strategies. In particular, the former priority 'reducing regional disparities', one of the 2007 Joint Report challenges as the multidimensional nature of poverty is correlated with regional disparities, is now part of the horizontal approach. Other challenges previously identified, like 'increasing the level of participation on the labour market especially for women, young people and older workers', are not dealt in-depth as the report refers to the PNR as indicated in the Common Overview. The new measures lack targets and indicators, which should be provided with the *White Paper.* Therefore, the amount and source of financial resources for the proposed policies are not identified.

The draft document lacks a complete assessment of progress with respect to the 2006-2008 report targets. It lists the measures adopted after 2006, such as: socio-educational services for children; a national family plan; improvement of advice centres and clinics for households; a national fund and family care for frail people; qualifications of household assistant workers; a national plan for public social housing and, increased resources for employment of people with disabilities. Other measures target immigrants, e.g. a fund and schemes for social inclusion of immigrants and Roma, providing housing support, and cultural mediators to improve the social inclusion of immigrant students.

3.3. Key challenges and priorities

Social inclusion policy is based on an approach which emphasises economic growth as an instrument to reduce poverty. It underlines the need to improve coordination between policies, and between national, regional and local authorities. It focuses on the four national priorities mentioned above. A comparison between the 2006-2008 and 2008-2010 reports shows that the new first priority 'extreme poverty and homeless people' can be covered by the previous priority 'reducing poverty'. Families in difficult conditions represent one component of the previous objective on 'ensuring a better access to rights and services'. Similarly, child poverty is one aspect of the former priorities 'ensuring a better access to rights and services' and 'reducing poverty' and 'immigrants, Roma and Sinti' and one aspect of the priority on 'vulnerable categories'.

3.4. Policy measures

The measures identified in the document under the four selected priorities, if properly implemented, could help reduce poverty and social exclusion. However, the frequent lack of sound analytical background and impact assessment of previous policies, coupled with weak targets and indicators, makes it difficult to judge their adequacy. The measures will be mainly funded from the national budget and the Structural Funds, but the allocation of financial resources to specific measures is not always clear. There is a foreseeable risk of fragmented management and difficult evaluation.

Under the first priority on 'Extreme poverty and homeless people', great attention is paid to the need to monitor the situation of homeless people, and specific measures will be taken, such as a national survey on statistics, needs, reasons and services concerning homeless people, a national programme to recognise a legal residence for homeless people in collaboration with municipalities, the possibility for homeless people to access measures and services targeting vulnerable people (e.g. the social card), national guidelines to fight extreme poverty in urban areas and a national round table open to people experiencing poverty.

No additional resources are yet defined to support this priority. The regional and local authorities and NGOs will be involved through an open method of coordination.

As far as the second priority on 'Families in difficult conditions' is concerned, Italy is committed to reducing the at-risk-of-poverty rate. This priority will be pursued mainly through a national plan of public housing that favours low-income and large families, families with disabled people or seniors and immigrants with low income. A second scheme is the social card giving reductions on food, energy and gas costs to the poorest people. The bonus (€480 in 2008 for each beneficiary) is available to nearly 1 300 000 residents with Italian citizenship. To qualify, recipients must be older than 65 years and on a very low income (< €6 000 per year); poor families with the same income and at least one child aged less than 3 or older than 70 with low income (up to €8 000). The social card is mainly financed by a new tax on the profits from specific business monopoly sectors (so-called 'Robin-tax'), and will be managed centrally by a national agency.

Regional and local authorities are involved in the national plan of public housing, as well as in social inclusion plans, according to the current legal framework.

The third priority is 'Child poverty'. The key existing measure, i.e. a national plan for socio-educational services, has been retained. The plan covers a series of schemes for children, including nurseries and 'crèches', and is implemented jointly by the State, regional and local authorities.

The still-awaited 2008-2010 national action plan for childhood and adolescence will include income support to households, reconciliation of work and family life, care for relatives, reduction of early school leavers and the fight against child exploitation, striking a balance between prevention and alleviation approaches.

The resources have yet to be identified. The draft refers to the 2007-2013 National Strategic Reference Framework, which identifies policies on nurseries in South Italy as a specific target.

Regarding the fourth priority on 'Immigrants, Roma and Sinti', the National Fund for the social inclusion of migrants, addressing in particular social and housing difficulties and provided for in the 2007 budget law, has been confirmed up to projects implemented with 2007 budget. Financial resources target the inclusion of foreign children in school, and specific attention is given to children from ethnic minorities.

Priority will be given to teaching Italian, access to regular employment and housing. Regarding ethnic minorities, and in particular Roma and Sinti, the schemes under the 2007–2013 National Strategic Reference Framework should help better assess the socio-demographic and economic situation of existing ethnic communities, as well as improve the services for them (e.g. education, vocational training, employment, health and social services), the selection, analysis and transfer of good practices against discrimination and the schemes and campaigns to stop prejudices and stereotypes against the Roma people.

As previously mentioned, no targets and indicators are given for most of the measures and priorities contained in the 2008-2010 draft report. Moreover, the gender perspective is not properly explored: references are made concerning the participation to the labour market and reconciling job and family life and health care. Schemes such as support to female immigrants, which was funded by the National Fund for Social Inclusion of Immigrants, have disappeared in the draft 2008-2010 document. This happened despite the fact that all relevant indicators for Italy continue to point to a significant gender gap regarding poverty and living conditions.

3.5. Governance

The Report underlines the need to improve coordination between policies, and an open method of coordination between national, regional and local authorities (through a permanent agency that will take on a significant role when the expected rules on fiscal federalism are enforced by law). These objectives will allow the national, regional and local governments to identify shared courses of action, plan initiatives and corresponding financial resources in a coordinated manner, create an adequate monitoring and evaluation system, correlate the national plan for social inclusion with regional and local plans, integrate social and employment policies for the most vulnerable categories and define basic levels of service delivery to ensure fair access for all citizens to civil and social rights nationwide.

The document reaffirmed mechanisms for multi-level governance based on subsidiarity, networking and partnership principles that: a) involve private, public and social sectors; b) give regional and local stakeholders the main role in regional cooperation; c) give centralised offices the role of strategic national coordination, supported by sub-national offices.

4. PENSIONS

4.1. Key trends

The 1995 pension reform contained public expenditure on pensions, which is set to increase from 14.2% of GDP in 2004 to only 14.7% in 2050 and the gross replacement rate to decline from 80% in 2006 to 77% in 2046. The gross replacement rate will be declining as a consequence of considerable ageing of the population. The effective labour market exit age in 2007 was 60.4 while life expectancy at birth in 2006 was respectively 78.2 for men and 84 for women.

The current pension system is primarily based on the 1995 reform, which introduced defined contribution benefits. The contribution-based method only applies in full to new entrants to the labour market after 1995. Workers with at least 18 years of contributions at the cut-off date remain in the earnings-related regime. Law No 243/2004 set the age requirement at 65 and 60 years for men and women respectively[140] and allowed only those with 40 years of contributions or 35 years of contributions and 60 years of age to retire earlier. As a result of the very long transition period under the 1995 reform, until 2013-2015 people will continue to retire on the basis of the more generous earnings-related regime; starting from that date defined-contribution methods will have a large and increasing weight to determine the amount of benefits and will be fully phased in only from 2033-35 onwards.

The 1995 reforms aimed to increase the amount of savings invested in pension funds. Despite legislative intervention, the number of workers enrolled in private pension funds has remained low. For this reason, the 2004 pension reform and Law No 296/2006 introduced further measures to boost the second pillar in two ways, by providing higher fiscal incentives and a silence-as-assent for transferring the TFR[141] to pension funds. Joining private pension funds remains on a voluntary basis.

4.2. Key challenges and priorities

The draft document focuses on pension expenditure in Italy and provides adequate statistical information on the stabilisation of pension expenditure over the past decade, and on mid- and long-term spending projections. It clearly identifies that, following the 1995 reforms, the main challenge is to ensure adequate pensions for future pensioners, in particular as the replacement rates already fall substantially for a 40-year career. Given that most careers in Italy are substantially shorter, this represents even more of a challenge.

The draft NSR also provides long-term projections on how much second pillar pensions will contribute to ensuring adequate replacement rates for pensioners. However the assumptions underlying the calculation contribute to increasing replacement rates expected from defined contribution private pension schemes. Given the current profile of the labour force, the rise in

[140] It should be recalled that, as regards public employees, the European Court of Justice stated in November 2008 that by maintaining in force a provision by which they are entitled to receive the old-age pension at different ages depending on whether they are male or female, the Italian Republic has failed to fulfil its obligations under Article 141 EC.

[141] See footnote 1

atypical work and the limited take up of private schemes, it appears rather unrealistic to consider regular lifelong contributions as the reference model to assess the future adequacy of pensions.

The NSR identifies a sensible strategy based on three pillars:

- Improve employment rates for all categories of workers;
- Improve coverage of supplementary pensions;
- Improve social security for those not well covered (atypical workers).

While progress is being made on the last point, it is not clear which policies will address points 1 and 2 above.

4.3. More people in work and working longer

The draft NSR rightly points out that more needs to be done in this field and that policy strategies should be developed in the future. However it does not develop such strategies.

Several measures are being taken to expand coverage: increased contributions from atypical workers, introduction of care credits and more scope to reconcile all contributory periods into a single fund. These measures should help improve the pension entitlements of most people who rely on short-term and atypical contracts, at least during part of their working life.

Concerning prolonging working life, the report mentions several regional and local individual policy measures that have been introduced over the past few years, also with a contribution from the ESF. It would be extremely interesting and useful to evaluate these experimental programmes carried out at regional and local level.

The document does not address in a satisfactory way the key issue of raising employment rates, particularly for women. Continuing the process aimed at harmonising the effective retirement age for men and women should also be better tackled in the document, since it would help reduce the gender gap in pension entitlements and boost the employment rates of older workers.

The importance of these challenges has been stressed in the context of the Lisbon Strategy. The 2008 Spring European Council asked Italy to focus on increasing the provision of childcare and elderly care facilities with a view to reconciling work and family life and fostering labour market participation of women. A more comprehensive active ageing policy strategy is indeed essential to increase employment of older workers and to improve pension adequacy.

4.4. Privately managed pension provision

The report shows that the situation is unsatisfactory, especially given the low coverage rates among young and low-income workers, women, and, more generally, small firms and southern regions. Privately managed pensions (statutory, occupational or individual) must be developed for these categories, but the document stops short of addressing the implications of its own analysis.

4.5. Minimum income provision for older people

There is a wide regional variation in the proportion of elderly people living below the poverty line, with as many as 23% of elderly people in southern regions, in contrast to 8.2% and 6.9% in the North and the Centre.

Recent legislation also provided for an upgrading of minimum contributory pensions. In detail, according to Law No 127/2007 implementing the 2007 Protocol on Welfare, pensioners over 64 with an income up to 1.5 times the minimum contributory pensions (i.e. up to €8 504 in 2007 and €8 640 in 2008) were entitled to an additional lump sum of €327 in 2007, going up to €420 in 2008. Increases have also been legislated for all types of non-contributory pensions, but only for pensioners over 70 years of age. The yearly increase amounts to €156. As a result, in 2008 public assistance pensions for this category of pensioners reached €580 per month.

The current government has also just introduced a further measure for low-income pensioners: a pre-paid electronic card of €480 per year (see social inclusion part).

4.6. Information and transparency

If private pension schemes are to cover larger proportions of workers than they currently do, information and transparency on all pension entitlements appear of paramount importance. The government is moving towards a system which would allow all pensioners to view their overall situation at any moment, but this is not yet operational. Further efforts are needed so that all categories of workers are aware of and understand the possibilities offered by complementary pensions.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

In Italy there is a public National Health Service (NHS), financed via general taxation. Since 2001, responsibility for local governance of health care has been devolved to the regions. The NHS retains the authority to define the framework of strategies and national policies, together with the basic benefit package (Livelli Essenziali di Assistenza, LEA) that must be provided uniformly throughout the country. Regions are responsible for organising and administering the healthcare system. Local health authorities, both community and hospital authorities, are responsible for delivering healthcare services. Funds are distributed from the central budget to the regions according to a series of parameters (population, frequency of health utilisation by age and sex, territorial epidemiological indicators). Nonetheless, health spending per capita ($2614 in 2006) still varies substantially from region to region. Some regional taxation also helps finance the system. There are co-payments but no pre-payments under the NHS.

Primary health care is provided by general practitioners (GP) and paediatricians, who are independent contractors of the NHS. Patients can choose the place and the healthcare professional they prefer (as long as the GP has not reached the maximum allowed number of patients), and generalists have a gate-keeping function. GPs are part of a network of services provided by the Health District, the basic community structure of the public health system.

Within this context, the draft report highlights the following two priorities: a) to increase the role of prevention and shift the focus from hospital to local and ambulatory care, and b) to reduce regional imbalances by monitoring regional financial management and quality (efficiency, appropriateness, equity) at regional level. These are, in fact, two priorities which, at least according to official documents, are shared by all major stakeholders at national and regional level.

5.1.2. Accessibility

Out-of-pocket payments covering cost-sharing for public services, pharmaceuticals and private healthcare services amounted to 20.4% of health expenditure in 2007. Since some concern has been expressed about the impact of cost-sharing on vulnerable groups, there are exemptions from co-payments based on age, income, disability/dependency and chronic or rare diseases. Local authorities (municipalities) cover the institutional care costs of people on low incomes. There are still long waiting lists for hospital and specialised care. The NSR draft only refers to the introduction of the 2006 National Plan aimed at reducing waiting times, without reporting on the results of implementation in different areas of the country.

There are differences in the quality of services offered between regions. This problem has been further exacerbated since 2001 and has lead to patients migrating to obtain highly specialised care from the best regions.

Access to dental care is also a major problem due to the very low proportion of dentists operating within the public sector (only 8% of the total), and the comparatively very high cost of private dental care.

The co payments system described in 2006-2008 report is still applied, whilst the 10 € contribution paid for every specialist prescription has been cancelled; consequently, the Government resources allocated to the NHS have been increased for years 2009, 2010 and 2011.

5.1.3. Quality

The NSR provides a detailed description of the methodology and procedures put in place to monitor the quality of healthcare service provision across the country. It highlights very strong North-South differences.

The NSR does not specifically refer to the implementation of priorities set by the 2006-2008 NSR but some important measures, such as the vaccination to prevent cervical cancer (‘papilloma virus’) for 12 to 13 year-old girls, has been implemented during 2008.

5.1.4. Sustainability

Total health expenditure is around the EU average at 9% of GDP in 2006, up from 8.1% in 2000. It is slightly below average at 2614 per capita PPP$ in 2006. Public healthcare expenditure as a share of total healthcare expenditure was about 77.0% in 2007. According to 2006 EPC/EC projections, public healthcare expenditure is expected to increase by 1.3 percentage points of GDP by 2050 due to population ageing.

Financial stability is a major concern, particularly as there are big differences between the regions and the highest spending regions do not have the best outcomes in terms of quality and efficiency. Quantitative and qualitative data confirm that a number of central-northern

regions are well equipped to efficiently and effectively manage their healthcare systems. Therefore the government is introducing cumbersome procedures to ration resources, allocate funding only to well performing regions, and withhold funding until underperforming regions reach the required quality standards. The central government will transfer money in instalments, which in certain cases is conditional on completion of an evaluation procedure. While it is certainly necessary to force improvements in the rational use of resources in underperforming regions, these new procedures could penalise high performing regions.

The NSR also gives a lot of attention to prevention measures. There is a National prevention Plan 2005-2007, and at the end of 2006 all regions had implemented at least 50% of the plan, producing a real impact (improved cancer screening and more calculations of individual cardio vascular risks of individuals).

5.2. Long-term care

5.2.1. Description of the system

The supply of long-term care is based on a system combining integrated home assistance and residential care. Responsibility lies with regional and local authorities, both health and social, depending on the specific kind of service provided. The system is still insufficient for an ageing population and there are significant geographical disparities in supply and quality.

Even in this area the new *White Paper* on the future of welfare in Italy should provide more indications and measures to overcome regional disparities, to reach the aims of integrating social and health assistance, integrating services and it will indicate adequate tools.

Public expenditure on long-term health care is expected to increase by 0.7 percentage points of GDP by 2050. No data are available for long-term care expenditure as a % of GDP.

5.1.2. Accessibility

The plan ignores coverage issues and proposes a model of long-term care, which is not related to explicit data concerning the situation on the ground. There is no mention at all of: a) the profile and territorial distribution of the disabled and frail elderly in need of long-term care; b) future projections of dependent elderly by age group and gender; c) coverage levels of institutional and home care services across the country.

The absence of this kind of information undermines the reliability of the report. To provide a clear example, the report makes no reference at all to the increasing use of immigrant labour, known as '*badanti*', to care for elderly people living at home. Italian families have increasingly resorted to migrant women who in many cases working illegally[142], because of the insufficient supply of public services.

It is important to note the very limited development of home nursing services ('*Assistenza domiciliare integrate'*) and the considerable gap between central-northern and southern regions. Similarly, the existence of often very long waiting lists for access to residential care is not mentioned at all

[142] Caritas "Immigrazione dossier statistico 2008" p.272

5.2.3. Quality

There is a lack of general standards for the quality of social care, both at home and in institutions. In the light of the Constitutional Reform of 2001, central government is responsible for defining and guaranteeing basic social and health standards across the country. This remains an issue of heated political debate between national and regional levels of government, but the draft report does not say how the government intends to address it. The absence of national standards also undermines effective and comprehensive monitoring of regional performance. It substantially reduces the scope to redress current regional disparities and leaves the option to regional governments' political discretion in a context of shrinking public resources, both at national and sub-national levels. The report acknowledges an improvement in the quality of long-term care services with respect to the 2006-2008 National Plan, but yet again no specific evidence is provided to support this claim.

To improve the quality of current long-term care arrangements one can hardly ignore the need to provide adequate training programmes for immigrant care workers. A number of regions promote experimental projects in this area but the report makes no mention of them.

5.2.4. Long-term sustainability

Long-term care is financed both by the NHS and the social policy fund, distributed from central government to local authorities. However, there is a clear recognition that, given the trend of demographic developments, resources are insufficient. Despite this, the draft report does not provide an overall assessment of the resources needed to guarantee the services it includes in long-term care system throughout the country.

Some regions have set up a dedicated fund for ageing people in dependency situations, aimed at financing services and allowances, within the framework of essential health services. A measure has been approved by the national parliament (National Fund for not-self-sufficient persons) in 2007 for 2007, 2008, and 2009 which amount to 100, 300, and 400 million Euros respectively. But the report does not mention central government commitments after 2009 making reference to future measures and means provided by the White Paper. The issue is very important and needs to be properly addressed, especially considering that the government's economic and budgetary plan for 2009-2013 (Law No 133/2008) does not contain spending commitments in this policy area.

6. CHALLENGES AHEAD

- To reduce regional disparities by improving co-ordination between national and sub-national measures and adequate allocation of resources.
- To increase the level of participation in the labour market, especially for young people, women and older workers, to meet future challenges arising from demographic trends and ensure the adequacy of pensions and the long-term sustainability of public finances.
- To improve efficiency by a more rational use of resources and to improve health and LTC service organisation and coordination, whilst reducing geographic differences in provision.
- In long-term care, to focus on community and home services as an alternative to residential and hospital care by moving towards an integrated approach between regional and local levels.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	15-64 Male	15-64 Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	15+ Male	15+ Female	15-24
2000	3,6	116,9	**2000**	53,7	68,0	39,5	26,4	27,7	**2000**	10,1	7,8	13,6	27
2005	0,6	104,7	**2005**	57,6	69,9	45,3	25,7	31,4	**2005**	7,7	6,2	10,1	24
2008*f*	-0,6	97,6	**2007**	58,7	70,7	46,6	24,7	33,8	**2007**	6,1	4,9	7,9	20,3

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	74,9	81,3	15,8	19,6	66,7	70,0	6,2	**1995**	7,3	70,8	26,6	-	-
2000	76,6	82,5	16,5	20,4	69,7	72,9	4,5	**2000**	8,1	72,5	24,5	**2005**	5
2006	-	-	-	-	65.8b	67.0b	3,8	**2006**	9,0	77.0**	20.4**	**2006**	4,7

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2007 instead of 2006*

3. Expenditure and sustainability

Eurostat	Social protection expenditure (Esspros) - by function, % of total benefits: Total expen-diture* (% of GDP)	Old age and survivors	Sickness and health care	Unem-ployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Age-related projection of expenditure (AWG): (2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
1995	24,2	63,4	23,2	3,0	3,2	0,1	7,1	**2004**	30,5	26,2	14,2	5,8	1,5
2000	24,7	63,2	25,1	1,7	3,8	0,2	6,1	**2010**	31,0	-0,5	-0,3	0,2	0,0
2006	26,6	60,5	26,8	2,0	4,5	0,3	5,9	**2030**	42,4	1,1	0,8	0,9	0,2
** including administrative costs*								**2050**	59,2	1,8	0,4	1,3	0,7

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate: Total	Children 0-17	18-64	65+	Poverty risk gap: Total	Children 0-17	18-64	65+	Income inequalities: S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	20	25	18	22	22	25	25	19	5,5	**2005**	19
Male	18	-	16	18	24	-	25	17	-	**2006**	20
Female	21	-	19	25	22	-	25	20	-	**2007**	20

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female	Long Term unemployment rate	% of people aged 15-64 Total	Male	Female	Early school-leavers	% of people aged 18-24 Total	Male	Female
2001	7	10,8	9,1	12,4	**2000**	6,3	4,8	8,4	**2000**	25,3	28,8	21,9
2004	5,7	9,1	7,9	10,4	**2004**	4	2,9	5,5	**2004**	22,3	26,2	18,4
2007	5,8	9,2	7,9	10,6	**2007**	2,9	2,2	3,9	**2007**	19,3	22,6	15,9

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,86	0,89	0,84	**Aggregate replacement ratio**	0,49	0,56	0,37

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions – Coverage rate (%): Statutory pensions	Occupational and voluntary pensions	Contribution rates: Statutory pensions (or Social Security)	Occupational & voluntary pensions: Estimate of current (2002)	Assumption
3	-3	-17	DB&NDC	14	DC	100	11,4	32,7	5,70	6,91

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Cyprus

1. SITUATION AND KEY TRENDS

Cyprus continues to demonstrate a positive economic performance, matched with overall favourable labour market situation. Poverty and social exclusion do not emerge as major problems, while pockets of exclusion are encountered within certain socio-economic groups. GDP growth has shown a progressive increase over the past few years, reaching 4.4% in 2007. Total unemployment rate of 3.9% is reasonably lower than the EU average of 7.1% (it remains relatively higher for women - 4.6%). Youth unemployment has taken a downward trend, standing at 10.1%, and is lower than the EU average of 15.3%. Employment rate of older workers (between the ages 55-64) is in a steady increase, reaching 56% in 2007 (with 73% for men and 40% for women). Overall employment rate is above the EU average with 71% (62.4% for women). Total activity rate also remains above the EU average at 74%.

Risk of poverty is at the same level with the EU average (16% in 2006). In work at-risk-of poverty is below the EU average with 7%. However, the risk of poverty rate for the age group over 65 reaches up to 52%, the highest by far among all EU countries, with the risk rate for persons living in one-person households reaching 70% within this age group.

Life expectancy at birth is above the EU average with 78.8 for men, one of the highest among all EU countries, and 82.4 for women. Same holds for life expectancy at 65, with 17.7 for men and 19.7 for women. Number of healthy life years at birth is on average 59.5 for men and 57.9 for women. Infant mortality rates have shown substantial decrease over the past decade, dropping to 3.1 per thousand in 2006. Old age dependency ratio is expected to rise from 18% in 2010 to 44.5% by 2060.

Total social protection expenditure of Cyprus was observed as 18.1% of the GDP in 2006. When broken down by main functions, it is seen that a major share is devoted to old age and survivors benefits (8.3% of the GDP), followed by sickness and health care (4.6% of the GDP). Disability expenditure constituted only a minute part of the total social protection expenditure (0.7% of the GDP). Pension expenditure amounted to 6.8% of the GDP in 2006 and is expected to reach 19.8% of the GDP by the year 2050.

According to LFS data, 17.7% of the labour force[143] in Cyprus is composed of foreign nationals. When the figure is broken down by nationality, the share of those born in another EU25 country is observed to be 6.4%, while those born outside the EU25 correspond to 11.2%. Of the total number foreign nationals, 52.1% state their main reason for immigration as seeking employment while a large proportion of the immigrant population (40.2%) is composed of unskilled workers.[144] Employment rate gap between persons born inside and outside the country is -0.6.

Public sector health expenditure presents a particular challenge. Cyprus has a very low percentage of public contribution to the total health expenditure (43.2% of the total spending) and majority of the spending on health is covered through individual out-of-pocket payments, giving rise to inequalities in access to quality health care.

[143] the population between the ages 15-64
[144] Population Census of 2001 of Cyprus (national data)

Concerning the recent financial crisis, the Government has assessed that the Cypriot economy is not expected to suffer any major detrimental consequences in the financial sector. However, economic activity, primarily in the construction and tourism sectors, is expected to slow down due to lower external demand. The downward revised national real GDP growth projection for 2009 is 3%. Although sufficient data is not yet available to judge the impact of the crisis and its effects on vulnerable groups, no major deterioration is expected in the short term.

2. OVERALL STRATEGIC APPROACH

In line with the general priorities set in its National Reform Programme, Cyprus identifies a set of specific priorities in its National Strategy for the term 2008-2010. Reduction of the risk of poverty, active inclusion of vulnerable groups in the labour market, prevention of the social exclusion of children, and modernisation of certain government departments come forward as important priorities for Cyprus. Reform of the education, health and pension systems, and the restructuring of the welfare and employment services constitute more tangible objectives which are currently promoted within the above spectrum.

The challenges and priorities identified in the Cypriot National Strategy for 2006-2008 and the Joint Report of 2007 remain relevant, especially with regards to risk of poverty and social inclusion of disadvantaged groups. The challenges regarding the proposed reform of the health system also stay relevant, due to slow progress. The pension system reform, aiming to ensure the sustainability and adequacy of the system, is advancing satisfactorily, and Cyprus is encouraged to continue further with the implementation of the agreed package.

Emphasis on measures for vulnerable groups has improved. However, there is still room for further improvement. Policies towards the training, adaptation and inclusion of immigrants and mainstreaming of persons with disabilities can be further enhanced. Gender equality is addressed in greater detail in accordance with the Government's National Action Plan for Equality, while further progress in the area is encouraged. Quantitative targets are limited mostly to reduction of poverty, and there are no quantitative targets addressing the gender pay gap which was at 25% in 2005. Health and long-term care systems are in need of greater attention, especially concerning equal access and quality.

Setting up of an interdepartmental committee for monitoring and evaluating the implementation of the 2008-2010 National Strategy is a positive development in ensuring adherence to the policy objectives.

3. SOCIAL INCLUSION

3.1. Key trends

Cypriot population is facing an unevenly distributed risk of poverty. Total risk of poverty is at 16% comparing favourably with the EU average. 11% of the children aged 0-17 are at risk of poverty after social transfers, compared to 20% before transfers. Poverty risk for those aged 18-64 is 11% while the rate reaches up to 52% for the 65+ age group. Poverty risk for persons living in one person households is 43% (52% for women) and 70% for those over 65 even after social transfers. At-risk-of-poverty gap is 19 for the total population and 22 for the age group 65+. The poverty threshold for one person households is €8.719 and €18.311 for a standard family[145].

[145] Two adults with two dependent children under the age of 14

According to 2007 figures, 3.7% of the children between the ages 0-17 live in jobless households. The corresponding adult rate (aged 18-59) is 4.5%. Youth unemployment is at 10.2%.

National data indicate that persons with tertiary education account for 30.5% of the population aged 25-64. Persons with low educational attainment account for 27.9% of the population, while the number drops down to 14.8% for the age group 25-34, comparing well with the EU average. The percentage of early school leavers in the age group 18-24 is 12.6%[146] compared to the EU average of 14.8%.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

In view of its positive economic and labour market performance, Cyprus seems well equipped to tackle the risk of poverty, although some challenges persist. There has been a slight decrease in risk rates over the past few years, together with diminishing youth unemployment and increasing employment rate for older workers. Progress concerning the integration of vulnerable groups to the society has been modest. On the other hand, Cyprus initiated certain institutional measures to address governance and administration problems, an area where further progress is expected.

3.3. Key challenges and priorities

The 2008-2010 Cypriot national strategy for social inclusion makes a sincere effort in identifying and acknowledging the policy deficiencies encountered in the previous years. In light of this approach, and taking into consideration the issues addressed in the 2007 Joint Report, Cyprus identifies correct challenges and priorities.

Reduction in the risk of poverty and social exclusion is taken on board as the first priority. Measures addressing the wage gap between men and women, quantitative targets for the reduction of the risk of poverty, and plans towards taking action for the problems faced by persons with disabilities and for refugees are positive developments.

Integration of vulnerable groups into the labour market is also a priority. Within this framework, Cyprus aims to improve the active involvement of different social groups through schemes targeting entrepreneurship, vocational training, flexible employment and further development of the social care network.

Prevention of social exclusion of children is addressed as a specific priority as well. Reform of the system of education is given importance. A need to counter domestic violence and juvenile delinquency is also recognised.

Institutional modernisation is presented as another national priority. There are plans for the reorganisation of the Ministry of Education and the Social Welfare Service while upgrading of the Public Employment Service is under way.

Budgetary considerations have been given on most of the policy measures, clearly highlighting the contribution of Structural Funds. It is particularly noted that ESF provides significant contributions to a large array of policy interventions, especially concerning gender

[146] Students abroad are not included among the reference population

equality, social inclusion of vulnerable groups, and vocational training of the youth. Overall, the general approach of Cyprus is in line with the overarching objectives for social protection and social inclusion.

3.4. Policy measures

Ten quantitative targets have been set by the Government, particularly regarding the risk of poverty. Most of these targets approach the key challenges with serious commitment. An ambitious reduction of twelve points in the risk of poverty among persons aged 65 and over (from 52% to 40%) is targeted by 2011. The target for the reduction of the risk of poverty for persons living in one-person households is three points (from 43% to 40%) however no specific targets have been set for the elderly living in such households (who are currently facing a risk of poverty at 70%). The target for the reduction of the risk of poverty among single-parent families is four points (from 34% to 30%). The target for the rate of female employment is to reach 63% from the current 62.4%.[147] The Government is also targeting a reduction in the proportion of early school-leavers (from 12.6% to 11%), however the target does not necessarily address the high rate of early school-leaving among men (which currently stands at 19.5%).

The Cypriot National Strategy for 2008-2010 outlines numerous policy measures, especially regarding the social inclusion of vulnerable groups. Although budgetary consideration has been given to most items, proposed policy measures do not always elaborate on tangible expected outcomes and how different policies relate with and impact on each other.

There are plans to develop actions targeting the wage gap between men and women (which stood at 25% in 2005) through schemes enhancing women's entrepreneurship and the reconciliation of work and family life, however no quantitative targets are set. Provision of subsidies towards childcare services is a positive step to encourage higher activity rates among women. Promotion of flexible forms of employment, with the financial support of ESF, comes forward as a promising project in addressing the employment of women and the youth.

Reform of the education system comes forward as an important priority. It is welcomed that the reform plans also take into account the need to improve the educational means available for children with special needs. Further progress regarding the New Modern Apprenticeship programme, another project co-funded by the ESF, is keenly expected.

Disability awareness has partly improved through policies targeting accessibility and self-employment of persons with disabilities. Plans to enhance mobility through more accessible transport services and urban infrastructures are especially significant. Measures towards the active inclusion of persons with mental disabilities can be further improved. Different policy measures for disabilities should be brought under an overarching policy framework to achieve greater efficiency.

Emergence of a programme for the prevention and treatment of domestic violence is a further development. Strengthening of the programme through awareness-building activities may further benefit victims of domestic violence.

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[147] It needs to be noted that employment rate in Cyprus is already above the Lisbon target. However, a gender employment gap is evident considering that male employment currently stands at 80% while the targeted female employment rate stands at 63%.

Recognition of the victims of trafficking and sexual exploitation is another important improvement. The matter has often been a neglected problem in Cyprus, and more comprehensive policies are needed to address the issue. Measures for post-trauma assistance and prevention of re-victimisation need to be taken into consideration, together with public awareness raising campaigns.

Elaboration of certain social inclusion schemes for refugees and immigrants is a positive step, however a more comprehensive framework needs to be established. Although this is recognised by the Cypriot authorities, progress appears slow. Further measures to prevent economic exploitation of refugees and immigrants need to be taken.

The Cypriot national strategy for social inclusion reports on a national awareness raising programme in anti-discrimination, diversity and equality. This is a significant development which needs to be strengthened and proliferated. Considering that Cyprus is starting to make some progress towards social inclusion in gender, disability and age, less visible forms of discrimination, such as sexual orientation, should be taken on board among policy priorities.

3.5. Governance

Preparation of the National Strategy Report was concluded under the coordination of Social Welfare Services of the Ministry of Labour and Social Insurance. An interdepartmental committee has been set up for monitoring and evaluating the implementation the 2008-2010 strategy. An enlarged committee is expected to meet annually with social partners, local authorities, and other related agencies.

4. PENSIONS

4.1. Key trends

The General Social Insurance Scheme (GSIS) constitutes the main pension system in Cyprus. The Social Pension Scheme is also part of the statutory pillar, while the Special Allowance to Pensioners (SAPS) supplements the GSIS pension and the Social Pension. 19.6% of the total number of GSIS pensioners receive the minimum pension which currently amounts to €4000 (less than half of the poverty threshold for single households). SAPS is a measure developed to provide subsidiary financial assistance to low pension earners. When SAPS is added to the minimum GSIS pension, the final figure corresponds to €5538. Social Pension is a separate measure to address those over the age of 65 with no pension income from any other source. It is a non-contributory scheme and 98% of the recipients are women. It amounts to €4735 including the SAPS assistance.

The pensionable age for all employees is 65. However, those who have completed a prescribed period of insurance are entitled to pension at the age of 63 without actuarial reduction of the pension. Currently, around 70% of insured persons are awarded pension at the age of 63. Compulsory retirement age for civil servants has been set at 63, whereas the age for those in public education, police and military stays 55 to 60.

The aggregate replacement ratio is 0.29 by 2007 figures, which is the lowest among all EU countries. Risk of poverty is highest for the age group over 65 (52%) and is even higher for persons aged 65 and over living in single households (70%). Although the Government has concluded certain increases in the GSIS and SAPS minimum rates, the impact of this on the risk of poverty of pensioners has not been substantial.

4.2. Key challenges and priorities

Long-term indicators are taken into consideration, the future adequacy and sustainability of the pension system is seen to be under serious pressure. Pension expenditure currently amounts to 6.8% of the GDP (2006), however projected evolution of pension expenditures indicates that it is expected to reach 19.8% of the GDP by the year 2050 (following a 12.9% increase). Gross theoretical replacement rate for Cyprus in 2006 was 46% (52% for net replacement rate) for an average worker retiring at age 65. Change in gross theoretical replacement rate is expected to take place at 14% between 2006 and 2046 (16% for net replacement rate). Pension system dependency ratio (number of pensioners for every 100 contributor) is expected to increase from 26 in 2004 to 64 in 2050.

Cyprus acknowledges this challenging picture. To enable sustainability and prevent depletion of the pension reserve, the Government is planning a gradual increase in the contribution rates (1.3% every five years from 2009 to 2039 until the contribution rate of long-term benefits reaches 23.4% from the current 14.3%). Minimum contribution periods are planned to be increased as well. Current pension reserve ratio was observed as 7.8 in 2007 and was expected to fall into deficit by -8.1 in 2050. Under the proposed measures, the Government is expecting this ratio to be 2.9 by 2050.

If the measures prove effective, sustainability of the pension system will be strengthened in the long run. However, high levels of risk of poverty among the elderly population make it difficult to implement short-term measures to relieve the burden on the current system. Restructuring of the SAPS on the basis of a needs-assessment method may facilitate the more effective transfer of benefits to those pensioners experiencing relatively higher levels of poverty. Measures addressing the sustainability and efficiency of the pension system can be further supported through policies targeting higher and longer employment and especially the employment of women.

4.3. More people in work and working longer

The employment rate of older workers currently accounts for 56% of the total number of people aged 55-64. This rate is higher than the EU average and Cyprus has already achieved the Lisbon targets, yet a gender gap is seen to exist when the employment rate concerning older male workers (73%) is compared to that of older female workers (40%). The Cypriot national strategy for the period 2008-2010 makes no detailed reference to measures targeting the promotion of the employment rate of older workers. Policies to encourage longer working lives, especially for women, may improve the pension dependency ratio and contribute to the sustainability of the overall system.

4.4. Privately managed pension provision

GSIS constitutes the main pension scheme in Cyprus for private sector employees. About 35% of the private sector employees are covered by occupational provident funds, though benefits are in the form of lump sum payments upon retirement, and not in the form of monthly pensions. A law was enacted in 2006 to establish a general framework for occupational retirement benefit funds, but no substantial practical development has been recorded. Although the Government encourages the promotion of privately managed occupational retirement schemes to supplement the overall pensions architecture, the collective bargaining process with the private sector representatives is not expected to lead to a break-through.

4.5. Minimum income provision for older people

There is a high risk of poverty for the age group 65 and over (52%). Figures are even higher for people of the same age group living in one-person households (70%). The Government targets to reduce the average risk of poverty for 65+ to 40% by the year 2011. However, no specific targets have been set for the elderly living in single households.

The Social Pension provision for persons with no other source of income is inadequate when compared with the poverty threshold of Cyprus, and does not address the risk of poverty faced especially by elderly women (who constitute 98% of the recipient population under this scheme). The Government is concerned that any increase in the Social Pension may create disincentives for longer employment and contribution to the GSIS. Any such disincentives may be addressed via, *inter alia*, policy measures targeting higher female participation in the labour market and the GSIS.

4.6. Information and transparency

Simplification of the social insurance legislation in 2009, creation of a website for the Social Insurance Administration (SIA) and opening of new local offices for the SIA are some of the developments that have been taking place to achieve greater access to information. Establishment of a comprehensive information and transparency policy may further facilitate the Government's efforts in the area of achieving better access to information.

Within the context of the proposed reform package, inclusion of social partners in the decision-making process seems to have taken place adequately and effectively through tripartite negotiations aiming to achieve consensus between the different parties.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Health care system in Cyprus lies on two separate pillars. Public Health Services under the Ministry of Health provide free or subsidised health care to a large share of the population (around 65-70%). Another pillar is the private sector which has grown significantly in size and coverage. Public contribution to the total health expenditure takes place at a rate of 44.3% while majority of the spending on health is covered mainly through individual out-of-pocket payments to private sector medical services. Absence of a universal coverage framework leads to inequalities in access to quality health care.

Recognising the structural problems of the current system, the Government initiated a reform process in 2001 for health care. A General Health System (GHS) is yet to be created to regulate and coordinate public and private medical services to provide universal coverage. Developments regarding the reform have been disappointingly slow, and implementation has long been pending, however further progress is expected.

5.1.2. Accessibility

Due to the current structure of the health care system, achieving equality in access to health care for all social groups is a challenge. Self-reported unmet need for medical care is close to the EU average with 3.2%. However, the figure reaches 6.3% with regards to dental care. In

both categories, it is observed that the unmet need is highest for the first three income quintiles. When self-perceived health status is taken into consideration, it is seen that 18.9% of the persons in the first income quintile declare bad health, while the figure drops down to 2.2% in the fifth quintile. Overall, figures are indicative of a greater density of unsatisfactory access to health care for lower income earners. Although it is likely that other vulnerable groups also suffer from the regressive impact of the inequalities in access to quality health care, specific data to measure such impact on the basis of gender, nationality, and disability is not present. It needs to be highlighted, however, that all accident and emergency departments of public hospitals provide emergency services free of charge, irrespective of residency status. It is expected that the introduction of the GHS, together with the Health Insurance Organisation (HIO) will contribute to ensuring greater equality in access to health care services. The scheme is envisaged to achieve universal coverage and establish a system of family doctors (local GPs) to act as a first point of contact with health services. The Government needs to look closely into the distribution of financial costs under the new system to assess the expected impact of the reforms.

5.1.3. Quality

The 2007 Joint Report had identified the absence of a comprehensive quality assurance system as a significant challenge for the health care system in Cyprus. The Ministry of Health established a central committee for quality control and risk management in 2003, but an integrated quality control system has not yet been introduced. On the other hand, public hospitals operate patient welfare committees which provide a medium for the patients to express concerns. It is unclear to which degree these committees have contributed to the improvement of patient rights and satisfaction. The Government is expected to further strengthen its efforts in improving the current accreditation procedures and clinical guidelines aimed at developing quality standards for both public and private health care providers. In this regard, development of uniform quality assessment structures is encouraged.

5.1.4. Sustainability

Total health care expenditure amounted to 6.3% of the GDP in 2004, 2.49% of which was covered through public expenses. The rest of the health care spending took place through individual out-of-pocket payments and to a small extent private health insurance schemes. Based on the 2004 data on public health expenditure, the projected public spending by 2050 was expected to reach 4% of the GDP. However, considering that Cyprus has undertaken a health reform to enable universal coverage through GHS, these projections would need to be revised.

The National Strategy Report of Cyprus for 2008-2010 does not make any detailed references to the long-term sustainability of the new GHS policy. It is submitted that HIO will act as the administering agency for the financing of the system, through a fund supplied by the contributions of care recipients, their employers and the State. It is very likely that the transition from the current health care structure to GHS will incur pressure on the public expenditure on health. As such, a comprehensive impact assessment study is necessary to determine the expected long-term consequences of the GHS and to analyse the future sustainability of funds and resources.

5.2. Long-term care

5.2.1. Description of the system

Government-run structures for the elderly and the disabled, community/municipal care facilities, and private care facilities provide the main long-term care services in Cyprus. Between 2005 and 2007, an 11% increase has been noted in the number of persons being provided with long-term care in these institutions. Government subsidy is provided towards long-term care costs for public assistance recipients. Long-term care expenditure was calculated as 0.11% of the GDP by 2005 figures. National data from 2007 indicates a carer ratio of 1.98 per every person receiving care, which is showing a worsening trend due to a decline in the number of carers providing service. The Government is expected to develop a framework for home nursing by 2010 and promote community mental health nursing facilities. A national centre for mental health with long-term care facilities is planned for 2013.

5.2.2. Accessibility

There is no clear data on the accessibility of long-term care facilities in Cyprus. Equality in access to long-term care is not possible to estimate due to a lack of data on the extent of the coverage by age, sex, socio-economic background and geographical distribution.

Regarding the specific area of long-term care for persons suffering from mental disabilities, the Government operates care facilities in three cities, with a limited number of care recipients. Voluntary social welfare organisations are supported by the Government for the operation of certain care facilities for persons with disabilities.

Government has prioritised deinstitutionalisation of long-term care services, and plans to encourage community care and family care. Certain monetary benefits (although mostly limited to lump sum provisions) are available for family members who accommodate and provide care for the elderly and persons with disabilities. Diversification of the range of benefits provided towards family-care can further incentivise and strengthen the deinstitutionalisation process.

5.2.3. Quality

The 1991 Homes for the Elderly and the Disabled Law prescribes certain standards for the operation of private and community care facilities (mandatory registration, regular inspection of premises). A new legal framework is expected to be prepared for home-care provided by voluntary organisations and other private bodies. It would be advisable to establish a comprehensive regulatory framework to provide detailed quality assurance and accreditation mechanisms for the long-term care sector.

5.2.4. Long-term sustainability

Cyprus operates a subsidy scheme for long-term care recipients who are dependent on public assistance. The Social Welfare Services also finance a grants-in-aid scheme through which voluntary bodies and local authorities involved with long-term care are supported. An estimate of the current and projected extent of individual (out-of-pocket) spending on long-term care services is not available. As such, there is no concrete information as to how costs in long-term care are shared or how different social groups are affected by the costs incurred through out-of pocket payments.

Overall, main financing and budgeting mechanisms for long-term care are currently poorly developed and sufficient data is not available to assess financial sustainability. The Government is expected to conduct a study in 2009 on the financing of long-term care to develop a comprehensive approach.

6. CHALLENGES AHEAD

- To continue to improve the position of women and vulnerable groups, especially persons with disabilities, immigrants and asylum seekers, through comprehensive mainstreaming policies for active inclusion in employment and social life and equal access to services;

- To continue the efforts towards achieving better governance and increased social participation in the development, implementation, monitoring and evaluation of policy interventions;

- To address the high risk of poverty among people aged 65 and over, promote further female employment, encourage longer working lives, and ensure the long-term sustainability of the pension system;

- To rapidly proceed with the introduction of the General Health System to guarantee effective universal care coverage, contain out-of-pocket payments incidence on vulnerable groups, whilst ensuring the long-term sustainability of the new structure;

- To improve monitoring, impact assessment and quality assurance mechanisms in the provision of services, concerning *inter alia* health and long-term care, in both the public and private settings.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	5,0	88,8	2000	65,7	78,7	53,5	37,0	49,9	2000	4,9	3,2	7,2	10,1
2005	3,9	90,9	2005	68,5	79,2	58,4	36,7	50,6	2005	5,2	4,3	6,5	13,0
2008f	3,6	89,3	2007	71,0	80,0	62,4	n.a.	56,0	2007	4,0	3,4	4,6	10,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	9,7	1995	n.a.	n.a.	n.a.		
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	5,6	2000	5,7	41,6	55,7	2005	3,3
2006	78,8	82,4	17,7	19,7	64,3	63,2	3,1	2006**	6,1	43,2	48,6	2006	3,2

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits / **Age-related projection of expenditure (AWG)**

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2004	17,7	16,4	6,9	2,9	n.a.
2000	14,8	48,7	27,2	7,2	6,3	7,1	3,4	2010	18,0	0,1	1,1	0,2	n.a.
2006	18,4	46,1	25,7	6,1	10,8	7,4	3,9	2030	27,4	4,1	5,3	0,7	n.a.
								2050	37,7	11,8	12,9	1,1	n.a.

**: including administrative costs; **: under the assumption that benefits are adjusted in l*

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20		Anchored at-risk of poverty Total - fixed 2005 threshold
Total	16	12	10	51	20	16	18	23	4,5	2005	16b
male	14	-	8	47	18	-	17	21	-	2006	13
femal	17	-	12	54	21	-	19	24	-	2007	10

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female		Long Term unemployment rate (% of people aged 15-64) Total	Male	Female		Early school-leavers (% of people aged 18-24) Total	Male	Female
2001	3,9	4,9	3,4	6,3	2000	1,2	0,5	2,2	2000	18,5	25	13,9
2004	2,6	5	3,8	6,1	2004	1,2	0,9	1,6	2004	20,6	27,2	14,9
2007	3,9	4,7	4,2	5,2	2007	0,7	0,8	0,7	2007	12,6	19,5	6,8

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,57	0,6	0,56	***Aggregate replacement ratio***	0,29	0,34	0,34

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
16	14	14	DB	/	-	86	/	16,6	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Latvia

1. Situation and key trends

Economic growth in Latvia has been considerable (peaking at 11.9% in 2006). However, it slowed abruptly in mid-2007 and GDP contracted by 2.3% (estimate) in 2008. The latest forecast projects a contraction of 6.9% in 2009. Inflation (15.3% in 2008), although falling now, is still the highest in the EU. Labour market has been resilient, although with unemployment rising in the third quarter of 2008, it is expected that employment will decrease and unemployment increase significantly during 2009-2010. Disadvantaged groups and young people are likely to see a reversal in employment gains.

Growth in itself did not prove sufficient to tackle poverty and inequality in Latvia. Although the at-risk-of poverty rate in 2007 improved slightly (at 21%) compared with 2006 (23%), it is still the highest in the EU. The risk is higher for women (23%) than for men (19%). Older people, especially women, face a higher incidence of poverty. It should be noted that the at-risk-of-poverty threshold is among the lowest in the EU. Although average earnings grew considerably, having a job is not enough to avoid poverty: in-work poverty is high (10%), especially for part-time workers (26%). Inequality of income is among the highest in the EU (the S80/S20 ratio being 6.3%). The Gini coefficient (35) also confirms very high income inequalities and an increasing trend until 2007.

Demographic prospects are bleak; the population has steadily fallen since 1991, with outward migration[148] adding to natural causes. Life expectancy at birth is low (65.4 for men and 76.3 for women in 2006) and infant mortality is high (8.7 per 1000 live births), though it decreased until 2006 (7.6 per 1000). Healthy life expectancy in 2006 was 50.5 years for men and 52.1 for women. Remaining life expectancy at 65 was 12.7 years for men and 17.3 for women. The current old age dependency ratio is below average (25% in 2008), but this will not continue and projections for 2060 are not favourable (64.5%). Expenditure on social protection and pensions is among the lowest in the EU and declining, at 12.2% and 6.1% of GDP in 2006. Total age-related social protection expenditure is projected to decline.

2. Overall strategic approach

The overall approach taken by the National Strategy Report on Social Protection and Social Inclusion for 2008-10 (NSR) emphasises its links to Latvia's Development Plan, which aims to achieve a balanced and sustainable development and ensure the country's competitiveness. In view of the downturn in the economy, and high levels of poverty and inequality, Latvia has identified the following broad priorities for future action:

– To facilitate more efficient participation and inclusion into the labour market;

– To improve income support systems;

– To promote access to quality services.

For pensions, the main effort will be directed to increasing adequacy. In health care, existing strategies e.g. to attract and retain much-needed human resources, will continue to be implemented. One improvement on the 2006 National Strategy Report is that the priorities are now linked to quantified targets and indicators. In the face of a recession, given a lack of information on how the measures will be financed, there are concerns that they might prove over-ambitious. Although the NSR stresses the need to work out an integrated strategic

[148] Mostly intra-Community mobility.

approach to implementing social inclusion policies, it is still fragmented. It comprises separate initiatives and lacks a coherent approach. A clearer assessment of progress towards 2006-08 priorities and explanations about the need to change them would have been beneficial. The focus on the gender perspective has improved. Mainstreaming is emphasised as the main tool to achieve gender equality and general equality (age and disability included). The contribution of the Community Initiative *EQUAL* in tackling discrimination is acknowledged. The NSR refers to the national Lisbon Programme, but does not link in to the Sustainable Development Strategy. This results, for example, in a lost opportunity to find a better balance between a focus on housing benefits (helping to meet heating expenses) and improving poor housing insulation.

There is no explicit recognition that the economic downturn will create new challenges. A likely scenario involves higher unemployment, fewer jobs — with public sector staff cut by 10% across the board (to be followed by further cuts), and a break in customary wage growth. Recent sharp cost of living increases, coupled with higher indebtedness, also have an impact on the situation of households. The very different economic background has major policy implications: because of lower revenues, fewer resources will be available for the planned policies. There will be a need to prioritise, whilst avoiding unnecessary hardship for the disadvantaged. Secondly, recent labour market trends will be reversed. This will increase expenditure: more unemployment benefit payments and increased demand for active labour market measures. Also, local government and other public services need adequate capacity and resources to cope with the increased work loads. The need for social assistance will grow.

3. SOCIAL INCLUSION

3.1. Key trends

Latvia's social protection system underwent significant reforms in the mid-1990s to ensure its sustainability, although changes have been slower in health care. Living costs have increased considerably, particularly food, housing, transport, health and education. Although inflation pressures could be abating soon, they have not gone yet: in October 2008, the prices of heating (+16.5%), gas (+68.9%), electricity, food and clothing were still increasing. Poverty and income inequality in 2007 were among the highest in the EU. Younger people saw slight improvements as regards poverty (21%), while the situation of older people deteriorated (aged 65+: 33%). The incidence of poverty is high among households with children, especially three or more (46%). The risk was also extremely high for the unemployed (57%), men in particular (66%). Note that the at-risk-of-poverty threshold (value for a one-person household in PPS: 3356) is among the lowest in the EU. Material deprivation, notably economic strain, is considerable. However, long-term unemployment has decreased significantly (to 1.6%). The share of people living in jobless households, children included, is slightly below the EU average.

In-work poverty is high. Finding better ways to make work pay has been a longstanding issue, as taxation on low wage earners is relatively high and marginal effective tax rates do not perform well. Thus unemployment traps reveal that income taxed away on transition to full-time employment varies from 83% to 100% in 2006 (being highest for lone parents and single-earner couples, who also experience 100% earnings loss when moving to a job from inactivity). The net income of jobless social assistance recipients in 2006 (as a percentage of the poverty threshold) seems high for lone parents (1.3%) and for couples with 2 children (1.1%). The proportion of early school leavers decreased slightly at 16% in 2007 but is still high. So are the numbers of people who report that in the last 12 months they had a need to visit a doctor, but did not do so.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

No significant progress was achieved in ensuring access to education and the labour market for children and disadvantaged youth, especially, access to resources and services for families with children and for pensioners. Note that recent economic growth, together with the labour market programmes supporting first employment and providing career counselling, helped to improve the overall employment situation of young people, but the impact of the economic downturn might change this trend. Some measures were introduced for children with special needs and those with learning difficulties. Action was taken to improve the provision of services, notably care. Increases in family benefits and pensions, together with wage increases, tackled the poverty risk for some families in 2007, but did not prevent an increase in poverty for pensioners (38%, from 35% in 2006). Some measures were not fully implemented for lack of financial resources even during economic growth. The scope of the measures proved insufficient, as poverty and inequality remain high, early school leaving needs to be tackled and access to care services needs to be improved.

The 2007 Joint Report included the following key challenges:

- To develop a coherent strategic approach to promoting social inclusion and breaking the cycle of deprivation, especially for families, including quantified targets which take into account regional and gender dimensions;

- To promote targeted active inclusion measures for the full range of vulnerable groups, by addressing the adverse effects of inflation on low and medium income groups and enhancing associated services and employment opportunities.

Although the efforts made — such as introducing ambitious targets and continuing to support first employment — should be acknowledged, on the whole, the key challenges identified remain valid.

3.3. Key challenges and priorities

The 2006-08 NSR took a lifecycle approach and identified as priorities: the need to ensure access to education and the labour market for children and disadvantaged young people; and access to resources and services for families with children and for pensioners. Latvia's current attempt to reach all important target groups has resulted in setting very broad priorities (participation in the labour market; income support systems; access to quality services). The need to focus on pensioners and families with children is still important and deserves to be highlighted, as their poverty risk remains high. Tackling the adverse consequences of inflation would seem most topical. As a reversal in employment trends is expected, it is important that employment opportunities for the disadvantaged continue to be improved. Priority tasks could have better reflected the evolving needs of vulnerable groups, and the situation in the regions, or mentioned the need for improvements in the interplay between taxes and benefits. As the new tasks are very broad, they can also be seen as addressing the key challenges identified in 2007. They are broadly in line with the 'social inclusion strand' objectives. However, in the face of a recession and due to rather weak targeting and consistency, it is unlikely that the current poverty risk will decline significantly, in-work poverty included. Latvia intends to use Structural Fund support and the ESF in particular, to carry out many of the measures, but implementation for the period 2007-13 is falling behind schedule. It also remains to be seen whether full implementation will be achieved in the light of the tighter budgetary outlook.

3.4. Policy measures

Policy measures are grouped according to three priorities, based on actions in the line ministries.

The priority *'Efficient participation and inclusion in the labour market'* will be addressed by improving accessibility and the quality of vocational education and vocational rehabilitation. Opportunities to find jobs will be increased for families with children, the unemployed, and specific disadvantaged groups. Quantified targets set for measuring progress include reaching the Lisbon employment target (70%) by 2010, increasing the share of students in vocational education to 28.85% (currently 26%), and, interestingly, reaching the long-term unemployment rate of 2.3% (which may reflect the unfavourable prospects for the economy). *'Improving income support systems'* will be achieved by increasing the monthly guaranteed minimum income benefit (from LVL 27 to 37 in 2009); improving the legislation governing housing benefits; and increasing benefits for those disabled from childhood. Families with children will be supported, for example, by providing free school lunches during the first school year. Benefits for children who lack parental support will increase. Pension benefits will be further supplemented and adjusted. Continuing to increase the minimum wage from 48% of the previous year's average in 2008 to 50% in 2010 is included in this priority. The tax-free threshold will increase slightly. The authorities expected that the at-risk-of-poverty rate would decrease to 21%.

'Access to quality services' will be ensured by improving vocational education and lifelong learning systems, providing better access for the disabled and Roma to education, and improving social workers' skills to help disadvantaged young people. Foster care will be supported, as will centres for family support and youth initiatives. Access to municipal housing will improve. Support will improve for groups like ex-offenders, the disabled and elderly. The lifelong learning indicator will increase to 12.5% in 2010 (from 7.1%), youth educational attainment will reach 85%, the share of successful graduates in basic education will increase to 89%, and the availability of municipal and social housing will grow (by 0.4% and 3%).

Latvia's budget for 2009 is undergoing further amendments. Information on the scale of resources allocated is lacking in the NSR. Considering the adverse effects of recession and a tighter budgetary outlook, reaching or maintaining most of the targets for 2010 is challenging.

3.5. Governance

A formal mechanism involving all stakeholders has been created. As previously, consultation and coordination on the NSR took place within the framework of Committee for Coordination of Social Inclusion Policy. The NSR does not provide information on the outcomes of the discussions. The involvement of partners other than line ministries seems limited to clarifying issues. Compared to 2006-08, discussions held in the media and with stakeholders lost in visibility. Better involvement of the poor in improving their own situation is still a challenge. The Coordination Committee referred to above will have a role in monitoring the progress of the NSR.

4. PENSIONS

4.1. Key trends

Latvia conducted a fundamental reform of the PAYG scheme in 1996 to ensure the long-term sustainability of pensions. Risks were diversified by putting in place:

– A public statutory scheme, comprising a state compulsory NDC PAYG tier and a funded statutory tier;

– A private, voluntary scheme allowing additional savings.

The reform strengthened the link between contributions made and benefits received. People with low pension entitlements can benefit from a minimum pension. The statutory minimum pensionable age has gradually increased, and stood at 62 years for both men and women on 1 July 2008. Provision for early retirement has been prolonged again and will be available until the end of 2011. So it is still possible to retire two years earlier and receive 80% of pension, calculated according to a general formula. The effective labour market exit age increased in 2007 (63.3) and was above the EU average, although, according to the NSR, a further decrease in retirement age for certain categories was introduced (like those working in hazardous conditions). In a tight labour market, employers appreciated the skills, experience and attitudes of older workers, which raised their employment rates to 57.7% (52.4% for women and 64.6% for men in 2007).

The issue of pension adequacy has gained importance, as even during a period of high economic growth the risk of poverty for older people increased (from 21% in 2005 to 30% in 2006 and further to 33% in 2007), especially for women (39%). Single elderly people are affected more (75%). Increasing the low pensions has been the key policy response. Given the high inflation rate, supplements to old-age pensions were introduced in 2006 to alleviate poverty among the oldest cohorts. From 1 January 2009 old age pensioners, will receive an increased monthly supplement of LVL 0.70 for each 'contribution' year accumulated before 1996. The new NSR also recognises the need to index all pensions, irrespective of amount. This was expected to happen in October 2009 (according to the price index for higher amounts). For the time being, the redistributive functions within the system have gained importance: raising minimum pensions, and indexing the lowest pensions (according to the price index and 50% of the real increase in contribution wages) twice a year. The higher pensions (five times the state social security benefit) are currently not indexed. Pension expenditure as a share of GDP in 2006 was among the lowest in the EU at 6.1%, and falling. This needs to be monitored, in the light of the inadequacy of pension benefits. Expenditure on public pensions, including funded statutory pensions, is projected to rise from 6.8% of GDP in 2004 to 8.3% in 2050.

Undeclared work and underreported wages are issues for the social security system. The social insurance contribution rate is 33.09% of the gross wage; pensions account for 20% of this. The pension contributions of those who have joined the funded statutory tier are divided as follows: 12% to the NDC PAYG tier and 8% to the funded tier. This was expected to change in 2010, when the share going to the funded statutory tier increases to 9%, to be followed by a further increase to 10% in 2011. Coverage is provided for all employees, the self-employed and part-timers included. The aggregate replacement ratio is 0.38%.

4.2. Key challenges and priorities

The 2006-08 NSR identified the resources to ensure adequate pensions as a challenge. Pension adequacy remains important, as costs increase for items such as food, heating, electricity, clothing and medical services. Compared to those of the general population, pension incomes have decreased. Pension adequacy issues have risen very high on the political agenda. A referendum on minimum pension amounts was held in August 2008, but the turnout was too low to have an effect. However, this put pressure on the Government and plans were drafted to increase the lower pensions, among them plans to increase state social security benefits, which did not come to fruition. Plans for indexation of pensions in 2009 are also not clear.

Pension reform seems (based partly on performance in 2007) to have succeeded in ensuring a sustainable pension system. The current demographic situation is favourable to the state pension system, as pensions are being drawn by small cohorts born during the Second World War, while those born in 1980s (when the birth rate was twice as high as it is now) are expanding the workforce. This will change when the small group of people born in the 1990s reaches working age while, simultaneously, people born during the high-birth-rate years start retiring. Although (since 2002) there has been a surplus in the special state social insurance budget, the introduction of a pension reserve fund has been postponed due to general budgetary constraints. The prospects for this fund do not look bright, as the current NSR only refers to the need for timely accumulation of social insurance budget revenue. A temporary arrangement for administrating the surplus has been reached with the State Treasury, allowing the budget to profit from savings at an interest rate of 6%.

The design of the funded statutory pension tier does not guarantee future levels of benefits. Issues of sharing and regulation of risk might become topical as the funded scheme, removing the risks of longevity and return from the state, matures. Concerns are already being voiced about the inadequate return currently granted by active and dynamic pension plans.

4.3. More people in work and working longer

The pension system strives to focus on incentives for people to remain in the labour market for as long as possible and go on working beyond the statutory retirement age. The pension formula was initially designed to encourage people to continue working after the statutory pensionable age without drawing a pension, thus accumulating additional notional pension capital resulting in a higher pension. Parliament took a decision to pay a reduced old-age pension along with a salary, but the Constitutional Court ruled against the measure. This has contributed to fewer incentives to postpone drawing a pension. Upon reaching the statutory pensionable age, workers prefer to combine pensions with wages if they remain employed. However, the option of combining a full pension with a salary encourages people to work longer and improves their income.

4.4. Privately managed pension provision

Latvia is among the countries that have reshaped their statutory scheme by providing a funded statutory tier to complement the unfunded NCD PAYG tier. This was also expected to prevent poverty among pensioners when the scheme (introduced in 2001) matured. With the deteriorating outlook for the economy, it remains to be seen whether there is still scope for financing transition costs through higher employment, declared work and salaries.

The administration of the second tier still largely falls to the State Social Insurance Agency (SSIA). The SSIA has contracted the Central Depository to administer the accounts of the second-tier participants. Decisions on the investment of assets are taken by the asset manager. The capital is kept in a custodian bank. The institutions involved in the scheme are supervised by the Finance and Capital Market Commission. The return rate from assets in 2007 was lower than in previous years and fluctuated between -0.82% and 5.09%. None of the pension plans managed to exceed the inflation rate (10.1% in 2007) and thus achieve pension capital growth.

The private voluntary scheme was introduced in 1998, offering to the option of improving pension income by making contributions to private pension funds, but coverage is low: by the end of 2007 only 9.6% of the economically active contributed.

4.5. Minimum income provision for older people

People with small pension entitlements can benefit from a minimum pension (introduced in 1996). This is linked to the amount of the state social security benefit (LVL 45) and length of career. In 2006, the state social security benefit increased, raising the minimum pension. Indexation system also improved. Now a monthly supplement is also granted for old age pensions. The national debate often revolves around another indicator: the minimum subsistence level, the monthly average value of a minimum basket of consumer goods and services. The average old-age pension remains below this minimum, but the gap is narrowing. In 2005, only 8.5% of all old-age pensions were above the subsistence minimum; this rose to 16.4% by the end of 2007. As a result of indexation in April 2008, and of the increase in the pension supplement in June, the average old-age pension has increased and in July 2008 it stood at LVL 144.20 (89% of the current subsistence minimum of LVL 161.91). However, pensioners, especially women, face poverty too often. The relative median income ratio (65+) in 2007 is 0.65%, while the relative median poverty gap is 19. The effect of social transfers, already weak, declined further to 5 in 2006. 2007 saw an increase by one percentage point. Social transfers (before pensions) reduce poverty from 27% to 21% (the fifth lowest effectiveness in the EU).

4.6. Information and transparency

After pensions were reformed, the public was informed about the new system. A series of programmes were shown on television, and banks are now advertising second- and third-tier pension scheme products. The mass media are the main source of information on the changes in pension law. An interactive web page is gaining importance. Nevertheless, a survey conducted in August by GE Money Bank revealed how little people know about pensions: 60% of the respondents did not see any difference between the tiers of the pension system. Most of them think that this has to do with poverty and exclusion. The lack of understanding is most striking among young respondents, low wage earners and people with primary education. 28% of respondents are sceptical about saving money in the third tier, and 68% do not trust private financial institutions. Interestingly, a high number of people are joining the statutory funded pension scheme. People aged 30 to 49 at the time of the reform can opt to join the scheme, but, evidently, the likely prospects of earning a higher old-age pension if sticking with the first tier alone have not been explained. The number of voluntary participants rose to 374 523 in 2006 (including 215 310 women) compared with some 28 000 in 2002.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Latvian healthcare system aims to provide universal coverage, although the services available free of charge are limited and the proportion may shrink in the near future: cost-sharing is widely applied and will likely increase. The Health Compulsory Insurance State Agency (HCISA) and its five territorial departments administer the resources allocated to health care from the national budget. Care is purchased on the basis of contracts with providers in accordance with set criteria. Primary care, provided by general practitioners (GPs) and nurses, sometimes in joint practices, is the cornerstone of the system. GPs are independent contractors and act as gatekeepers for specialist and hospital care. Most specialist and hospital care provision is public. Dental practices and pharmacies have been privatised.

The 2006-08 NSR identified the following challenges: access to health care; continuing the reforms; improving human resources; and improving financing. The NSR states that 'the overall situation in public health sector is improving — long-term objectives have been interposed, tasks defined and policy planning documents developed for the implementation of different measures.' Indeed, many policy documents have been drafted. Some are under way, including a policy paper on financing models for out-patient and in-patient services and a development programme for out-patient and in-patient service providers for the new planning period. It is estimated that public funding for health will represent 3.37% of GDP in 2009 (compared with 3.65% in 2008). In fact, a decrease in resources is expected, impairing the system's ability to operate even at current levels. Patient fees and contributions will rise and some services will possibly no longer be provided free of charge. This will increase the burden on households, while local governments might not be able to fully cope with the new challenges of helping large numbers of residents also to access care. Life expectancy at birth is low (especially for men) and infant mortality is high by the EU standards. The gap between healthy life years and life expectancy is high. The major causes of death are diseases of the circulatory system, followed by tumours. This situation will be improved through health promotion and disease prevention, e.g. screening programmes; for example, from 2009 a centralized cancer screening will be organized and monitored by HCSIA. The targets set include increasing life expectancy at birth to 95% of the EU average by 2010, and the authorities expect that health inequalities will decline, especially for the most disadvantaged.

5.1.2. Accessibility

As stated, the number of services available free of charge is limited. Public expenditure on health care is low and private expenditure, mostly out-of-pocket payments, is very high and growing (accounting for 38.6% of total expenditure in 2006) despite exemptions for certain categories of patients and vulnerable groups or upper limits introduced on payments. Some state support is available to obtain cheaper or free medication for certain diseases. Latvia has set quotas for planned services. Usually by the end of year (and as early as October in 2008) hospitals stop or limit planned operations. Patients can either pay, or wait until the next year. Depending on the doctor, waiting times to get an appointment continue to be lengthy. On the positive side, GPs have addressed the situation by setting aside one hour a day for urgent cases. The Health Ministry intends to allow people to visit the doctor during weekends (once every two to three months).

The generally limited public resources allocated to health sector can impair access. EU-SILC monitoring data reveal that 19.3% of respondents in 2005 and 15% in 2007 had needed medical treatment or a health examination over the last 12 months, but had not obtained it. The main reason for not visiting the doctor (or dentist) in 2005 and in 2006 (especially for women) was the high cost of medical services. However, 2006 saw some improvement. A 2006 opinion poll also showed a slight increase in the number of respondents judging their health to be relatively good or good.

5.1.3. Quality

On the positive side, the NSR reports that help to ensure adequate medical technology is provided in the regions and that efforts are made to improve cost effectiveness. The infrastructure and use of e-Health information technology will improve. Emergency medical service is being modernised and the structure of service providers optimised. Although wages have gradually improved and plans are in place to support medical studies, current staff shortages, overtime and dissatisfaction among medical staff affect quality. NSR data show rising mortality rates for new-born children and women after giving birth, which increased further in 2008. There is growing dissatisfaction with the management of the system. The Health Ministry and agencies and institutions under its supervision have been criticised for bureaucracy, overlapping functions, etc. Patient satisfaction, according to EU consumer surveys, is very low. The NGO representing patients' interests, the Patient Rights Protection Centre, folded in 2007 for lack of finance.

5.1.4. Sustainability

The sector has received more resources in recent years and expenditure is projected to increase from 5.1% of GDP in 2004 to 6.2% in 2050. Outpatient visits are rising, and the number of hospitals and days spent in them is falling, although the average length of stay in hospital was still high in 2005, at 9.6 days. Moreover, hospitals still spend the bulk of healthcare financing. Hospitalisation is still high, at 234 hospitalisations per 1000 residents in 2007.

Over the years, the number of primary care doctors (internists, family doctors or general practitioners and paediatricians) has been stabilising. The long-term programme 'Development of Human Resources in Health Care 2006-2015', drafted in 2006 and cited in the NSR for 2006-08, has tackling low pay as one of its priorities. The age profile of doctors and other personnel remains a serious concern: over 40% of doctors are in the pre-retirement age group, or have reached statutory pensionable age but continue to work. There are also serious problems in attracting and retaining nurses and emergency care staff. To this end, the ESF will support medical studies during the 2007-13 planning period.

Note, though, that due to the economic downturn some of the programmes might be suspended. The Minister of Health has said that the human resources programme could also be suspended. Promised salary increases have been put on hold, and the burden of payments for patients could rise. The 2007 Joint Report states that health expenditure in Latvia is below the EU average and recommends allocating more public resources to the health sector. This remains valid. Since the Government has declared a cost-saving budget for 2009, and all line ministries have cut their expenditure, it is estimated that resources will remain at the same level as in 2008. The estimate was that, after inflation, this will translate into a LVL 44 million decrease. The funding for this sector is likely to remain at the same level for the next three years. As capacity in hospitals and primary health care is relatively high, there is still scope for improving health outcomes by continuing to tackle the issues of quality and efficiency.

5.2. Long-term care

5.2.1. Description of the system

Long-term care (LTC) is based on an assessment of the individual’s needs and means carried out by social work specialists. The main decision to be taken is the choice between home care or a residential solution. The criteria are rather restrictive: services are provided only based on an appraisal of person's needs abilities, resources and support available. If a person is recognised as capable of taking care of himself or herself, LTC is refused. Clients have to pay for LTC. Local governments, responsible for the bulk of LTC, support the needy. Some groups are exempt from payment. At the same time, if a person has sufficient means (or someone covers the full cost), the services will be provided immediately. The share of alternatives to residential care is increasing. Work has started on providing integrated services by combining multidisciplinary services within one institution.

5.2.2. Accessibility

How long elderly and disabled people can stay in their homes depends to a large extent on the support available from local governments. The latter organise and prioritise the services according to the available budget. Alternative forms of LTC include day-care centres for retired people, social residential houses, social and group apartments. Unfortunately, the NSR provides only absolute numbers, making it difficult to estimate the extent to which needs are satisfied, whether all local governments can provide adequate services, and the share of clients on waiting lists.

5.2.3. Quality

Although Latvia has made efforts to set quality standards for LTC, regional disparities exist, as the quality of care depends on the resources allocated. There are difficulties in providing sufficient numbers of care staff and social workers. Although organising home care is more complicated in rural areas, there are local governments who find ways to provide services to their residents. Thus, the home care centre in the Sigulda district has organised mobile units with care workers and a driver visiting all customers three times a week, supplying them with basic goods and providing some services. An extra service is provided: changing and laundering of bed linen and clothing.

5.2.4. Long-term sustainability

The current, rather low LTC spending (representing 0.4% of GDP) is projected to increase to a modest 0.7% by 2050. Taking into account the growing number of old people, and the number of severely disabled people, LTC options would need to be extended to cover all those who really need support. However, given the unfavourable economic prospects, the short term perspective is becoming more important. The coming winter is expected to be very hard for people. Local governments have expressed concern about their capacity to cover residents' needs. Support for the needy and services, like social housing and night shelters, is funded entirely by local governments.

6. CHALLENGES AHEAD

- To develop a coherent strategic approach to promoting social inclusion and effectively breaking the cycle of deprivation, especially for families with children.

- To promote targeted active inclusion measures for vulnerable groups, by addressing the adverse effects of price increases on low and medium income groups; increasing the effectiveness of social transfers; and enhancing associated services and employment opportunities.

- To ensure that resources for adequate pensions are available in both schemes and actively tackle the issue of pensioner poverty, while continuing to monitor the effects of the maturing funded scheme.

- To ensure that public sector spending cuts do not affect healthcare, given the low health status of the population and low overall expenditure; to reduce the individual financial burden of health care; to improve the quality of care services; and to address human resources issues while continuing to improve the efficiency of healthcare.

- To ensure that public sector spending cuts do not adversely affect the provision of long-term care; to address human resource issues and ensure continuity of services.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	6,9	36,7	**2000**	57,5	61,5	53,8	29,6	36,0	**2000**	13,7	14,4	12,9	21,4
2005	10,6	48,6	**2005**	63,3	67,6	59,3	32,6	50,0	**2005**	8,9	9,1	8,7	13,6
2008*f*	-2,3	52,6	**2007**	68,3	72,5	64,4	38,4	57,7	**2007**	6,0	6,4	5,6	10,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**1995**	n.a.	n.a.	n.a.		-
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2000**	6,0	54,7	43,9	**2005**	19,3
2006	65,4	76,3	12,7	17,3	50,5	52,1	8,7	**2006****	6,4	60,5	38,6	**2006**	15,0

s: Eurostat estimate; p: provisional

**THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	25,0	n.a.	6,8	5,1	0,4
2000	15,3	60,1	16,7	3,8	10,2	1,4	7,9	**2010**	25,2	-2,9	-1,9	0,4	0,0
2006	12,2	48,3	29,1	3,7	10,2	1,4	7,3	**2030**	34,6	-1,5	-1,2	0,8	0,1
								2050	51,2	-1,3	-1,2	1,1	0,3

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	21	21	18	33	25	28	30	19	6.3	**2005**	19
male	19	-	18	21	27	-	32	12	-	**2006**	18
femal	23	-	19	39	24	-	28	19	-	**2007**	10

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female		Long Term unemployment rate (% of people aged 15-64) Total	Male	Female		Early school-leavers (% of people aged 18-24) Total	Male	Female
2001	10,7	12,8	12,3	13,2	**2000**	7,9	8,3	7,5	**2000**			
2004	7,2	7,8	7,1	8,4	**2004**	4,6	4,8	4,3	**2004**	15,6	20,5	10,7
2007	8,3	6,6	6,7	6,6	**2007**	1,6	1,9	1,2	**2007**	16	19,7	12,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,65	*0,7*	0,63	***Aggregate replacement ratio***	0,38	0,33	0,44

Change in theoretical replacement rates (2005-2050) - source ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
-12	-11	-11	NDC/DC	/	-	100	/	20	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Lithuania

1. SITUATION AND KEY TRENDS

The Lithuanian economy experienced a period of impressive growth in 2001-2007. In 2007 GDP grew by 8.9% and GDP per capita in PPS reached 61% of the EU average (a 20% catch-up in 7 years). The labour market situation also benefited from the favourable macroeconomic trends. In 2007 the employment rate reached 64.9% (EU: 65.4%) compared to 57.5% in 2001 and the unemployment rate fell to a record low of 4.3%. The relatively high employment rate of women and older workers further increased to 62.2% and 53.4% respectively and youth unemployment decreased to 8.2% (against EU: 15.3%).

The strong economic performance did not, however, result in a substantial improvement in the relative poverty level, which stood at 19% in 2007. Looking at the different age groups, the at-risk-of-poverty rate is higher for children (22%) and elderly women (37%). The demographic situation is challenging in Lithuania. Life expectancy for men is low (65.3 years at birth but 13 years at 65 in 2006). There were minor increases in the fertility rate but it remains low (1.31). The old-age dependency ratio projection is relatively favourable in the medium term (23.2 against 25.9 in the EU in 2010) but is projected to skyrocket to 51.13 in 2050. In addition, the demographic and labour market situations have been heavily affected by very high economic emigration in the last decade.

Although the amount allocated to social protection has increased in absolute terms, the share of total expenditure for social protection remains one of the lowest in the EU (13.2% in 2005, half of which goes on pensions) and yet shows a declining trend. It is also important to stress that the economic situation started to deteriorate in 2008, with inflation reaching double digits and the projected slowdown of GDP growth to -4% in 2009[149]. That will adversely affect public finances, the labour market situation and the situation of the poorest groups in society. What is more, the deteriorating economic situation in the EU might cause the return to their country of Lithuanian citizens who left for economic reasons, something that would pose an additional challenge to the labour market and public finances.

2. OVERALL STRATEGIC APPROACH

The Lithuanian NSR structures its overall strategic objectives in line with the overarching objectives of the OMC for social protection and social inclusion. However, the overall approach is presented in conceptual terms and lacks clear strategic directions which would allow those overarching objectives to be achieved. The NSR states that the key challenges remain broadly unchanged, such as unfavourable demographic trends, a declining labour force activity rate, substantial regional differences, an increasing need for health and social services and the financial sustainability and adequacy of the pension system, which to a degree puts a question mark on the effectiveness of the measures applied in 2006-2008. It also identifies a new set of challenges related to the economic slowdown in Lithuania, but does not reflect on how the social inclusion and social protection policies should be redesigned in 2008-2010 to cope with the effects of this downturn. The NSR claims mutual interaction with the National Lisbon Strategy in particular in terms of activation and employability of vulnerable groups and the incentives provided by the pension and healthcare system to stay longer and in better health in employment. Gender equality is presented as a horizontal principle to be mainstreamed in all policies. Support from the Structural Funds is mentioned as one of the key tools to moderate regional differences.

[149] European Commission Interim Forecast January 2009

3. SOCIAL INCLUSION

3.1. Key trends

Good economic performance in recent years has helped to improve the situation of the poorest groups in society in absolute numbers. Nonetheless, although the at-risk-of-poverty threshold rose to 3512 in PPS in 2007 it remains among the lowest in the EU. Further, relative poverty stayed high (19% and EU: 16% in 2007) and deep (26% poverty gap). The same population groups as in 2004 faced the highest risk of relative poverty in 2006: the unemployed (down from 63% to 57%), single parents with dependent children (48% to 42%), families with three or more children (44% to 38%) and single adult households (up from 32% to 49%). National statistics reveal a persistently high at-risk-of-poverty level in rural areas (34%). Social transfers reduced the at-risk-of poverty rate for the total population by 7% (from 26%) but were less efficient than in the EU-25 on average (9% reduction), one of the reasons being the limited public resources allocated to social expenditure.

The growth of the employment rate in recent years (64.9% in 2007) significantly reduced unemployment (4.3%), youth unemployment (8.2%) and long-term unemployment rates (1.4%), with the share of people living in jobless households falling from 7% in 2006 to 6.3% in 2007. Conversely, it is a matter of concern that the share of children in jobless households increased from 5.3% to 6.9% in the same years. Furthermore, the National Strategy Report reveals an increase in unemployment and youth unemployment in 2008. And although the population as a whole got richer and there was some decrease in the inequality of income distribution between the highest and the lowest quintile, the gains in wealth remain highly uneven (6.3 against 4.8 in the EU in 2006). Furthermore, while the situation in the labour market improved, in-work poverty remained relatively high (9% in full-time and 25% in part-time against 7% and 11% in the EU-25 in 2006).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Four priorities were established in the 2006-2008 National Strategy Report: (1) increasing labour market participation, (2) improving access to quality services, (3) eliminating child poverty and enhancing assistance to families, and (4) tackling disadvantages in education and training. Three challenges on social inclusion for Lithuania were identified in the 2007 Joint Report: these concerned child poverty, rural poverty and governance.

In the area of the labour market, the overall improvement of the situation was significant, the employment rate of different groups increased and unemployment went down. The decisive factors for this progress were the expanding economy and the shrinking labour supply because of high out-migration of the labour force from Lithuania. Some progress has been reported as regards the improvement of the most vulnerable groups on the labour market, such as the increased number of social enterprises employing disabled people and subsidised employment. However, the effect and adequacy of those measures for the whole vulnerable population is not assessed in the NSR. Concerning the priority of improving access to quality social services, the progressive trend of shifting from stationary to non-stationary social services (provision of services at home or at day centres) is intensifying. However, the NSR still reports a substantial lack of social services, in particular for elderly and disabled people and significant regional inequalities in the access to services. As for the quality of social services, no progress was reported in relation to the plans in the 2006-2008 strategy to set quality standards and introduce control mechanisms. Some progress has been achieved in tackling child poverty. The NSR reports moderate decreases in the poverty risk for children, mainly due to the improved situation on the labour market and increased social benefits for

children and families. However, the at-risk-of-poverty rate in single parent households and for families with many children remains very high and the share of children in jobless households increased in 2006. The 2006-2008 strategy revealed the highest risk of poverty among 3-5 year olds. The new strategy does not, however, report on the progress made in this respect. Regarding the priority of tackling disadvantages in education and training, Lithuania performs well as regards the rate of early school leavers or the share of young people with at least secondary education. Some progress has also been reported in relation to the integration of children with special needs and the disabled into the educational system. However, the coverage of those measures and their adequacy is not assessed.

Combating rural poverty, identified as a challenge for Lithuania in the 2007 Joint Report, has not yielded encouraging results despite a number of measures reported. The rural population lived at high and deep poverty risk and the rural/urban divide widened. Progress on the better governance challenge is analysed in section 3.5.

3.3. Key challenges and priorities

The social inclusion strand of the National Strategy Report has an overall objective of reducing the risk of poverty by 2.5% to 17.5% in 2010. However, this target seems to be declarative as it is not split by target group and does not have a clear-cut operational strategy behind it. The strategy focuses on three important priorities: (1) *Eliminating child poverty and enhancing assistance to families.* The stress is on the high poverty risk of single-parent households and households with many children, children in 'social risk' families, children of economic migrants living in Lithuania and children's rights. (2) *Increasing labour market participation.* The focus of this priority is on the high relative poverty of the unemployed and the economic activation of disadvantaged people using their potential as a countermeasure against the shrinking labour force and better integrating them in society. (3) *Improving access to quality services.* The emphasis is on the underdeveloped social services in general and the rural/urban and smaller towns/biggest cities differences in access to services. The new NSR thus keeps its focus on the same priorities as the 2006-2008 strategy with the exception of the 2006-2008 priority of tackling disadvantages in education and training. In addition, gender equality, balanced regional development and active ageing have to be integrated in the implementation of the NSR as horizontal principles. The highlight on regional differences under the third priority reflects to some extent the challenge identified in the 2007 Joint Report on combating rural poverty. The 2007 Joint Report challenge of better governance by developing, in partnership with all the relevant stakeholders, monitoring, evaluation and mainstreaming systems is not prioritised.

3.4. Policy measures

The measures under the first priority, *eliminating child poverty and enhancing assistance to families*, are split into two groups: (1) eliminating child poverty and social exclusion and guaranteeing children's rights and (2) preventing social risks to families and supporting families at social risk. 'Families at social risk' is a concept for dysfunctional families. There is therefore a risk that not all poor families will be addressed as due account is not taken of the high at-risk-of-poverty rate in single-parent households and families with many children. Despite the fact that every fourth child is at risk of poverty in Lithuania, the NSR does not set a quantified target in this respect. The quantified targets set in the NSR are taken from different national programmes. Although they are important, their choice for the purpose of reducing child poverty is not backed by argument. Most of the measures under this priority merely refer to the recently adopted national strategies and programmes such as the Child Wellbeing Strategy, the Programme on Social Inclusion of Orphans and Children without

Parental Care, the Anti-Violence against Children Programme, the National Demographic Strategy and the Social Housing Programme. Some other measures are formulated as broad statements without operational background, such as making sure that benefits for children in families at social risk are used for their needs or assisting economic emigrants' children living in Lithuania.

The second priority, *increasing labour market participation*, covers two objectives: (1) increasing employment and participation in the labour market and (2) enhancing social inclusion. The quantified targets for this objective are taken from the National Lisbon Programme. The most relevant of these are the targets for activity and employment rates by different age groups. However, there are no specific targets set for disabled and other vulnerable groups, with one exception: activation of the long-term unemployed. Furthermore, the link between the targets set and the policy measures is not demonstrated. Again, the measures either refer to the national programmes (mostly mainstream programmes such as on vocational training, higher education, labour force mobility, economic migration) or are of a declarative nature (such as encouraging social partnership, developing entrepreneurship among the population, enhancing ALMP to make sure the potential of disabled people is used on the labour market.). Specific well-planned measures for the vulnerable groups are lacking. Neither is due account taken of financial and other work incentives/burdens and relatively high in-work poverty.

The third priority, *improving access to quality services*, covers three objectives: (1) improving the quality of social services, prioritising the progressive forms of social services and increasing their accessibility; reducing regional imbalances in accessibility, (2) enhancing social integration of the disabled, elderly, victims of human trafficking, ex-prisoners and refugees, and (3) increasing the participation of all groups in cultural, sports, community and self-education activities. Three out of five quantified targets for this priority are related to greater accessibility and efficiency of professional rehabilitation services for the disabled. The other two targets relate to the increase in the number of social workers and the recipients of social services. There are no targets set for the first and third objectives of this priority, and the targets are not split by vulnerable groups with the exception of the disabled. Important measures are planned on the setting of quality standards for social services, improving the infrastructure for social services and working conditions of social workers, developing non-stationary infrastructure, social inclusion of the disabled and refugees, better access to cultural and sports activities. However, as in the previous priorities, the measures are often not specific enough to be operational and lack analytical background.

3.5. Governance

Like the previous NSR, the 2008-2010 strategy was developed by the Ministry of Social Security and Labour, assisted by a working group representing government institutions, social partners, NGOs and municipal authorities. This group will also monitor implementation of the new strategy. However, the new strategy does not reveal how the quality of stakeholder involvement was assured in the drafting and how it will be assured in the monitoring of the NSR; neither are the governance lessons from the 2006-2008 period specified.

Being a framework document, the 2008-2010 strategy consolidates national social inclusion policies and accommodates relevant national programmes and other initiatives as its measures. However, the formulation of these measures in the NSR often lacks the clarity, baselines and specific targets necessary for assessing their achievement in future. Nor does the NSR specify what mechanisms will be put in place for mainstreaming the social inclusion policies in the relevant public policies and the Structural Funds. Therefore, the issue of effective monitoring, evaluation and mainstreaming, identified as a challenge already in the 2006 and 2007 Joint Reports, still has to be addressed.

4. PENSIONS

4.1. Key trends

Lithuania has a statutory social insurance pension system financed by contributions (23.5% of gross wage paid by the employer and 2.5% by the employee in 2008). Pensions consist of a PAYG, flat-rate basic pension and a supplementary pension depending on years of service, individual wage and insurable income in the country. In 2005-2007 coverage by the statutory system rose from 85% to 92% of the labour force. The second tier of the statutory system, the mandatory funded privately managed pension scheme, was introduced in 2004. It is funded by a fraction of the social insurance contribution (5.5% of gross wage, between 2009-2010 3%). This scheme attracted 69% of those covered by full social insurance (including 92% of eligible >30 year olds) by 2008 — substantially more than projected. Supplementary voluntary pension provision also exists but its take-up remains marginal at 0.1% of the labour force. Tax breaks are available for this provision as well as for life insurance products. In addition, the provision of a social assistance pension (90% of the basic pension) was extended in 2006 to cover all elderly and disabled persons without entitlements in the social insurance system. The rapid economic growth of the last few years has allowed the government to increase pensions, though at a lower pace than the real growth of salaries. The aggregate replacement ratio remained below the EU average (0.44 compared to 0.51 in the EU in 2006). The poverty risk for the elderly (65+) was substantially higher for women in 2006 (28%, compared to 10% for men).

4.2. Key challenges and priorities

There were several improvements in terms of wider coverage of the population by statutory pensions (identified as a challenge in the 2007 Joint Report). Coverage of the labour force increased to 92% and the unemployment level fell to a record low of 4.3% in 2007 although starting to pick up in 2008. Nevertheless, some population groups such as farmers and performers remain excluded from the statutory system. In addition, the effects of the grey economy (which appears to be shrinking in recent years) on the pension system, in particular in the light of the economic downturn, would merit further analysis. As from 2008, persons taking care of children under three or other dependent family members are insured for the full social insurance pension (they used to be covered only for a basic pension). However, despite the increased share of the population entitled to full pension rights, the level of pension

remains low. In 2007 the aggregate replacement ratio was 40%. According to projections of the theoretical replacement rates, a drop in net retirement income as a ratio of work income at the point of retirement is expected to drop by three percentage points between 2006 and 2046 for a worker retiring at age 65. Pension expenditure compared to the EU average is rather low, at 6.7% of GDP in 2004. Statutory pension expenditure over the period 2004-2050 is projected to grow by 1.9% for the statutory pension and 3.7% including the privately managed funded scheme. The old-age dependency ratio projection of 65+ is relatively favourable in the medium term (23.2 against 25.9 in the EU in 2010) but a sharp increase to 51.13% is projected in 2050 (this projection in 2004 was 44.9%).

The transfer of contributions to the mandatory funded privately managed scheme reduces the resources of the statutory pension system. This loss was partly compensated by the state budget. However, there are no long-term funding commitments in this respect. This poses a risk for the financial sustainability of the statutory pension system and may possibly hold down the increase in statutory pensions. The NSR target to increase the average pension from 42% at present to 50% of the net average wage by 2015 is not backed by adequate financial measures.

4.3. More people in work and working longer

The employment rate of elderly people has grown steadily and is above the Lisbon target of at least a 50% employment rate among older workers (55-64) by 2010. It reached 53.4% in 2007 (60.8% for men and 47.9% for women). The overall employment rate came close to the EU average in 2007 (64.9% and EU: 65.4%). The legal retirement age was 62.5 years for men and 60 years for women in 2008. The NSR refers to a preliminary plan to start increasing the retirement age gradually from 2012 until it reaches 65 years for both men and women in 2026.

This increase would bring the level of women’s pensions closer to those of men and would have positive effects on the sustainability of the statutory pension system. The average labour market exit age in 2007 was 59.9 years (61 in the EU). In 2007, the pension supplement was introduced for the years in service exceeding the 30-year qualifying period. Staying longer in work is rewarded by a pension benefit increase of 8% per annum compared to the average pension. On the other hand, the early retirement scheme for long-term unemployed persons has been in existence since 2004, reducing the pension by 0.4% for every full month remaining until the retirement age. From 2008 full pension rights were ensured for those taking care breaks to look after a child or dependent person as described above.

4.4. Privately managed pension provision

The high participation rate can be described as a success of the new system yet forebodes the risk of inadequate pension benefits for some population groups (in particular older and low-paid workers) and threatens the financial sustainability of the statutory pension system. In the early years most private pension funds were not sufficiently profitable for their participants to cover the loss due to their partial opt-out from the statutory system. This shortfall seems to be deepening in the face of the current financial turmoil. The effectiveness of this new system needs to be monitored as it matures.

The administrative costs of some private funds have also attracted criticism both in the recent report of the National Audit Office and from some independent experts. In this respect, the NSR indicates the Government’s intention to introduce ceilings for administrative charges. In addition, as already stated above, the lack of long-term planning to cover the loss to the statutory system due to the private provision constitutes a risk to the financial sustainability of

that system. Furthermore, some research on the effects of the private provision on income (in)equality of future pensioners would be beneficial, either compared with those who did not opt for the system or those that have chosen different risk profiles, or based on the differences in the current wages from which the pension contributions are paid.

4.5. Minimum income provision for older people

The poverty risk for the elderly (65+) is close to the total rate in Lithuania (22% and 20% total). The risk increased by 5 percentage points from 2005 to 2006 because benefit levels were not uprated in line with rapid wage growth. Similar falls were recorded in the 65+ share of income of the 15-64 age group and in replacement rates. To correct this erosion of relative benefit levels the government increased the main flat-rate part of the pension benefit by 10% from 1 January 2008, resulting in increases in all pensions with relatively higher increases for lower pensions.

For minimum income provision for older people the ambition is further that the social assistance pension (SAP: 90% of basic pension) should be higher than the level of social assistance for adults (state-supported income or SSI). This was achieved in 2006 when the SAP amounted to 125% of the SSI. But in 2007 ad hoc increases in the SSI reduced the SAP to 101%. The SSI benefit amounted to €101 in 2008, which is insufficient in terms of alleviating the poverty risk. Thus on a relative scale commitments to reinforce minimum pension guarantees have only partly been met.

The at-risk-of-poverty rate is considerably higher for women (28% compared to 10% for men), in particular in the 75+ age group (still 10% for men and as much as 35% for women). One of the reasons for this gender gap is the different statutory retirement age, giving women less time to build up pension rights. Women are also more affected by career breaks, but that issue is being resolved from 2008 as described above. As the private pension provision is based on the separate mortality tables for women and men, private pension payouts will be lower for women owing to women's higher life expectancy. The reformed survivors' pensions and planned increases for single older persons should improve the situation of women.

4.6. Information and transparency

The websites of the State Social Insurance Board[150] and the new privately managed pension provision[151] provide exhaustive information on pensions (some of which is also available in Russian and in English). From 1 July 2007 private pension funds are required to provide enhanced information to all participants in the system. However, the pension funds' managers publish only the nominal results of the funds, which do not reflect the impact of inflation. There is also a lack of transparency on future pension benefits under both the statutory and privately managed pensions. So far these have been largely dependent on economic performance and ad hoc adjustments.

[150] http://www.sodra.lt.
[151] http://www.pensijusistema.lt.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Lithuanian Health System is organised by public authorities at municipal, county and national level. Compulsory health insurance paid as part of social insurance taxes at 3% of gross wage and 30% of personal income tax provides 99% coverage of the population. Health services are predominantly public but the government indicates its intention to promote private provision, in particular in primary care. Concerning health outcomes, healthy life expectancy was low in 2006 (51.2 for men and 54.3 for women) and the NSR reveals disquieting trends for the population's health status in many areas. Life expectancy at birth in Lithuania was 71.1 years (78.4 in the EU in 2004), low for men (65.3 compared to 77 for women). This gender gap was smaller at the age of 65 (13 for men and 17.6 for women). The percentage of people reporting bad or very bad health was considerably higher in the two lowest income quintiles (about 16%) compared to the two highest quintiles (6.2% and 3.4%) in 2006.

5.1.2. Accessibility

Healthcare facilities are concentrated in major cities and regional inequalities in the access to healthcare services are recognised. However, the NSR does not provide information on actual access to health care. The system is still under-resourced and historically oriented towards stationary services and hospital care, with one of the highest inpatient care ratios and number of doctors per 1 000 inhabitants in the EU. Ambulatory care, preventative care and the promotion of healthy lifestyles are insufficiently developed and certain specialities are lacking in the periphery. Although the healthcare budget has increased, the NSR does not provide evidence on improvements in accessibility.

The total self-reported unmet need for medical care (due to waiting time, costs or distance) stood at 8.2% in 2006 compared to 3.1% in the EU on average and was up on 2005 (7.2%). The level of self-reported unmet need was dependent on income level, with a substantially higher level of unmet need in the low income quintiles. The self-reported unmet need for dental care was 11.1% in 2006 (5% in the EU). Transparent and comprehensive monitoring of accessibility should be developed, in particular taking into account the large number of self-reported unmet needs. In this respect, the NSR reports that public monitoring of waiting lists for healthcare services was introduced in 2007 and claims that waiting times have been reduced, although the claim is not backed by data. Support from the Structural Funds is intended to reduce regional differences in the provision of and access to primary care.

5.1.3. Quality

Lithuania is implementing a Health Care Quality Assurance Programme 2005-2010. However, many of the measures are still at the conceptual level and, according to a recent WHO publication, have not been implemented yet for lack of funds. This publication also refers to the 2007 report of the National Audit Office of Lithuania which claims that no comprehensive quality assurance system exists in the healthcare system and that quality indicators and evaluation by the municipalities are lacking. Quality management systems, in particular in the larger hospitals, nevertheless seem to be in place. The NSR does not, however, provide information on the functioning, efficiency and development of quality assurance systems.

5.1.4. Sustainability

Despite a welcome increase in resources allocated to the sector, the health system in Lithuania is still under-resourced as compared with other EU Member States, with low health expenditure as a % of GDP and per capita. Total health expenditure accounts for 5.9% of GDP and is among the lowest in the EU (9% on average in 2005). GDP per capita expenditure was 862 in US$ PPP compared to the EU average of 2 454. In addition, the NSR admits that the use of resources is not efficient enough and sets increased funding and greater efficiency as key priorities. However, no comprehensive commitments are made in this respect. The projected increase in public health expenditure 2004-2050 of 0.9% of GDP due to population ageing is relatively modest compared to other MS (partly due to the underdevelopment of the current system).

The NSR identifies planning of human resources as one of the key priorities. However, no data on the HR situation, high staff migration, and skills shortages is provided. A 2002 survey revealed that 60.7% of specialist trainees and 26.8% of physicians expressed the intention to emigrate. The methodology for planning of healthcare specialists and pharmacists was approved in 2007. The NSR fails, however, to provide a comprehensive strategy to overcome the risk of staff shortages. Part of the solution to this challenge will be provided by ESF-supported training for medical staff.

Given the low health status of the population the strong focus on health promotion is welcome.

5.2. Long-term care

5.2.1. Description of the system

While at present the bulk of long-term care is delivered in the home by informal carers, formal long-term care services are provided at municipal and county (state) level by public, private and non-governmental institutions. Both public and to some extent private funding is involved. LTC is provided in inpatient institutions and nursing services are provided in both inpatient and outpatient institutions. In 2006-2007 several legal acts were adopted to coordinate health care, nursing and social care services. It is also planned to integrate inpatient nursing care into the regular hospitals. The target is to have at least 80% of those services in regular hospitals and at least 50% of nursing services combined with social care services by the end of 2008.

5.2.2. Accessibility

The NSR points out regional differences in access to LTC and high demand for it. In this respect it announces that the number of inpatient nursing beds can be increased from 3 832 to 6 480 in 2008-2010. The strategy is not clear, however, about the likelihood of this increase to happen, neither does it provide data on the need for this type of care. It is also admitted that the need for nursing and social services at home has not yet been surveyed and established. Nor does the NSR cover the issue of the remuneration/compensation/support mechanisms for informal carers. Concerning services for the disabled, the state-funded rehabilitation process, with a predominantly medical rehabilitation approach and underdeveloped professional and social rehabilitation services, is not efficient enough and does not provide adequate coverage.

5.2.3. Quality

The social care standards were established in 2007. According to the NSR, they will help in eliminating the differences in the quality of services between regions and different providers. Yet the strategy does not explain how and when it will be done. The NSR also mentions that surveys of satisfaction with care services were carried out in 2007, although their outcome is not revealed.

5.2.4. Long-term sustainability

Public long-term care expenditure constituted 0.43% of GDP in 2005. It is projected to increase by 0.4% of GDP by 2050 due to ageing according to the EPC. The NSR recognises the challenge of ageing and shrinking of the population but does not provide a clear-cut strategy to handle it. Given the increasing old-age dependency ratio, long-term care will be less and less able to rely on the currently predominant informal care.

6. CHALLENGES AHEAD

- To combat child poverty, in particular providing support to single parents and families with many children and increasing access to social and community-based services, to the labour market, and to high quality education for all.

- To review the efficiency of social transfers and to combat rural poverty by promoting active inclusion and moderating substantial regional inequalities in the access to social services.

- To reinforce governance, in particular by developing proper monitoring and evaluation systems and the mechanisms to mainstream social policies.

- To continue efforts to ensure that adequate pensions are available in both tiers of the mandatory pension scheme and actively tackle the issue of pensioner poverty, particularly for elderly women facing a high risk of poverty, while continuing to carefully monitor the financial situation and consequent effects on benefit adequacy in both the PAYG and funded schemes.

- To ensure that the current economic context and possible public sector expenditure cuts do not affect healthcare access, in view of the low health status of the population and the low overall expenditure; to use the current situation as an opportunity to improve the value for money in the system notably through stronger use of primary care, better coordination of services and promotion and prevention strategies to improving health status. In the medium run, to continue to address the geographical and socio-economic disparities in access, improve the quality of services and address human resources issues.

- To develop a comprehensive quality assurance system in the healthcare sector based on indicators.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	4,2	39,3	**2000**	59,1	60,5	57,7	25,9	40,4	**2000**	16,4	18,6	14,1	30,6
2005	7,8	52,9	**2005**	62,6	66,1	59,4	21,2	49,2	**2005**	8,3	8,2	8,3	15,7
2008*f*	3,4	59,9	**2007**	64,9	67,9	62,2	25,2	53,4	**2007**	4,3	4,3	4,3	8,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	63,3	75,1	12,9	16,9	n.a.	n.a.	12,5	**1995**	n.a.	n.a.	n.a.		-
2000	66,8	77,5	13,7	17,9	n.a.	n.a.	8,6	**2000**	6,5	69,7	26,1	**2005**	7,2
2006	65,3	77,0	13,0	17,6	52,4	56,1	5,9	**2006****	5,9	67,3	32,2	**2006**	8,2

s: Eurostat estimate; p: provisional — **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	15,8	47,8	29,8	1,8	8,8	3,4	8,4
2006	13,2	44.8p	32.1p	1.9p	9.0p	1.6p	10.7p

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
2004	23,0	16,0	6,7	3,7	0,5
2010	23,2	-0,7	-0,2	0,3	0,1
2030	34,7	0,3	1,2	0,7	0,1
2050	51,1	1,4	1,8	0,9	0,4

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	19	22	16	30	26	30	29	15	5,9	**2005**	21.0b
male	17	-	15	15	28	-	30	12	-	**2006**	13
female	21	-	16	37	23	-	28	16	-	**2007**	8

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	:	10	10,1	10
2004	6,5	8,1	8,3	8
2007	8,3	7	7,3	6,8

	Long Term unemployment rate: % of people aged 15-64 Total	Male	Female
2000	8	9,4	6,5
2004	5,8	5,5	6,2
2007	1,4	1,4	1,3

	Early school-leavers: % of people aged 18-24 Total		Male	Female
2000	n.a.	n.a.	n.a.	n.a.
2004	15,6		20,5	10,7
2007	16.0p		19.7p	12.3p

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,69	0,74	0,65	***Aggregate replacement ratio***	0,4	0,38	0,44

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-3	1	1	DB/DC	/	-	89	/	26	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)* — *p - provisional data*

Luxembourg

1. Situation and key trends

GDP growth remained strong in 2007 (5.2%) but is projected to slow down this year as the financial crisis and the slowdown in the international economy take their toll. These trends will continue in 2009: real GDP growth is likely to be the slowest recorded in 25 years. Job creation, still buoyant in the first half of 2008, is expected to slow down while unemployment, which had begun to decline in 2007, stopped decreasing this summer and has already started to rise.

The employment rate of the resident population remains below the EU average (marginal improvement since 2000 to 64.2% in 2007 —– with a significant gender gap of 16.2%), with that of older workers being particularly low (2006: 33.2%; 2007: 32% — way below the EU target of 50%) and that of females (2007: 56.1% — below the EU target of 60%) still unsatisfactory despite a positive trend since 2000. Youth unemployment still represents an important issue (its level has increased twofold since 2000, from 7.1% to 15.5% in 2007, reaching the EU average).

The old-age dependency ratio (21.1% in 2010 and 37.8% in 2050) is expected by 2050 to become one of the lowest in the EU (37.8% against 50.4% as expected for the EU as a whole). In 2006 the level of social protection expenditures reached a total of 20% of GDP. Sickness/health care and pensions constituted the two main groups of functions, accounting respectively for 25.4% and 36.7% of total public expenditures. By 2050 Luxembourg is expected to record one of the highest increases in total public social expenditures, corresponding to 8.3% of GDP.

Non-nationals currently account for 42.6% of the total population. Portuguese are the most significant group (37.2%). Non-nationals are more subject to unemployment (59% of total unemployment) and are more at risk of poverty (19.5%, compared with 7.2% for nationals)

2. Overall strategic approach

The overall strategic approach builds on and follows the 2006-2008 strategy while reinforcing specific fields of action in line with the challenges identified in order to respond even more adequately to the common objectives of the Social OMC. Recognising the interlink between economic and social aspects, the approach supports the reinforcement of the welfare state — which promotes equal opportunities for all and investment in human capital as a preamble to economic development — by encouraging a competitive and stable economic environment, sound public finances and a sustainable social security system. A major aim of promoting social cohesion is described as ‘to prevent the emergence of parallel groups within Luxembourg society’. The main priorities are illustrated in connection with the three common overarching objectives of the Social OMC. In terms of promoting equal opportunities for all, the emphasis is placed on: (1) immigrants’ social inclusion into Luxembourg society; (2) combating poverty by promoting equal access to equitable incomes, goods and services and through specific actions targeted at vulnerable groups; and (3) taking up the challenge of gender mainstreaming. Considering mutual interaction with the Lisbon Strategy, links are made visible in a coherent and realistic way, although the priority objective addressing school failure has been removed from the current NSR (early school leaving is currently defined as a ‘point to watch’). Policy integration is particularly noticeable in the case of child poverty. Seen as highly correlated with the low level of parents’ participation in the labour market, reconciliation between work and private life is thus supported by quantitatively and qualitatively enhancing affordable childcare structures in full accordance with the promotion

of a 'life cycle approach' (IG No 18) and the fight against poverty (Social OMC). Finally, regarding governance, Luxembourg features an effective institutionalised social dialogue and well-established 'tripartite' structures that have a consultative role and seek systematically to find consensual solutions to social and economic problems. The preparation of the NSR is based on wide-ranging talks involving all relevant stakeholders, from public authorities and social partners to NGOs. Coordination of the NSR with the Lisbon Strategy and the Sustainable Development Strategy is partly carried out by two inter-ministerial committees in charge of those strategies (the link with the Sustainable Development Strategy and the ESF is not developed except in a purely formal way).

3. SOCIAL INCLUSION

3.1. Key trends

Overall, the level of poverty in Luxembourg remains relatively stable. In 2007 the poverty threshold was twice as high as the EU average (the highest in the EU) and stood at €17 929 (one-person household) and €37 650 (two adults and two children under 14 years old). Standing below the EU average (16% in 2007), the risk of poverty continued to affect 14% of the total population in 2007 (against 13% in 2005 and 12.3% in 2004). People aged 65+ are less exposed to poverty (7% in 2007 against 19% for the EU-25). Children aged 0-17 years remain a group critically exposed to the risk of poverty (20% in 2007). Households with dependent children account for 70% of the population facing poverty in 2007 (particularly concerned are: jobless households (mainly lone-parent households); single parents; and large families). Other groups severely exposed are non-nationals (19.5%, compared with 7.2% for nationals) and tenants (30%, compared with 9% for home owners).

In 2007, in-work poverty affected 9% of the population working full-time and 10% of those working part-time (compared to 7% and 12% in the EU-25). Although the level of total unemployment is low (4.1% in 2007, mainly affecting non-nationals and low-skilled), the increasing risk (46%) for this group of facing poverty should be kept in mind. In general, social transfers satisfactorily alleviate the risk of poverty, from 23% to 14% for the total population, from 33% to 20% for children (0-17 years) and from 23% to 13% for people aged 18-64 years. In 2006, net social assistance income is among the highest, corresponding to 80% of the poverty threshold for single persons, 80% for lone parents with 2 children and 70% for couples with 2 children.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Luxembourg achieved some progress in addressing 2006-2008 priorities as well as 2007 Joint Report challenges. Considering that since 2000 Luxembourg's overall employment rate only showed limited progress, the employment rate of older workers remained low, youth unemployment increased, there is still room for improvement concerning the priority objectives of restoring full employment. As regards preventing early school leaving, Luxembourg remained well below the 2010 target (Eurostat, 2007: 15.1%; EU-25 2007: 14.5%); although progress in this field is supported by figures based on national indicators. In line with the 2007 JR challenges, current objectives are explicitly targeted at promoting labour market participation of young people and older workers. With an increase since 2005 of 3 751 available places in public childcare facilities ('Maisons-Relais', total available places in 2007: 11 751) and of 347 places in 'parental assistance' arrangements since 2003 (total available places in 2007: 437), the progress achieved in the field of reconciliation between work and private life with regard to the ambitious intermediate target set for 2009 (an increase

of 10 000 places in childcare structures) is more than reasonable. Finally, some advancement can be reported in the field of promoting access to housing. The 'housing pact' was adopted on 11 June 2008 and measures will now enter into force, given the second constitutional vote by Parliament (on 22 October 2008). In accordance with the 2007 JR challenges, this priority has been focused on vulnerable groups.

To enable progress to be monitored effectively, specific attention has to be paid to adequately quantifying outcome targets. This is particularly the case when looking at priorities focused on restoring full employment and preventing school failure. These have not been sufficiently specified as to timeline, including intermediate steps, which could be measurable (the quantified objectives are much too global). More precision is needed here on the inclusive aspects of the employment and education policies/measures in order to define reasonable, specific and measurable intermediate outcome targets and show how the different policy instruments are to interact

3.3. Key challenges and priorities

The 2008-2010 report pursues four priority objectives: ensuring the well-being of children; encouraging the labour market participation of young people and older workers; modernising social assistance; and facilitating access to housing. These objectives build on and follow the objectives set in the previous report (except for preventing school failure and raising the overall level of education) and consistently reflect the current key trends. In line with some challenges identified in the 2007 Joint Report, the new objectives explicitly reinforce the former strategy on almost all priorities, with a stronger focus given to the social inclusion dimension (poverty reduction) and to actions targeted at specific vulnerable groups. Nevertheless, considering Eurostat figures, the issue of school failure should be dealt with alongside the main priorities (young men, children with an immigrant background and from families with a low socio-economic status are more affected). It is also noticeable that arrangements for mainstreaming social inclusion in all relevant public policies (economic, employment, education, etc.) have not been sufficiently prepared, while mainstreaming in the ESF has only been officially established. Finally, the four priority objectives for 2008-2010 take gender equality issues into account; although sometimes in a very general way (more information and evidence are from time to time needed to support statements).

3.4. Policy measures

Concerning the priority objective addressing the *well-being of children*, existing measures are continuing, such as the extension and individualisation of care services (for children with specific needs). New actions are also introduced, such as a 'child bonus' (being simultaneously a family allowance and a tax measure benefiting mostly families with low incomes) or 'cheque-services' ('services vouchers', to be provided when using childcare facilities). This policy combines, in an integrated way, a preventive and a remedial approach aimed at improving the situation of all households with children (by increasing the level of disposable income and the opportunities to (re)enter the labour market through easier access to structures and services). This priority objective thus globally reinforces actions taken in the field of reconciliation of work and private life. Actions also reinforce measures targeting children with an immigrant background, at risk of social exclusion or material poverty, etc. (draft Law No 5764 on assistance to children). Ambitious in terms of scope, actions need some reinforcement to attain the main objective (clear targets are only fixed in the field of increasing childcare facilities). Even if the gender dimension has been taken into account, efforts should continue in the field of mainstreaming of disability issues. The report does not mention the scale of resources allocated, nor does it describe in sufficient detail how the ESF

is contributing in concrete terms to achieving this priority objective (i.e. through OP priority axis No 1).

Concerning the priority objective of *encouraging the labour market participation of young people and older workers*, no new measures have been identified (the approach is basically a carryover of the former objective) and specific quantified targets have not been set. With regard to young people, the approach is sufficiently multi-dimensional and integrated (activation measures, orientation services, and mechanisms supporting skills and competences recognition which are coupled with the reform of the primary and secondary education system, including vocational education). But when assessing the situation of older workers, the scope of the approach as well as its instruments (mainly a 'plan for maintaining workers in employment' and an individualised right to vocational training) appear to be quite unsatisfactory. The gender dimension is said to be taken into account, but without giving sufficient evidence in relation to the measures undertaken. There is no information on whether adequate attention is paid to the mainstreaming of disability issues. Sufficient resources are being allocated to achieve the objective and the ESF is making an effective contribution (through OP priority axis No 1).

Concerning the priority objective of *modernising social assistance*, the reform was already announced in the first NAP/Inclusion in 2001 (the need to reform 'paternalistic/arbitrary social assistance' with extensive and complicated administrative procedures). This reform (draft Law No 5830) is structured around a few key features: merging local welfare offices into regional services, harmonising operating methods around a 'one-stop-shop approach', and enhanced professionalisation, efficacy and transparency. The reform also redefines the concept of 'assistance' (an enforceable right; subsidiary and supplementary; multi-purpose; and individualised). The idea of follow-up and partnership is underlined through a 'solidarity contract'. The new system is not expected to be completely in place before January 2010. The approach is sufficiently multi-dimensional and integrated, although it would have been useful to show some measurable intermediate steps. The reform develops a gender perspective (by supporting single parents, often women) and the mainstreaming of disability issues (by supporting 'mobility' as a 'basic need'). It takes into account the situation of non-nationals and third-country nationals, including those staying illegally in the country (Article 28 provides for short-term discretionary humanitarian aid). The allocated resources are sufficient and clear monitoring arrangements are planned (annual reports, structured social surveys, solidarity contracts, etc.).

Concerning the priority objective of *facilitating access to housing*, it has been decided — on the basis of an in-depth analysis of the housing structure and the social situation of households — to supplement the overall policy on access to housing with a specific initiative supported by NGOs — i.e. the creation of a 'social estate agency' targeted at households with low effective income and people facing multiple problems. The main missions of this structure are: real-estate prospecting, rental management (intermediate role in rental contracts and control of payments) and technical assistance (repairing dwellings). Clear targets are set: 50 dwellings for 2009, an increase of 50 dwellings per year, and in the medium term, around 500 dwellings to be administered in the whole territory. The reform is sufficiently multi-dimensional, integrated and takes into account a gender perspective (by supporting single parents with children — often women — with a supplementary rental allowance), the multi-dimensionality of child poverty (as material deprivation), and the situation of immigrants. The allocated resources are sufficient and clear monitoring arrangements are planned (annual reports based on the quantitative targets).

3.5. Governance

Governance issues are considered to be well addressed in Luxembourg. In comparison with former reports, the present NSR can be seen as the result of a strategic planning process, which has improved even further. Preparation arrangements promoting administrative coordination in the field of social inclusion can be considered quite effective and sufficiently inclusive. Nevertheless, some minor weaknesses (in terms of procedural outcomes) can be observed at the level of coordination with the Lisbon Strategy and the Sustainable Development Strategy. Concerning mobilisation and involvement of actors, the social inclusion process is based on broad consultations with all relevant stakeholders. The government — in cooperation with local authorities — also supports NGO initiatives (e.g. an annual conference on poverty and inclusion) and takes into consideration conclusions and demands emerging from these activities. In this respect, the role of non-governmental actors seems to have been strengthened while their views have, to some extent, been taken on board (e.g. the 'social estate agency'). At this point, it might perhaps be regretted that little overall visibility was given to the social inclusion process (e.g. in official political discussions, in the media). Appropriate arrangements are generally made to monitor and assess the reforms and measures undertaken (although expected outcomes could sometimes be specified more and/or quantified at an intermediate level).

4. PENSIONS

4.1. Key trends

The pensions system in Luxembourg is dominated by a public scheme that covers employees and self-employed persons. It is financed in equal parts by employer, employee and general budget contributions, is based on a strong political consensus and ensures a high level of adequacy (a system with very high aggregates replacement ratios compared to international standards — 0.61 compared to an estimated 0.49 for the EU-25). It is organised as a pay-as-you-go defined-benefit system based on a financial model with a contribution rate fixed for a period of 7 years and a reserve fund for compensation (up to 2008 the fund accumulated assets worth 25% of GDP). Pension benefits are calculated on both the length of contribution periods and the accumulated lifetime amount.

A major feature is that the rise in age-related government expenditure is projected to be among the highest in the EU, reaching 8.3% of GDP (3.4% in 2050 for the EU-25). Despite this, very little has been done to reform the pensions system and no progress was recorded in 2008. With the prospect of the upcoming parliamentary elections in June 2009 and the relative complexity of this subject, which covers various policy areas in the fields of social security and labour, a ground-breaking outcome is not to be expected.

A Working Group on Pensions was created in November 2007 to evaluate the system's performance and to develop strategies to adapt the system to demographic and structural changes in order to guarantee future pensions commitments with stable, adequate revenues and also to safeguard the achievements of a minimum pension based on inter-generational and inter-economy solidarity. The first results are expected for 2009.

4.2. Key challenges and priorities

Luxembourg has, over the last 25 years, pursued a strategy to adapt its social security system. Currently, the challenges identified in the 2007 Joint Report are reflected in the activities of the above-mentioned Working Group. The system's financial sustainability should be reinforced by an increase in employment rates among the resident population and in particular women and over-55 year olds. The financial sustainability of the pension system depends on relatively high rates of economic growth in the future, and mainly on a very large contribution by non-resident workers to the Luxembourg economy and pension schemes. Despite the existence of a substantial reserve fund, the fact remains that in the event of a decline in the employment of non-residents, an ageing population would then have to finance not only resident pensioners' pensions, but also a large number of pensioners outside Luxembourg. It is furthermore likely that the current predominantly young (cross-border) professionals will, when they reach retirement age, have a strong impact on today's very advantageous dependency ratio, while many of them will tend to have acquired full pension rights. The long-term sustainability of public finances and the viability of the pension system thus remains a challenge of vital importance. Luxembourg should therefore concentrate its efforts on reforming the pension system, mainly to encourage the labour market participation of older workers.

As regards the first priority, discussions focus on how to increase the effective retirement age, which has not changed over the years (men: 59.2 and women: 60.3 according to OECD data) and falls below the EU average (especially for men), while Luxembourg's life expectancy remains higher. Meanwhile — according to the European Commission's Macro Fiscal Assessment (to which the OECD also refers) — an increase of 7.4% of GDP (from 10% to 17.4%) in Luxembourg public spending for pensions between 2004 and 2050 is projected, which is one of the strongest growth rates in the EU (2.2%).

The second priority concentrates on how to overcome drawbacks related to work incapacity. According to Statec data, 15% of the active population aged 50+ leave their job because of health difficulties or work incapacity. A total of 5% become unemployed. This shows the importance of prioritising prevention of work incapacity and measures for job retention for older workers, as well as supporting measures such as rehabilitation and redeployment programmes.

Luxembourg is also striving to improve the individualisation of pension rights (the question of divorcees' acquisition of pension rights).

4.3. More people in work and working longer

Several incentives aimed at the voluntary extension of professional careers, which were introduced by the 2002 pension reform, have not yielded the expected results. In fact, the employment rate of the elderly has decreased slightly (from 33.2% in 2006 to 32% in 2007), although the rate for females has shown a positive trend since 1997. The NSR illustrates that an increase of 0.02% in the accrual rate of 1.85% for every year between the age of 55 and the effective retirement age for people with a minimum of 38 contribution years is not much of an economic incentive to defer retirement. Nor do *part time* early retirement options constitute an attractive alternative, as income above one third of the minimum wage will directly lead to a reduction of the early retirement pension. It is expected that better incentives for health prevention at work combined with stricter supervision of medically justified work absenteeism could bring positive results.

4.4. Privately managed pension provision

Private pension plans are offered as financial products to individuals (neither very popular nor financially substantial). They are governed by income tax law and the Grand Ducal Regulation of 25 July 2002. They enable individual supplementary pension benefits to be paid in addition to the state pension, and allow tax deduction on an income amount of between €1 500 and €3 200 per year, depending on the age of the policy holder. Benefits are paid starting from the age of 60 at the earliest. Property ownership is another form of private saving for old age.

4.5. Minimum income provision for older people

The guaranteed minimum income (€1 146.50 per month in 2008) applies to the elderly in the same manner as to the rest of the population. In the 60+ age-group, about 1.2% receive supplements to make up the shortfall, compared to 3% for the population as a whole. In 2009, a new measure will replace the former tax deductions allowable for pensions with a tax credit paid to every taxable person, which will enable pensioners with little income who are exempted from tax to enjoy the same advantages as taxpayers.

As minimum income provisions for those who have not worked a full pension career are nearly as generous as minimum pension provisions, the adequacy of pensions does not pose a great challenge for Luxembourg. Nevertheless, it should be kept in mind that this parameter might constitute a disincentive to work for a full pension career

4.6. Information and transparency

A tripartite coordination committee, composed of representatives of government, employers' organisations and trade unions, is the most important political advisory group in the field of pensions. Information on public pensions is available for the public on the Ministry's website. The pension funds inform their members via mail on a yearly basis on the years of pension rights acquired. A preliminary determination of the pension amount to be expected is only provided on request.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Life expectancy at birth (men: 76.8 and women: 81.9 in 2006) is slightly higher than the EU-25 average (men: 75.8 and women: 81.9 in 2005) while healthy life years at birth reached 61.0 for men and 61.8 for women in 2006 (latest estimates for the EU-15, men: 64.5 and women: 66 in 2003). Luxembourg has the lowest infant mortality rate in the EU (1.8% in 2007).

Compulsory health insurance provides coverage to 99.7% (2005) of the population. Total health expenditure was 7.8% of GDP (2005), below the EU average in spite of a steady increase between 1998 and 2004. The healthcare system is mainly publicly financed through social health insurance. Health care is provided by public services, private practitioners and not-for-profit associations paid from the Ministry's budget. Preventive services are the responsibility of the Ministry of Health. Luxembourg imports all pharmaceutical products and bases most retail prices on those set in the country of origin.

The national strategy is focused as a priority on the financial sustainability of the system and is aimed towards cost containment and better use of resources. Common drug and technology purchasing is also envisaged (single hospital procurement centre) with a view to achieving efficiency gains and moving towards greater use of generic medicines.

Since 2004 a Joint National Action Programme has been implemented to improve the quality of the system through increased spending efficiency. A better communication and information system has also helped to increase the transparency of the healthcare system.

In the short run, there is no need for new measures. It would be desirable for the strategies adopted to follow the policy cycle through to their strict implementation and monitoring (this is also true for long-term care).

5.1.2. Accessibility

The health insurance system is mandatory for all economically active persons. In 2006, the national data showed that it covered 98% of the resident population (including family members as 'dependants'). Another 174 200 non-resident people are affiliated as cross-border workers (or family members thereof).

Self-reported unmet needs for medical care (0.4 in 2006; EU: 3.1) and dental care (0.8 in 2006; EU: 5) are very low compared to the EU average.

Although a few new measures have slightly increased the level of co-payments (i.e. from 5% to 10% for the first GP consultation within a month in 2005) and reimbursement rates for dentistry services, out-of-pocket payments as a share of total health expenditure have remained stable (6.7% of total health spending in 2005 — the lowest among OECD countries; OECD 2008).

5.1.3. Quality

Since 2004 a Joint National Action Programme (updated on an annual basis with new priorities) has been pursued to improve the quality of health care through increased spending efficiency. In terms of quality assurance, the Ministries of Health and Social Security are encouraging hospitals and healthcare units to establish synergies and collaboration with other healthcare providers at the wider regional level. The aim is to increase the quality of care through the creation of specialised care centres.

Since 2005, the scientific council has been developing, in selected areas, treatment guidelines based on international scientific standards of evidence-based medicine. Impact evaluation is not yet formalised. However, impact analyses of the guidelines for prescription of antibiotics have shown positive results regarding the prescription patterns of paediatricians and internists (not the case for most GPs). Quality assurance was implemented in 2003 for some specific areas: the rate of hospital infections, mammography quality (EFQM framework generalised but not yet evaluated), etc.

With regard to e-health, research and other work has been undertaken: an inventory of the different software systems used in hospitals and specialised national health centres aimed at identifying potential interoperability of the various systems in place; establishment in 2005 of a secure computerised data communication network for health professionals and healthcare institutions; and a project aiming at establishing electronic prescriptions.

5.1.4. Sustainability

In 2005, per capita expenditure in PPP reached USD 4 153 (€3 341 — OECD 2008) while total healthcare expenditure (7.8% of GDP) was below the EU average (9%).

Healthcare expenditure has to be considered in conjunction with the specific characteristics of Luxembourg's labour market (largely based on cross-border workers). If non-residents (25% of the total population insured by Luxembourg's health insurance system) currently place the country in a favourable demographic situation (they are 9 years younger on average, only 0.2% percent of 65+), their use of healthcare services is expected to rise with increasing age. Another source of concern are figures showing 3.37% higher healthcare spending growth against real GDP growth between 1995 and 2005, a figure among the highest in Europe (due to the increase in the covered population and the modernisation of the healthcare infrastructure and technology; OECD 2008. The introduction of the System of Health Accounts can also partly explain this figure). The financial situation of the system being challenged in the medium term, cost-controlling measures have been introduced which concern: doctors' prescription behaviour, new management practices and centralised procurement of medicines, the use of generic medicines (identified in the 2007 Joint Report as a core challenge), strong health promotion and prevention policies.

Promotion and prevention policies as well as disease management schemes are being developed. In recent years, the system has strengthened its internal and external communication. Since 2007, social security statistics have been made available online. The health portal aiming to support healthy lifestyles, preventive actions, and better orientation in the health sector should be in place in 2009. The number of prevention programmes has also increased (cancer detection programmes have been run and show positive results). By developing a proactive attitude, some budgetary effects are expected (the system of preventive medicine will be analysed and cost-benefit studies are planned).

5.2. Long-term care

5.2.1. Description of the system

LTC services are provided in a social security framework, with a compulsory social contribution allowing access to services on the basis of need, independently of the ability to pay. Concerning home care, recipients of care can obtain a cash payment allowing them to receive care from an informal carer (limited to 10.5 hours a week in order to guarantee follow-up by the formal care services). Palliative care is under the responsibility of hospitals, although the authorities intend to promote it outside hospitals and ensure its financing through the social security system.

Long-term care expenditure amounts to 1.54% of GDP (2005), which exceeds the EU average, and is projected to grow by 0.6% (EU-25: 0.6%) by 2050. As such it has been identified by the authorities as a risk to the social security system.

5.2.2. Accessibility

Public long-term care insurance guarantees equal access for the whole working population, including cross-border workers, irrespective of age and health status (only people covered for long-term benefits by international organisations are excluded). The crucial criterion to qualify for benefits is proven dependence on another person for daily life activities for a minimum of 3.5 hours per week.

Access to long-term care cannot be mentioned without considering the problem of the price of accommodation in both nursing homes and integrated centres for the elderly. This accommodation price is significant and is borne by the resident himself/herself. Here, the National Solidarity Fund provides means-tested support ('accueil gérontologique').

Overall, accessibility problems are well addressed, through the compulsory dependency insurance and co-payments for vulnerable groups requiring additional care which are not covered by long-term care insurance. Specific measures allowing the payment of informal carers and simultaneous follow-up by formal institutions are already in place. A cost-effectiveness evaluation of these schemes would be interesting, particularly to examine the incidence of co-payments for additional expenses not covered by the comprehensive scheme on vulnerable groups' accessibility patterns.

5.2.3. Quality

Market entry to the care sector is subject to the approval of the Ministry of Family Affairs (endorsement of quality standards and the conclusion of a framework contract with the health insurance organisation). The new Long-Term Care Act (23 December 2005) established a quality commission and a so-called 'Cellule d'évaluation et d'orientation (CEO)', evaluating long-term care needs, including monitoring of quality standards for long-term care and measuring mismatches between the care provided and the needs of the dependent person. Following a survey of patients' satisfaction in the area of home care conducted in 2006 (by the CEPS/INSTEAD institute), a series of measures have been implemented: streamlined administrative procedures, minimum requirements for keeping patient records, and information on application procedures provided in four languages (Luxembourgish, French, German and Portuguese). Concerning long-term prevention and rehabilitation, the NSR already provides examples of good practices: for medium-term geriatric rehabilitation, more than 100 beds have been made available. During the last five years the area of psychiatric care has undergone major reforms: new psychosocial day centres, sheltered workshops, and therapeutically accompanied housing facilities have been built. An ambulatory multidisciplinary psychiatric care service for adolescents facing difficulties has been launched. Better coordination with social services and the coverage of more remote areas in the north of the country remain key issues.

5.2.4. Long-term sustainability

Overall, long-term care insurance is facing a steep rise in expenditures. These reached 1.54% of GDP in 2005 and increased by 25% between 2004 and 2006, in particular benefits in kind (roughly 70% of the total expenditure). According to the EPC/EC projections, public long-term care expenditure is set to increase by 0.6 pp of GDP by 2050 due to population ageing. The Law of 23 December 2005 (implemented in 2007) changed various parameters in order to ensure the financial equilibrium of the system.

6. CHALLENGES AHEAD

- To strengthen the control and coordination of the inclusion strategy and to reinforce the mechanism for monitoring and evaluation.

- To promote active inclusion by strengthening multi-faceted efforts towards specific vulnerable groups, namely young people, older workers, and non-nationals.

- To address the long-term sustainability of the pension system to ensure that it is sustainable also in circumstances of low economic growth.

- To address the financial sustainability of LTC and improve the quality of LTC services through the integration of the various LTC services with healthcare services in order to ensure continuation of care at home and in the institutional setting.

- To assess and evaluate improvements in reducing the overuse of antibiotics and in the use of generic medicines (with regard to quality and financial sustainability).

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita **	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	8,4	243,7	**2000**	62,7	75,0	50,1	31,9	26,7	**2000**	2,3	1,8	3,1	7,1
2005	5,2	254,1	**2005**	63,6	73,3	53,7	24,9	31,7	**2005**	4,5	3,5	5,8	13,7
2008*f*	1,0	261,1	**2007**	64,2	72,3	56,1	22,0	32,0	**2007**	4,1	3,4	5,1	15,5

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	73,0	80,6	14,7	19,7	n.a.	n.a.	5,5	**1995**	5,6	92,4	6,2		-
2000	74,6	81,3	15,5	20,1	n.a.	n.a.	5,1	**2000**	5,8	89,3	7,0	**2005**	0,4
2006	76,8	81,9	17,0	20,3	61,0	61,8	1,8	**2006**	7,3	90.9s	6.5s	**2006**	0,4

s: Eurostat estimate; p: provisional — **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure* (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	20,7	45,1	24,9	3,1	13,1	1,2	12,7
2000	19,6	39,9	25,4	3,2	16,6	1,5	13,4
2006	20,4	36,7	25,4	4,9	16,9	2,9	13,2

**including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes			
		Total social expend.	Public pensions	Health care	Long-term care
2004	20,9	19,5	10,0	5,1	0,9
2010	21,1	-0,1	-0,2	0,2	0,1
2030	30,8	5,5	5,0	0,8	0,2
2050	37,82	8,3	7,4	1,2	0,6

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	14	20	13	7	19	20	20	9	4	**2005**	13
male	13	-	12	7	19	-	20	8	-	**2006**	13
femal	14	-	13	8	19	-	19	12	-	**2007**	14

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	3,4	6,7	5,3	8,1	**2000**	0,6	0,5	0,6	**2000**	16,8	15,9	17,6
2004	3,4	7,1	5,7	8,5	**2004**	1,1	0,8	1,4	**2004**	12,7	12,6	12,7
2007	3,4	7	6	7,9	**2007**	1,2	1,2	1,1	**2007**	15,1	19,2	11.1u

**: excluding students; i: change in methodology; b: break in series; u: data lack reliability due to low sample size*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,96	0,95	0,97	***Aggregate replacement ratio***	0,61	0,59	0,58

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	Statutory pensions	Occupational & voluntary: Estimate of current (2002)	Occupational & voluntary: Assumption
0	-1	-1	DB	/	-	92	/	24 (d)	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions);*
*** (DB/DC); (d) For Luxembourg, one third (8%) also comes from the general State budget.*

Hungary

1. SITUATION AND KEY TRENDS

The government's fiscal consolidation measures to reduce the very high budget deficit caused a significant slowdown of GDP growth in 2007 (1.1%), which is likely to further decrease substantially in 2009 according to the EC forecast (-1.6%) that takes the rapidly deteriorating economic outlook into account. The labour market situation has remained unchanged in the last few years, and after a modest improvement it is still characterised by one of the lowest employment rates (2002: 56.2%; 2007: 57.3%) in the EU. It is coupled with an unemployment rate (7.4%) close to the EU average but slightly rising and expected to increase further to 8.8% by 2009. The activity rate (61.9%), still well below the EU average, remains the most significant labour market challenge. The poor employment situation can partly be explained by the low youth employment level that has continued to fall since 2004 from 23.6% to 21.0% in 2007. The employment rate of older people, after increasing for years and attaining 33.6% in 2006, also dropped somewhat (to 33.1%) and is still very low in comparison with the EU average (44.7%). The employment level of low-skilled people has also continued to decrease (27.3% in 2007) and is more than 20 percentage points lower than the EU-27 average (48.6%) and only one third of the employment rate of people with tertiary level education. Inactivity is mainly concentrated among the young and older cohorts as well as the unskilled and other disadvantaged groups, including the Roma population and people with disabilities. In line with EU trends, the employment rate of men (64%) is higher than that of women (50.9%); however, the difference is somewhat lower than the EU average. Regional labour market differences have also remained the second highest in the EU and micro-regional disparities are even more marked.

The old-age dependency ratio was 23.5 in 2008, below the EU average (25.4), but the projected figure for 2010 (24.2) may even double by 2050 in line with EU trends. Life expectancy at birth was 69.2 years for men and 77.8 years for women in 2006, one of the lowest among MSs, though steadily increasing. The poor health status of the population lessens life expectancy and also has negative implications for the overall labour market situation. Social protection expenditure was 22.3% of GDP in 2006, which remains well below the EU average (26.9%).

2. OVERALL STRATEGIC APPROACH

The 2008-2010 NSR does not bring any new approach in terms of strategic orientation compared to the previous report. Although the main objectives of the strategy are not explicitly listed in a transparent manner, major challenges can be identified on the basis of the assessment, including the policy responses to these challenges. The chapter on the overall strategic approach does not refer directly to the three overarching objectives but the separate strands address all their important aspects. Priority objectives of the strands build to a large extent on the strategic approach of the previous report and interventions also show continuity with former measures. This can be regarded as reasonable, since the main indicators show limited progress.

The document tends to build considerably on the overall reform agenda of the government across the three strands. Nevertheless, links to former reform concepts, as well as the coherence of planned strategies, are not always evident. The government confirms its commitment to the Lisbon process; accordingly, the NSR is in line with the aims of growth and jobs and is consistent with the country's National Reform Programme (NRP). As properly presented by the chapter on the overall strategic approach, all strands make significant

contributions to the Lisbon targets, foremost to improving the employment situation. However, the presentation of positive 'feeding-out' effects of the growth and jobs agenda to the social protection and social inclusion (SPSI) objectives remains at a general level. Coordination could be strengthened even further in order to optimise the mutual interaction between the SPSI strategy and the policy priorities in the NRP.

Despite efforts made in the field of promoting good governance, the report remains weak in terms of tangible measures to improve the effective monitoring and evaluation of the implementation of former actions and the channelling of the lessons into the planning process. The effectiveness of the extensive funding (including EU resources) in delivering the measures announced in the 2006-2008 Report is still not clearly visible because of the lack of a comprehensive system of monitoring and impact assessment. Structural Funds and especially the European Social Fund (ESF) remain a major resource for implementing the strategy. Gender equality and the disability perspective are partially reflected in the strategic approach.

3. SOCIAL INCLUSION

3.1. Key trends

Poverty has continued to affect broad segments of society. The at-risk-of-poverty rate for children (19% in 2007) is much higher than for the general population: 12%, which is below the EU average. The favourable rate for elderly people masks a substantial gender gap. The poverty threshold for families (2 adults and 2 dependent children) was €4 959 in 2007, less than a third of the EU average. The main risk factors of poverty are still joblessness, parents with low education attainment, 3 or more children or lone-parent families and small-size settlements. The share of people living in jobless households (11.9% in 2007) is the second highest in the EU and the 13.9% rate for children is even farther from the EU average (9.4%). The 3.4% long-term unemployment rate is somewhat above the European figure. Poverty factors continue to characterise the Roma disproportionately to the majority society. According to estimates, half of the Roma are considered to be living below the poverty threshold. Prevention of intergenerational transmission of poverty, as well as some new societal phenomena (e.g. the rising number of ethnic-based insults and increasingly hostile climate in society; the growing risk of multitudinous indebtedness because of personal loans), require more attention. Moreover, the risk of poverty may increase in the near future for certain groups due to the effects of the financial crisis and further austerity measures to cut the budget deficit. Although unemployment and inactivity traps are not particularly high, work incentive elements of the benefit system need further improvement.

The performance of the social benefit system in terms of fighting poverty can be regarded as satisfactory. The poverty rate before social transfers for the total population (29%) is 17 percentage points higher than with transfers (the difference is 25 percentage points for children). A general minimum income scheme is not in place, but a minimum income is guaranteed for everybody in need through different entitlements. Overall participation in education has grown steadily over the last few years but the composition of the student body by attainment levels and forms of education shows considerable deviation from international patterns. Participation at secondary and tertiary level has increased steadily but the share of those in secondary level or higher vocational training is extremely low. Although the drop-out rate was 3.9 percentage points lower (10.9%) than the EU average in 2007, over-representation of disadvantaged groups, e.g. Roma, is striking. While the performance of Hungarian students in the PISA survey is in most fields around the OECD average, between-school variance arising from economic, social and cultural status is one of the highest. Access

to other quality public services, as well as the labour market situation and risk of poverty, remains very much influenced by size and location of settlement.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Although priority setting in the previous report is adequate, the effectiveness of the intervention mix, as well as instruments to monitor it, remains debatable since only very few indicators have reached their target values. Some of them have even deteriorated. Negative labour market trends can partly be explained by the adverse impact of the restrictive measures to improve the state budget (even measures such as the raising of labour costs or the cutback of public administration staff). At the same time, expenditure on social inclusion has not decreased in the years of budgetary restraint. Respecting the challenge identified by the 2007 Joint Report, efforts have been successful so far to protect the most vulnerable groups and to counterbalance the negative effects of austerity measures, since the relative income position of the poor has not deteriorated.

In spite o the government's commitment to fighting child poverty, the main indicators in this field have not shown significant improvement. Nevertheless, the approval of a long-term national strategy by Parliament represents a positive development. Cash allowances granted to families with children have preserved their value in relative terms since 2006. Support for day-care institutions for facilitating parents' return to the labour market has increased significantly. The document reports on numerous measures targeted at the group most affected by economic, social and territorial disadvantages, namely the Roma. While the multidimensional nature of their disadvantaged situation can only be addressed by complex solutions, programmes have remained on a general level in terms of integrated approach. In spite of the efforts of the government to monitor more closely and evaluate the efficiency of social inclusion measures, tangible results have been limited in this field. EU funds have been predominant in financing social inclusion developments.

3.3. Key challenges and priorities

As indicators show limited progress since the last cycle, priorities justifiably remain unchanged in the National Action Plan for 2008-2010, namely: promoting labour market inclusion and decreasing inactivity; fight against child poverty; reducing territorial and housing disadvantages, with special regard to the social inclusion of the Roma.

Challenges identified by the 2007 Joint Report are addressed within the three priorities. Accordingly, *promoting active inclusion by implementing the reform of the social benefit system* remains a concern for Hungary. This includes mainly elements aimed at improving interaction between employment and social services. Further incentives to encourage workers to remain in the labour market tie up also with the pension strand. In the light of the emerging difficult economic situation, the government should reiterate its commitment to *maintaining the level of resources dedicated to combating poverty and exclusion*, which has been successful so far. Efforts to *strengthen the governance of social inclusion policies by improving monitoring* should be more tangible since sufficient feedback of evaluations to the planning process is not given due attention throughout the implementation stage.

The aspects of social cohesion are largely included in the New Hungary Development Plan, the National Strategic Reference Framework (NSRF) of Hungary for the implementation of the Structural Funds, which are the major sources for social inclusion developments in 2007-2013. Besides being a horizontal objective of the NSRF, social inclusion has targeted

measures with earmarked resources, primarily as a separate priority axis (€444 million) in the Social Renewal Operational Programme co-financed by the ESF and also in the Social Infrastructure OP (co-financed by the European Regional Development Fund).

3.4. Policy measures

Promoting labour market inclusion and decreasing inactivity is based on active labour market policies in line with the NRP and built largely on the measures launched previously. Policy actions will primarily focus on disadvantaged groups, opportunities for alternative employment, work incentive aspects of the social benefit system and training of people with low qualifications. Employment schemes for a widened range of disadvantaged groups will continue to provide mainly reduced contributions for employers. The target group of the Public Employment Service (PES) will be extended to inactive people capable of work. A joint effort of the PES, the social benefit system and the disability pension scheme will continue to help people with reduced working abilities to remain in or return to employment through active participation in a rehabilitation process financed partly by the ESF. Entitlement to some social benefits will be linked to labour market services. In spite of their doubtful effectiveness, public work schemes can expect further support. The practical implications of the proposal whereby EU-funded investment projects employ registered job-seekers for up to 10% of their workforce remain to be seen. The focus on addressing the special problems of the Roma population could be emphasised further. Training schemes for low-skilled people will continue to be a dominant feature of the support system. After the success of the former programmes, additional regional integrated vocational training centres ('TISZK') will be established with the help of the Structural Funds in order to rationalise institutional operation and tailor the training supply better to labour market needs. Target values for 2010 appear to be feasible. Nevertheless, the 2010 targets for the most important indicators are less ambitious compared to the previous NSR. The gender dimension is not adequately addressed.

Although no significant changes in policy measures are noted since the last report in the field of *fighting child poverty*, the adoption of a comprehensive long-term strategy, 'Let it be better for children!' (2007-2032) and its Action Plan for 2007-2010, is an important step towards mainstreaming the issue as well as in coordinating efforts in this field. In line with the strategy and with the previous NSR, the government is committed to strengthening the income position of parents, including their employment situation, supporting daytime care services, ensuring equal opportunities in education and training as well as protecting the health of children. Although target values of current indicators appear realistic, the number of indicators is not sufficient to monitor overall progress. Among a number of supportive changes in the benefit system, a differentiated increase in the family allowance in 2008 favours disadvantaged families to a greater extent. Child welfare and protection services continue to play an important role in breaking the cycle of poverty. A further expansion of day-care facilities financed mainly by the ERDF will contribute to fulfilling the target of the indicator set for the priority. In order to strengthen the role of the education system in eliminating social inequities, reinforcement of the regulatory framework for local governments to ensure kindergarten attendance of children is welcome. The revision of the school district system to prevent school segregation is still ongoing. Transparency in this field should remain the primary objective.

The policy mix of the priority *'reducing territorial and housing disadvantages'* represents a collection of discrete measures rather than a coherent strategy to address this highly complex problem. Access time for micro-regional centres, as the only indicator, is not enough to assess progress realistically across the diverse set of policy measures. Financial resources earmarked for the priority (domestic regional development funds, ERDF, EARDF) appear sufficient.

Real coherence within complex programmes aimed at resolving multidimensional problems of territorial disadvantages (mostly with assistance from the Structural Funds) remains to be determined. The development of multipurpose micro-regional cooperation schemes to improve access to public services, as well as various initiatives to combat housing disadvantages, is welcome. The aspects of the Roma as a particular target group for this priority are addressed only in general terms.

3.5. Governance

Considerable efforts have been made to involve not only all government departments concerned, but also the most important social partners such as consultative bodies representing civil organisations as well as special target groups (also the Council for Gender Equality) in the preparation of the NSR. The engagement of the regional and local level seemed insufficient, however. The first draft was available to the general public for consultation via the internet. Plans aimed at involving stakeholders in implementation over the full policy cycle are not included. Although the government's commitment to setting up a comprehensive monitoring and evaluation system for social inclusion measures was expressed already in the previous report, details on the operation of such a system and its actual outcomes are only partly visible.

4. PENSIONS

4.1. Key trends

The Hungarian mixed pension system is characterised by the dominance of a statutory pay-as-you-go financed public scheme (3/4 share) supplemented by a mandatory fully funded tier (1/4 share). A voluntary funded pillar was established in 1993. The coverage of occupational pensions that started in 2008 is not significant. The relative living standard of elderly people is nearly equal to that of the 0-64 cohort (the relative income ratio was 0.97 in 2007; EU average: 0.84). The poverty risk of the elderly is lower than for the population as a whole, even though the level of pensions is only 52% of the EU average in purchasing power parity.

The statutory retirement age is 62 for men and has been gradually increased to the same level (from the former 55) for women by 2009. However, a great majority of people (94% in 2004) retired earlier, so that the effective retirement age is 3-5 years lower (58.6 in 2007) than the statutory age, though rising. The recent raise (from 18% to 24%) of the pension contribution rate to be paid by employers was partly due to a regrouping of health care contributions. An increase was carried out between 2006 and 2008 also on the individual pension contribution side, from 8.5% to 9.5%. In 2001, the former wage indexation was replaced by a 50/50 mix of price and wage indexation resulting in a lower rate of pension increase which, however, is still more generous than the pure price indexation used in most MSs.

Reform of the pension system has been ongoing since the early 1990s, gathered pace in 1997 and is constantly on the agenda of the government as part of the comprehensive structural reform package. Nevertheless, counter-effective measures have often curtailed its positive resultants. Reform steps taken in 2006-2007 aimed at ensuring long-term sustainability of the system, mainly by lowering incentives for taking early retirement or claiming disability pensions. Even after these steps are taken into account, Hungary remains at high risk regarding the long-term sustainability of the system as a whole.

4.2. Key challenges and priorities

The main challenge facing the system continues to be sustainability. The old-age dependency ratio will more than double from 23.5 (2008) to 50.8% in 2050 while total pension expenditure is likely to rise from 10.4% (2004) to 16.8% of GDP by the same date. The system dependency rate may also increase significantly. While currently 76 pensions should be financed from 100 contributions, this number is expected to rise to 103 by 2050. The general ageing of the population, low employment rates, the very low retirement age, and contribution evasion will together have a significant detrimental effect on sustainability. As a result, Hungary is assessed as a high-risk country regarding public finance sustainability, particularly taking the most recent economic forecasts into account. Measures taken in order to address this issue identified already under the 2007 Joint Report do not appear to be sufficient.

The current performance of the pension system can be considered adequate. Theoretical replacement rates are relatively high for an average worker retiring at age 65 and they are projected to remain at this high level even in the future. This partly reflects the lower legislated retirement age than used in the calculations. The at-risk-of-poverty rate for the 65+ age cohort (6%) is significantly more favourable than both the EU-25 average (19%) and the figure for the rest of the population (13%), but there is a considerable gender gap (3% for men against 8% for women). While the relatively good position of current pensioners is due to the high coverage of the current public tier, income from pensions may become extremely low for populous groups that were most severely hit by the employment crisis after the transition in the early 1990s and who will soon reach retirement age with inadequate accruals and incomplete work records. The growth of the informal economy and the extension of other forms of contribution evasion also endangers adequacy for wide cohorts of people.

The challenge of ensuring long-term sustainability and adequacy calls for an immediate and comprehensive reform of the pension system coupled with further efforts to increase the employment rate of elderly people.

4.3. More people in work and working longer

Increasing the number of contributors by raising the employment level and preventing early exits from the labour market are crucial tasks for Hungary to ensure sustainability. As one of the most noteworthy labour market changes in recent years, the employment rate in the 55-64 age bracket improved notably, especially for women (13 percentage points from 2000 to 2007) primarily due to the increasing retirement age. Several measures were taken in 2005-2007 regarding the conditions of early retirement in order to encourage people to remain longer in the labour market by e.g. providing contribution allowance for employers hiring workers over 50. The government's intention to block early exits by administrative measures, e.g. sharpening the age criteria and minimum service period requirements, is welcome. As of 2007, work during retirement became liable to pension contributions; as of 2008, accumulated earnings higher than the annual amount of the minimum wage will result in the suspension of early pension payments. Arrangements to lower the level of initial pensions have a direct positive effect on the sustainability of the system and also make retirement less attractive.

4.4. Privately managed pension provision

In 1997, the public pension scheme was extended by a privately managed mandatory fully funded tier. Since new entrants to the labour market have been required to join private pension funds, the number of participants in the new mixed system is steadily increasing and is currently approximately 70% of the insured. The private pillar is in an accumulative phase with payouts starting in 2013. Some components of the pillar are considered unpredictable due frequently changing contribution rules. In themselves, the regulations do not provide guarantees for benefits i.e. payments depend on returns obtained and contributions. After formerly pursuing conservative investment policies, from 2007 onwards portfolios became more diverse. Under a recent amendment, private pension funds are required to offer different investment options whereby members can choose between 'secure' or more 'risky' portfolios. Recent escalation of the turmoil on financial markets has drawn attention to the potential risks of these funds, since pension funds lost on average 20% of their value within a period of a few months. Achieving a balanced portfolio management will remain a real concern for private pension funds, particularly in the unstable market environment anticipated.

4.5. Minimum income provision for older people

Subsistence guarantees provided to the elderly include pension and supplementary statutory social benefits linked to their income and life situation. The minimum pension is due after 20 years of service and can be obtained by social security contributions paid at least on the basis of the minimum wage. Its relative level has fallen significantly over the last decade, amounting to HUF 28 500 (€114) per month in 2008, which is 35% of the average old-age pension and 40% of the minimum wage. Contrary to an earlier decision, the minimum pension will not be withdrawn as of 2009. For those unable to qualify for a pension or qualifying only for a low amount of pension, old age allowance provides support as a social transfer to those over 62, supplemented by targeted financial in-kind benefits and grants.

4.6. Information and transparency

Conscious behaviour with regard to pensions remains at a rather low level, particularly among the younger generation. In the last decade, the government has made various efforts to increase the transparency of the system e.g. by providing sufficient information to contributors and beneficiaries. These were more successful in the funded private scheme. The pension authorities sent reports to the insured on contributions to the PAYG scheme only once, in 2001. Since then contributors have been unable to check the accumulation of their accruals. In the private tier, annual reports are sent to fund members about their accumulations. Regulations and supervision have forced the funds to make comparable statements in particular about the structure of their costs and rates of return. However, the NSR remains vague with respect to concrete measures to be taken in order to increase transparency. The role of social partners and other stakeholders regarding communications on pensions, as well as their involvement in the decision-making process, has been limited.

5. HEALTH AND LONG-TERM CARE

5.1. HEALTHCARE

5.1.1. Health status and description of the system

The general health of the population is poor. Life expectancy at birth was 73.5 years in 2006, the sixth worst figure in the EU, and the gender gap is also significant (69.2 vs 77.8 years). Indicators on self-perceived health show substantial inequalities in the health status of groups with different income positions. A mandatory health insurance scheme administered by the National Health Insurance Fund (NHIF) gives universal access to comprehensive care. Municipalities and local governments are responsible for providing primary and specialist health care. General practitioners (GP) are independent contractors. A GP referral is needed to access specialist and hospital care but this gate-keeping function is often bypassed. Despite the dominance of public institutions within specialist care, there is a significant share of private ownership in a few areas. The system is financed through an earmarked payroll tax on employers and employees and through contributions from national and local governments. Informal payments are common.

A comprehensive healthcare reform was one of the main priorities of the government elected in 2006. Key components of the reform plans included partially privatising the health insurance scheme, reducing the excessive use of services through patient co-payments, and rationalising capacities through restructuring. After the rejection of some key components by a referendum in March 2008, the government also withdrew the law on health insurance reform. As a consequence, mandatory health insurance remained public and co-payments for doctor visits and daily hospital fees were abolished. Other reform measures, such as controlled patient routes and capping of public expenditure on pharmaceuticals, were more successful and helped to keep expenses under control. Further reform steps seem to have gained more consensus but plans presented in the report appear to be too ambitious for the next two years.

5.1.2. Accessibility

The basic package of healthcare services is universally available to every person staying in Hungary. The self-reported unmet need for medical care indicator was 2.4 in 2006 (EU average: 3.1). At the same time, the number of doctor consultations was the second highest in the EU. Regional inequalities in the geographic accessibility of healthcare services exist despite the high coverage. Facilities are concentrated in the major cities, while there is a lack of GPs and specialists in some disadvantaged rural areas. Major EU-funded programmes aim to restructure the capacities and catchment areas of inpatient and outpatient care institutions. Under these programmes, a rationalised network of regional and micro-regional outpatient care centres will be established. To improve the accessibility of emergency care, ambulance capacity is being restructured with the help of the ERDF. To reduce health inequalities, access to preventive and curative care needs to be improved for disadvantaged groups. Out-of-pocket payments are high (22.6% of total health expenditure), and extensive informal payments affect mainly the poor. Poor people also pay proportionally more for public health care than the rich.

5.1.3. Quality

Minimum standards for quality of care are in place and surveys have been conducted to identify the demand for care and to develop a needs-based approach. Further measures to improve quality will include implementing a monitoring and evaluation system based on defined indicators. Major IT development plans include establishing a database for the insurance system, developing a personal identification system, improving remote diagnostics and telemedicine. More attention will also be devoted in the future to standardisation, the use of protocols and measuring patient satisfaction. The average salary in the healthcare sector is still lower than in most other sectors. Several measures have been taken to improve administrative capacity. Medical equipment and infrastructure are poor in many institutions. Quality is considered by the NSR as an issue linked mainly to the institutional structure of the healthcare system.

5.1.4. Sustainability

Healthcare expenditure (8.3% of GDP in 2006) is slightly below the EU average, but growing steadily (1.4 percentage points since 2000). Health problems of the population induce a high financial burden, which is amplified by high contribution evasion. After years of constant deficit, the budget of the NHIF closed with a 0.1% surplus in 2007, whereas the government failed to introduce some measures (see above) to further reduce expenditures. Inpatient care was formerly notable for one of the highest numbers of acute hospital beds in the EU, indicating inappropriate and excessive use of hospital care. A recent restructuring of capacities created the basis for replacing inpatient acute care by one-day hospital care and outpatient specialist care. Plans include strengthening primary care, developing outpatient care and concentrating specialised care. Further arrangements to improve rehabilitation, chronic care, home nursing and strengthen GPs' gate-keeping function are welcome. Converting inappropriate allocation of human resources and combating the shortage of professionals in rural areas are main goals of the human resources strategy in recent reform plans. Various preventive actions, such as comprehensive screening programmes and healthy lifestyle campaigns, are under way with the assistance of the ESF, but should be further stepped up.

5.2. Long-term care

5.2.1. Description of the system

Long-term care services are provided by both health and social care institutions. Ongoing harmonisation of the responsibilities of the two systems aims to avoid overlaps and parallel activities. Local governments play a vital role in providing residential and home care. Funding for services is ensured by earmarked central budget support. The institutional framework includes chronic and nursing wards and residential institutions maintained mainly by municipalities. Acute care sectors of hospitals, as well as NGOs and religious organisations, also provide long-term care services. Family carers can apply to local authorities for a nursing fee. A fair number of measures have been taken to address the improvement of home care.

5.2.2. Accessibility

Long-term care capacities are at full stretch. The effective waiting list is estimated to be about 5-7% of the places available. Insufficient capacity, long waiting times for nursing care and geographic disparities in day and residential care lead to overuse of acute hospital beds by chronic patients. To tackle this, the government will continue to support home care with the

aim of providing country-wide coverage. Modernisation programmes of residential institutions, financed by the Structural Funds, will contribute to ensuring proper living circumstances for those who cannot be treated in their homes. Planned arrangements concerning supplementary support for micro-regional cooperation schemes providing social services may help to eliminate geographic disparities in access. Aspects of long-term care services should be taken into account in the ongoing process of restructuring healthcare capacities.

5.2.3. Quality

The report remains silent on the assessment of quality aspects of long-term care. Comprehensive quality assurance and accreditation mechanisms are lacking. A component of an EU-funded programme will provide for residential care protocols for the elderly, together with the establishment of a uniform electronic administration system. A pilot scheme is being launched to establish a new service management model in order to make services more adaptable to changing demands through better coordination. An inventory of social facilities and a national capacity monitoring system is also planned. The aim is to allow the elderly to stay in their homes for as long as possible. A patient follow-up system is also needed. Further measures are still called for to establish an improved comprehensive training system and to restore the prestige of professions in this field.

5.2.4. Quality

The lack of a separate institutional system means that long-term care is financially over-reliant on hospitals. Measures for better coordination between health and social sectors, backed up by a separate financing system, are still lacking. Closer regional coordination through the development of care networks, urged by the former NSR, has partly been achieved by the restructuring of hospital capacity. The implementation of arrangements promoting home care will contribute to the sustainability of the system.

6 CHALLENGES AHEAD

- To promote active inclusion by implementing the reform of the social benefit system, including improving links to labour market services, ensuring the conditions for comprehensive rehabilitation and introducing further incentives to remain on the labour market;.

- In the context of budgetary restraints and economic downturn, to maintain the level of resources dedicated to combating poverty and exclusion among vulnerable groups, in particular the Roma;

- To strengthen the governance of social inclusion policies, primarily by improving monitoring and evaluation and by supporting the involvement of civil society;

- To address the long-term sustainability of the pension system and ensure the adequacy of pensions, in particular by further limiting early retirement and reducing the inflow into disability pensions, and reducing contribution evasion;

- To reach political and public consensus on implementing a coherent healthcare reform across government cycles, and to improve the health status of the population through the promotion of healthy life styles and prevention;

- To enforce GPs' gate-keeping role, to tackle the financial burden of health care for disadvantaged groups, to reduce inequalities in access to care through further restructuring of capacities and to develop a quality assurance system;

- To improve long-term care provision, especially home care.

7 TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	*GDP growth rate **	*GDP per capita***	Eurostat	*Employment rate (% of 15-64 population)* 15-64 Total	15-64 Male	15-64 Female	15-24	55-64	Eurostat	*Unemployment rate (% of labour force)* 15+ Total	15+ Male	15+ Female	15-24
2000	5,2	56,1	**2000**	56,3	63,1	49,7	33,5	22,2	**2000**	6,4	7	5,6	12,4
2005	4,0	63,2	**2005**	56,9	63,1	51,0	21,8	33,0	**2005**	7,2	7	7,4	19,4
2008*f*	0,9	61,5	**2007**	57,3	64,0	50,9	21,0	33,1	**2007**	7,4	7,1	7,7	18

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	*Life expectancy at birth* Male	Female	*Life expectancy at 65* Male	Female	*Healthy life expectancy at birth* Male	Female	*Infant mortality rate (2007 instead of 2006)*	WHO - OECD	*Total health exp %GDP*	*Public health Exp % of THE**	*Out-of-pocket payments % of THE*	EU-SILC	*Unmet need for health care % of pop*
1995	65,3	74,5	12,1	15,8	n.a.	n.a.	10,7	**1995**	7,3	84,0	16,0		-
2000	67,4	75,9	12,7	16,5	n.a.	n.a.	9,2	**2000**	6,9	70,7	26,3	**2005**	3,9
2006	69,2	77,8	13,6	17,7	54,2	57,0	5,9	**2006**	8,3	70,9	22,6	**2006**	2,4

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	*Total expenditure * (% of GDP)*	*Old age and survivors*	*Sickness and health care*	*Unemployment*	*Family and children*	*Housing and social exclusion*	*Disability*
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	19,3	41,4	27,9	4,0	13,2	3,8	9,6
2006	22,3	42,2	29,0	3,1	13,0	3,1	9,6

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	*(2008) Old age dependency ratio Eurostat*	*Expenditure (% of GDP) Level in **2004** and changes* Total social expend.	Public pensions	Health care	Long-term care
2004	23,5	n.a.	10,4	5,5	n.a.
2010	24,2	0,3	0,7	0,2	n.a.
2030	34,1	2,8	2,7	0,8	n.a.
2050	50,8	7,0	6,4	1,0	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	***At-risk-of-poverty rate*** Total	Children 0-17	18-64	65+	***Poverty risk gap*** Total	Children 0-17	18-64	65+	***Income inequalities*** S80/S20	***Anchored at-risk-of-poverty***	Total - fixed 2005 threshold
Total	12	19	12	6	20	19	21	13	3,7	**2005**	-
male	12	-	11	3	21	-	21	10	-	**2006**	14
femal	12	-	12	8	19	-	21	15	-	**2007**	10

	People living in jobless households Children Total	% of people aged 18-59* Total	Male	Female
2001	13,5	13,2	12	14,3
2004	13,2	11,9	11,1	12,7
2007	13,9	11,9	10,8	12,9

	Long-term unemployment rate % of people aged 15-64 Total	Male	Female
2000	3,1	3,5	2,5
2004	2,7	2,8	2,6
2007	3,4	3,3	3,6

	Early school-leavers % of people aged 18-24 Total	Male	Female
2000	13,8	14,3	13,2
2004	12,6	13,7	11,4
2007	10,9	12,5	9,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,97	1,04	0,93	***Aggregate replacement ratio***	0,58	0,6	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046) *Net* Total	*Gross replacement rate* Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	*Assumptions* Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
5	13	13	DB/DC	/	-	100	/	26,5	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Malta

1. SITUATION AND KEY TRENDS

In 2007 the Maltese economy recorded a growth rate of 3.9%. And for the 2008 the GDP is estimated to a positive 2.1% also in front of emerged crises of the last months. In the context of the present challenging international economic conditions, and taking into account the specific domestic situation, in its Budget for 2009, the Government adopted a number of measures which aim to stimulate economic activity whilst at the same time addressing the challenges facing the Maltese economy, within the context of the renewed Lisbon Strategy. In fact the total employment rate has gradually increased (54.6% in 2007 compared to 53.9% of 2005), though below the EU average (65.8%). The female employment rate has shown only a modest increase (35.7% in 2007 compared to 34.9% in 2006) and to the employment rate of older people which has decreased from 30.8% in 2006 to 28.5% in 2007. More positive is the youth employment rate, which increased to 46% in 2007 from 44.7% in 2006, staying above the EU average. The unemployment rate remains relatively low compared to the EU average; after rising steadily it has fallen in the last two years, dropping to 6.4% in 2007. By contrast, the long-term unemployment rate (2.7% in 2007) remains below the EU average (3.1% in 2007).

Malta is expected to experience similar demographic trends as most other Member States, due to a currently falling fertility rate. Life expectancy at birth is 79.5 (2006) with 77 and 81.9 for men and women respectively. Healthy life expectancy was 69.1 for women and 68.1 for men in 2006. Infant mortality rate (6.5 for 1000 live births in 2007). The old-age dependency ratio for people 65+ years old (19.8% in 2008) is somewhat lower than the EU average of 25.4% and is projected to increase at the same pace as the EU as a whole (49.8% and 50.4% respectively by 2050), even if the data is quite stable with respect to 2006. Demographic trends indicate a slow gradual ageing of the population (in 2007 the population aged 80 years and over was about 3% of the total population and those aged 65-79 years old made up 10.8% of it) with life expectancy at 77 for men and 81.9 for women. The demographic ratio is also affected by the immigration increase (13877 in 2007 against 12000 in 2006, an increase of 13.6%). Irregular migration represents a major challenge for Malta, and has a strong bearing on the social situation. The early school-leavers rate remains by far the highest in the EU (37.3% in 2007), but is showing a remarkable downward trend (from 54.2% in 2000).

2. OVERALL STRATEGIC APPROACH

With the National Strategy Report (2008-2010) the Maltese Government has confirmed its commitment from the previous round to ensure adequate social protection and to consolidate social cohesion. As a result of the current crisis, Malta expects to have a negative impact on the most vulnerable groups of society. Therefore the short term strategy aims to maintain the rate of those experiencing risk of poverty stable at 14.2%, complemented by a medium-term goal to reduce the rate of people at risk of poverty and social exclusion below the present rate of 14.2%.

The report highlights that the main social policy challenge for Malta is to ensure more appropriate and sustainable approaches that sufficiently correct or compensate against social imbalances and inequalities within an overall sustainable public budgeting process. The overarching objectives for socio-economic development and social protection/social inclusion are listed taking an approach based notably on the following pillars:

– Ensuring continuous investment in human capital, education and training.

– Providing social protection and support especially to those who are more vulnerable and in need of help.

The Report highlights employment as a key issue bridging economic and social development. In general, the strategy is focused on the key priorities and well explains that Malta is going through a comprehensive reform, marked by a shift from government provision to a growing emphasis on the responsibilities of the individual. Malta's employment strategy addresses in particular the need to increase access to employment through the introduction of more flexible forms of work, through the provision of services aimed at reconciling family and work and support of Education and Learning system. Beside active measures, the Maltese government intends to overhaul the interaction of taxes and benefits, to ensure a positive impact on the labour market.

However, the strategy report displays some general weaknesses. While the overarching objectives are listed, an adequate analysis is not provided. Synergies and linkages between the three strands (social inclusion, pensions and health care) are not sufficiently explained. The continuity with the previous plan could have been more adequately highlighted through providing more in-depth analysis of the shift in priorities and policy responses.

In the preparation of the Report an extensive involvement of other stakeholders has been ensured. As to gender, the strategy makes an important contribution to the promotion of women's participation in employment with comprehensive measures. Nevertheless, gender mainstreaming is missing from a number of measures related to access to services and to avoiding the risk of exclusion. The Report highlights the use of ESF to support labour market reintegration and social inclusion of vulnerable groups, as well as promoting youth and female employment. ESF also supports reform and capacity building in the public sector.

3. SOCIAL INCLUSION

3.1. Key trends

The at risk poverty rate in 2006 was standing around at 14%, just below the EU average (16%). The groups most exposed to poverty risk are children and people over 65, with a rate of around 19% and 21% respectively, around EU average for both rates. Moreover, single parents, the unemployed and persons in rented housing are also faced with higher risk of poverty.

The percentage of people living in jobless households was reduced to 7.7% in 2007, from 8.6% in 2004, whereas the EU average is around 9.3%. For children living in jobless households, the trend is quite negative (9.2% in 2007 respect to 8.2% of 2006), although the rate is closer to the EU-27 average (9.4% in 2007). The number of early school leavers strongly decreased in 2007(37.3%) from 41.7% in 2006, but it is still by far the highest in the EU.

In-work poverty risk for families with children is also high, which can be explained by a low number of two-earner families (two-adult households with 1, 2 and 3+ dependent children: 11%, 15% and 24%, respectively; EU-25: 12%, 14% and 24%, respectively). This problem is closely linked in particular to high female unemployment.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The 2006-2008 National Action Plan on Social Inclusion placed children and young people at the centre of policy formulation and implementation. In this context, important efforts to combat illiteracy and raise the general level of education have been made and significant progress has been achieved, which is also underpinned by the favourable trends in early school leaving. Similarly, youth and female employment rates have increased. The effectiveness of the welfare system has been improved. During the period between 2006 and 2008 various measures were adopted in the area of social inclusion and protection, such as:

– Amendments to the social security legislation,

– Initiatives aimed at consolidating family friendly measures,

– Reform in the children's allowance system,

– Measures to increase solidarity,

– Measures to enhance the well-being and social inclusion of persons with disability,

– Measures that spur people to work and improve their employability,

– Reform in the income taxation system, and

– Pension reform.

Notwithstanding the above, making work pay to bolster labour market activity, strengthening the fight against benefit fraud and aligning the social benefit and social security system more effectively with emerging needs remain important challenges for Malta.

3.3. Key challenges and priorities

The Maltese National Strategy identifies as main challenges for the programming next period:

– Tackling school absenteeism and pursuing the commitment to reduce educational underachievement;

– Increasing the overall employment rate, particularly through the inclusion of older workers, women and vulnerable groups within the labour market;

– Promoting greater availability of adequate and affordable housing;

– Combating the intergenerational transmission of poverty and social exclusion, especially for children and elderly people;

– Addressing the social aspects of migration and promoting equality and diversity; and

– Reforming the social protection system to ensure its sustainability, adequacy and comprehensiveness.

On the basis of the challenges, the following three priority policy objectives are established in the Report:

– Improving the social inclusion prospects of children and young persons;

– Promoting active inclusion; and

– Promoting equality of opportunities.

These three priority policy objectives are a fair choice because they reflect the main preoccupations of the Maltese population at present and build on those selected for the 2006-2008 NSRSPSI.

The strategy document is exhaustive in setting out the range of short and medium term solutions (especially for the subjects indicated above) to Malta's immediate problems, and take a multi-dimensional approach for tackling poverty and social exclusion. The document explains the procedures for implementation and the way in which the objectives are to be achieved. A number of quantified are targets are identified for the various policy objectives, most of which are rather ambitious.

3.4. Policy measures

The Plan reports some measures linked to the overall objectives.

Under the policy objective "*Improving the social inclusion prospects of children and young persons*" measures aim at combating the intergenerational transmission of poverty and social exclusion, particularly by promoting children and young persons' personal development, well-being, rights, interests and responsibilities. By way of example, interventions in the field personal development include continued reforms in the educational system, modernisation of schools and colleges, investment in education and ICT training, enhancing informal learning and active citizenship, consolidation of youth employment services offered by the Public Employment Services. The well-being of children will be improved through measures which increase the availability of adequate housing and improve child-care services and other services to families. Moreover, community mobilisation programmes regarding children's rights, and a review of the Juvenile justice system and youth policy are envisaged to safeguard the rights of children. Through the implementation of the above measures in this field Malta aims to reduce the risk of child poverty below 19% and increase the percentage of 20-24 year olds with upper-secondary qualifications and above to 70% by 2013.

Under policy objective "*Promoting active inclusion*" measures will be supported under all the three pillars of active inclusion: adequate income support, access to inclusive labour markets, access to quality services. For example at the moment, the unemployment subsidy can correspond to 72% of net minimum wage, but can reach 85% or even more in particular cases (married people with children). The impact of the benefit system on the access to the labour market is substantially connected with the phenomenon of undeclared work; some workers can be discouraged to enter into work by the opportunity to combine unemployment benefit with a non declared salary. However, the action plan does not relate a detailed indication by how adequate income support will be ensured. The Report lists a broad range of measures to promote equal access to training and employment for all. In relation to access to quality services, great emphasis is placed on improving accessibility, affordability and quality of child-care services with a view to increasing work-life balance. Moreover measures aim ate reducing burdensome procedures to access social welfare services for all citizens. A series of rather ambitious targets are also identified. Malta aims to raise by the overall employment rate to 57%, female employment rate to 41% to 2013 and the employment rate of older workers to 35% by 2010. Other targets include reducing the long-term unemployed on active measures at any one time to 20%, increasing the number of adults in lifelong learning by 8% by 2013. The target of increasing the provision of formal childcare for children under 3 years to 15% by 2010, would imply significant progress, however, would still remain well below the Lisbon

target of 33%. More specific targets are also set for training of public sector employees, percentage of households connected to broadband, and ICT literacy of the population.

Under policy objective "*Promoting equality of opportunity*" Malta aims to ensure full social participation irrespective of religion or belief, disability, age, gender or sexual orientation by combating discrimination, promoting the integration of third-country nationals, and the mainstreaming of social inclusion and anti-discrimination issues. Specific measures are aimed at increasing the employment rate and enhancing the well-being of disabled people, however, no concrete target is defined in this respect. Other measures include enacting legislation, promoting diversity by awareness raising campaigns and combating stereotypes. Another important target group for which specific measures are mentioned in the Report are third-country nationals, including asylum-seekers and refugees.

3.5. Governance

Following the Plan there was an extensive involvement of all the various actors and stakeholders in the preparation of the document from the earliest stage. The report provides a detailed overview of existing monitoring and evaluation arrangements, and briefly describes planned arrangements. Globally, the consultation process can be considered satisfactory although no detailed indications are provided on the involvement of social partners. It is positive that linkages with the use of Structural Funds are put in evidence.

4. PENSIONS

4.1. Key trends

As regards the challenge on the participation of older workers in the labour market, no progress can be registered. In fact, the employment rate of older workers has decreased. This entails an increased risk for exclusion of elderly citizens and an important impact on Pension system.

In Malta the Pension system is an earning-related mandatory system. It is called *two third pensions* because the initial benefits at the moment of retirement are calculated as two thirds of the average income of the best three years during the 10 last years prior to the retirement, after a contribution period of 30 years. For self- employed people the income averaging period is extended to the last 10 years. The contribution base is such that all income higher than 133 % of average annual earnings is not taken into account when calculating the pension entitlement. The full rent of a pension is payable to a person who has paid contributions over a 30 years period. Private pensions still do not form part of the obligatory pension framework. The measures adopted in 2007 and 2008 are focused to improve minimum incomes and to improve sustainability with measures to enhance flexibility and to change the retirement age from the present 60 years for women and 61 years for men to 65 years for both men and women from 2015 to 2027.

The relative median income ratio for people aged 65 years and over is 0.79% in 2007 compared to EU average 0.84%; while the aggregate replacement ratio was 0.5 % in 2007, respect to EU -25 0.49%.

4.2. Key challenges and priorities

The main challenges of Maltese's system affordability and substitutability of the so called "two third pension" system in an environment where the share of ageing population is expected to rise; and where worrying examples as the decreased employment rate of older workers may be risk of exclusion for elderly citizens and an important impact on Pension system.

This will result a gradual increase in the share of expenditure on current pensions system in the Gross Domestic Product (GDP) from 7.3 in 1995 to 7.4% in 2004 and to 8.7% in 2010 and its projected that to peak at 9.1% in 2030 and will reduce to 7% in 2050.

Therefore Maltese Government Priorities to tackle these key issues are:

- To support and encourage extend working life;
- For increasing pension system awareness of the importance of personal savings that should be enhanced further. In particular the Pension Reform of March 2006 recognised the need of strengthening, in especially for public sector, the link between contributions and benefits;
- .To create the condition for a sustainable financial system of Pensions expenditures.

There is a need to boost the employment among women since their higher exposure to poverty and lower theoretical future replacement rates compared with men.

The Gross replacement rate for Malta in 2006 was 65 (79 for Net replacement rate). Change in Gross theoretical replacement rate is expected to take place as -17% between 2006 and 2046 (-21 for Net replacement rate).

In anyway it is not clear if 2007-2008 reforms are enough to guarantee adequacy and sustainability of the current pension system.

4.3. More people in work and working longer

To prevent early exit from the labour force, as Malta has the lowest effective labour market exists age, 58.5 years compared to 61.2 years average of EU, the operations of the Benefit Fraud and Investigation Directorate contributed indirectly in limiting the number of persons seeking to exit the labour market through fraudulent claims for social benefits

Also to enhance the flexibility of the labour market the government has adopted some measures as introducing a register of persons seeking part-time employment, granting the crediting of Social Security contribution to parents who temporally opt out of the labour market to care children and other measures to ease the burden of job to job transition on workers. In addition, in 2008, the capping of the National Minimum Wage on earnings from pensioners under 65 years was removed, and such pensioners will no longer forfeit their right to a social security pension if their earnings from employment exceed the National Minimum Income capping. This initiative should encourage elderly persons to remain active in the labour market and help them maintain an adequate relative standard of living. A substantial number of persons have already benefited from this measure and the positive effects of this Budget 2008 measure will be evident in future measurements of the ARPRs. The change of the invalidity pension system will also remain a key target to ensure that people spend more time at work by reducing the number of invalidity Pension awards. The employment rate was

55.7% in 2007 compared to 54.8 % in 2006. The gender gap was around 37 % in 2007 as for men reached 74.2 % and for women 36.9 % and in 2006 this gender gap was around 40 % as for men was 74.5 % and for men 34.9 %.

Malta has implemented different measures to attract women into the labour market (also through the implementation of the new ESF programme), for example with fiscal measures such as tax credits returning to work and fiscal support for part-time workers. It will be crucial to step up these efforts: the employment rate for women with at least one child below 6 is the lowest in the EU while the rate for younger women, mainly before maternity, is above the EU average.. The government has also taken some initiatives to encourage older workers to re-integrate in the labour market, such as paying social security contributions in specific cases or pensioners to work without having their pension reduced.

4.4. Privately managed pension provision

The Government is considering introducing a mandatory second pillar scheme. The consultation document contained a large section on this issue. In fact with the green paper 2006 the Maltese government has proceed to consult the stakeholders and the social partners to introduce a second pillar scheme; but now it is not clear if it will be made in the future and in which conditions. However so far this has not been implemented, also because of the unfavourable economic conditions. During 2007 two provisions relating to out-of-court dispute resolution in the Markets in Financial Instruments Directive (2004/39/EC) were transposed in article 20, effectively extending the role of the Consumers complaints Manager beyond products and services falling under this directive. This will help engender positive perceptions towards private pensions.

4.5. Minimum income provision for older people

The issue of poverty of elderly people is about adequate pension provision, but it is also an issue of diversified income in old age. The at-risk-of- poverty rate of older people has raised because it was 21 % in 2006 and 16 % in 2005.The gender gap in 2006 was very low, 2 points, as for men reached 22 % and for women 20 %.

The national minimum pension was pegged against a minimum of 60 % of the median national equivalence income; and the retirees can now work and earn an unlimited amount without any reduction in their pensions. Further measures were introduced in the 2007 and 2008 budgets to improve adequacy of incomes as persons receiving severe disability pensions are now entitled to receive this pension up to five years after marriage to persons without any disability regardless of the income earned by the spouse,; the same period for widows and widowers who remarried, some tax has been removed in the inheritance of the residential home, the service pension (466 €) will be ignored in the calculation of the social Security pension, the 2008 budget adjusted the income tax bands in order that the lowest earners don't pay taxes, pension credits for children care and deduction for elderly care in private residential services.

Again the pension's reform launched in 2006 reform set a new maximum pensionable income up to 2013 when the MPI will be capped at a weighted average of wage growth and inflation rate.

One of other measures in the 2008 budget led to the introduction of pensioners' entitlement to a cost of living increase (COLA) comparable to that of employed persons. In other words, previous two-third pension beneficiaries will be getting a full COLA, fixed at Lm1.50 (€3.49) in this budget year.

4.6. Information and transparency

Discussions on the subject of second Pillar pension scheme (SPPS) or Third Pillar Pension Scheme TPPS have been ongoing throughout the period 2006-2008 with the intention of roping in the major players in the are a of pension provision. The department of Social security has a well established network of district offices from which people can obtain information on the various pensions and benefits that they may be entitled too. This information process is also backed up by regular TV and radio call in programs where the audience can ask questions or participate in live discussions.

Given that The SPPS and the TPPS are still not formally introduced there is scope for more awareness and information campaigns.

The Consumer Complaint Unit (CCU) of the Malta Financial Services Authority (MFSA) is responsible for protecting consumer rights by providing, advice and information on financial services or related products. It performs this public duty very well by using various tools eg media campaign, chat shows on television and radio programmes.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

A National Health Service (NHS) provides free comprehensive public healthcare to all residents. Primary healthcare - PHC is provided in health centres by general practitioners (GPs), nurses and some specialised services. Following a referral, patients' access specialist and hospital care in public hospitals. The NHS is funded out of general taxation and cost-sharing applies to pharmaceuticals and some dental and optical care, all means-tested. 25% of the population purchases voluntary private health insurance to access private PHC and basic outpatient specialist care which co-exist with public services.

The Maltese Government, together with the country's main stakeholders, have recognised the need to enhance equity in access to care, promote quality and excellence and safeguard sustainability as the main priorities. Health inequalities are seen not only as a humanitarian cause but also leading to economic losses both in terms of lost productivity and higher health care expenses. Hence, the Directorate for Health Information and Research will be seeking to identify and map out existing epidemiological health inequalities in Malta.

Considerable progress has been registered since Malta's first involvement with the NSR process two years ago. One particularly important aspect of this progress is the effort made by Government to consult with a wide range of stakeholders on a variety of health issues, not merely those pertaining to the NSR. The next major challenge is translating policy into action.

The self perceived health rate is above the EU average, with an interesting spread between men (Very Good or Good together 72.7%) and women (66.2%).

5.1.2. Accessibility

Free comprehensive public healthcare (including preventive care) contributes to ensure access to all. This is coupled with means-tested entitlement (for low income household) to pharmaceuticals, dental and optical care, i.e. benefits that are excluded from the public healthcare basket. The additional long-term capacity will bring waiting times down by reducing the number of bed blockers. Extra capacity is to be coupled with an analysis of waiting lists and a new waiting list management system including waiting time targets, new agreements with doctors and longer ward hours. The Maltese Authorities have to ensure that their engagement to bring waiting time for interventions down to an acceptable level materialises. The Government wants to ensure fairer and more transparent prices for medicines, which includes a greater monitoring of prices and, an increase the use of generics. A pilot "pharmacy of your choice" scheme has been launched to enhance access to medicines. Several proposed e-health solutions (health portal, electronic patient record, phone counselling) should improve information to patients and patient flows through the system.

5.1.3. Quality

As promised in last year's report the new Mater Dei hospital now offer modern/latest medical equipment and ICT. The new cancer facility that is being planned will also incorporate these new developments. The 2008-2010 report also indicates that a number of quality services charters have been implemented. The Maltese Government stresses that the future Health Care and Mental Health bills, to be presented to Parliament, provide for far-reaching changes in the legislative framework of patients' rights and will ensure that uniform standards are applied throughout the system (public and private providers). Providers will be encouraged to set up systematic patient care protocols to enhance patient safety and clinical outcomes. Comparable indicators are seen as relevant to allow informed decision making. According to the authorities there is a large degree of patient choice and the above mentioned bill will further consolidate patient rights, responsibilities and representation within the system. It is hoped that this will also lead to a more sensible use of the system. The plan is to use population surveys to monitor satisfaction on the nature and quality of health services, and providers will be required to conduct an in-depth survey of the views of service users. The Maltese Government further expects that ICT and e-health solutions can improve coordination between PHC and secondary care and supply providers with better information. The Maltese Authorities are satisfied that the increasing immunisation rates will help to improve influenza and hepatitis B vaccination coverage.

A task force to be set up in 2009 will oversee the implementation of reforms in primary and community care. In the meantime the following measures will be undertaken:

- Health centres will be refurbished and equipped with the capability to treat minor emergencies. This will allow patients with minor injuries and ailments to be treated more rapidly and will allow the emergency service at MDH to focus its resources on the more serious emergency and acute cases;

A central emergency call triage centre will be established. This will ensure better response times to emergency domiciliary care and streamlining of human resources required for home visiting.

5.1.4. Sustainability

Total health care expenditure (8.4% of GDP in 2005) is under the EU average in GDP terms (9% in 2005). Ageing is seen as a challenge, resulting in an increasing demand for services, together with increased costs of medical devices and pharmaceuticals (also related to stricter

quality requirements). Other issues (changing patterns of morbidity, increasing expectation of patients to be treated on the island and not referred abroad, cancer treatment, the costs for giving health treatment for immigrants, etc) add pressure on the Maltese National Health System which might impact on sustainability for an effective sustainable financial system. A central unit of financial management to monitor and control the financial management of the system has been set up within the public health sector.

The Government is not intending to take over the provision of primary health care from the private sector since the private community family doctor plays a vital role in the health system. Rather, the objective is to find a way of strengthening and supporting these doctors to develop into primary practices and teams with formal patient registration.

5.2. Long-term care

5.2.1. Description of the system

Services are provided by the State, the church and private/voluntary organisations. Complementing PHC and rehabilitation, the Department for the Care of the Elderly runs residential homes for the elderly (who pay a part of their annual income), a geriatric hospital, a home help service (e.g. household activities and shopping, meals-on-wheels, household maintenance) for a nominal charge but free for low income individuals, and the telecare/telephone system. The system is funded through taxation and income-linked co-payments. The church provides free residential care for the disabled. The private sector also provides home care and support. Government policy focuses on keeping people at home and in the community for as long as possible and on ensuring a healthier and more active elderly population.

5.2.2. Accessibility

The report recognises that an increasing demand for services and limited availability of institutional care in the public and church sectors have resulted in long waiting lists, whilst the private sector is only affordable to a segment of the population. Initiatives to enhance provision include increasing the numbers of public sector beds and contracting private beds. Authorities are focusing on enhancing the provision of community services such as day centres and adult learning centres. A legal framework for voluntary organisations has been enacted, supporting the role of NGOs in this field. A needs assessment for elderly people, especially those living in the community, is planned.

5.2.3. Quality

Legislation on quality standards is deemed rudimentary and is to be updated, and licensing and monitoring will be strengthened. Better coordination between levels of government and the church, the private sector and NGOs is being sought. A step-down facility was created to facilitate transition from acute to long-term care.

5.2.4. Long-term sustainability

The 2008 health and long term care expenditure projections foresee an increase of 1.8 percentage points of GDP to 2050 Authorities expect that a number of initiatives such as privately managed, state funded homes and support to family carers that maintain people at home will help to control costs and ensure an efficient use of resources. Training of human resources ranges from basic care skills to specialised professional training and is considered fundamental by the authorities. Thus, a manpower plan will focus on requirements of staff and their skill mix, as well as training and retraining for staff and carers. Specific promotion and prevention campaigns for the elderly are planned. The plan of Government is to increase the bed capacity accompanying by a concomitant expansion in skilled human resources, particularly carers.

6. CHALLENGES AHEAD

- To combat poverty among children and the elderly and break the intergenerational transmission of poverty and social exclusion and to tackle early school leaving and educational underachievement.

- To promote the inclusion of women, young people and vulnerable groups within the labour market and to address the social aspects of migration.

- To improve the sustainability and adequacy of pension system though higher female employment and longer working lives;

- To promote greater availability of adequate and affordable housing.

- To reduce waiting times for health and long-term care services, ensuring better reimbursement of medicines and enhancing the provision of long-term care services are priorities in the health and long-term care field, as the gap between life expectancy and healthy life years may indicate that more effective health promotion and disease prevention is needed.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	15-64 Male	15-64 Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	15+ Male	15+ Female	15-24
2000	n.a.	83,6	**2000**	54,2	75,0	33,1	52,4	28,5	**2000**	6,7	6,4	7,4	13,7
2005	3,5	78,2	**2005**	53,9	73,8	33,7	45,3	30,8	**2005**	7,3	6,5	9,0	16,4
2008*f*	2,1	76,4	**2007**	54,6	72,9	35,7	46,0	28,5	**2007**	6,4	5,9	7,6	13,8

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	74,9	79,5	15,3	17,5	n.a.	n.a.	8,9	**1995**	n.a.	n.a.	n.a.		-
2000	76,2	80,3	15,2	18,5	n.a.	n.a.	5,9	**2000**	6,8	72,5	26,7	**2005**	1,6
2006	77,0	81,9	16,1	19,5	68,1	69,2	3,6	**2006****	8,4	77,4	20,2	**2006**	1,8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	16,1	50,2	27,6	2,3	12,8	2,4	4,7	**2004**	19,8	18,2	7,4	4,2	0,9
2000	16,9	50,5	29,3	2,6	9,4	2,4	5,9	**2010**	21,2	n.a.	1,3	0,3	0,0
2006	18,1	52,8	28,4	3,4	6,3	2,8	6,3	**2030**	39,1	n.a.	1,7	1,3	0,1
								2050	49,8	n.a.	-0,4	1,9	0,2

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	14	19	12	21	14	19	12	21	3.8	**2005**	14br
male	14	-	10	24	14		10	24	-	**2006**	11r
femal	15	-	14	18	15		14	18	-	**2007**	11

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	7,9	7,8	5,7	9,9
2004	9,2	8,6	6,8	10,4
2007	9,2	7,7	6,2	9,3

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female		Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	4,4	4,5	4,2	**2000**	54,2	56,1	52,5
2004	3,4	3,7	3	**2004**	42b	39.5b	44.2b
2007	2,7	2,8	2,4	**2007**	37,3	32,9	41,1

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0.79	0.77	0.78	***Aggregate replacement ratio***	0.5	0.52	0.48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
-21	-17	-17	DB	/	-	n.a.	/	30	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

The Netherlands

1. SITUATION AND KEY TRENDS

After a prolonged stagnation during the first half of the decade, the Dutch economy has performed well during the last three years. Real GDP growth strengthened and outperformed the EU average in 2007 (3.5%; EU 2.9%). As a consequence of the global economic crisis, growth is currently slowing down and estimated to have reached 1.9% in 2008. In 2009, GDP growth is projected to contract by 2%, while light recovery is expected in 2010.

The Lisbon employment targets have been met (2007: overall 76%, older workers 50.9% and women 69.6%)[152]. While the female employment rate is significantly higher than the Lisbon target of 60%, the high incidence of part-time female employment gives a significant reduction in full-time equivalents from 69.6% to 44.4%. The unemployment rate fell to 3.2% in 2007, which is low compared to the EU average (7.1%). Due to the slackening of economic activity, unemployment is expected to rise rapidly (4.1% in 2009 and 5.5% in 2010). The youth unemployment rate (5.9%) is the lowest in the EU. The national target has been met: youth unemployment is not more than double the overall unemployment rate. Ethnic minorities are overrepresented among the unemployed in all age categories. At 1.3%, long-term unemployment is below the EU average (3%).

The at-risk-of-poverty rate before social transfers except old age and survivors benefits is 21%, while the overall poverty risk after social transfers is 10% (one of the lowest in the EU). The at-risk-of-poverty rate for children aged 0-17 years is 14%. Those most affected by poverty are members of non-Western ethnic minorities[153], single-parent families and households living on benefits other than pensions.

Life expectancy at birth was 77.7 years for men and 82 years for women in 2006: an increase of three years for men and one and a half years for women over the last decade. Healthy life expectancy remained fairly constant for men (61.7 years in 2003), but decreased from 62.1 years in 1995 to 58.8 years in 2003 for women[154]. The Netherlands is one of the Member States with the lowest old-age dependency ratio (20.7% in 2005). This ratio is projected to rise to 45.6% in 2050, but remains below the EU average (50.4%). The total public social expenditure on pension, health care, education and unemployment transfers is currently 20.9% of GDP.

2. OVERALL STRATEGIC APPROACH

The choice of priorities for the social inclusion part of the NRS is in line with the 2006 – 2008 report. The guiding principle of the Dutch government is that work is the best remedy against poverty. The key emphasis in preventing long-term poverty is therefore placed on increasing participation through work acceptance and training. This means equipping people with the necessary skills and giving them the opportunity to engage in paid work or, if this is not feasible, in volunteer work. To increase effectiveness, priority has been given to preventing poverty and exclusion in future generations, e.g. by combating child poverty. In addition, the NSR includes measures to address the non-use of provisions and over-indebtedness.

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[152] The Dutch government has set a national employment target of 80% by 2016. The *Labour Participation Committee (Bakker Committee)* was established to come up with proposals for increasing participation and average hours worked. Its report, entitled *Towards a future that works*, was presented in June 2008

[153] Members of non-Western ethnic minorities are people who have at least one parent who was born in Turkey, Africa, Latin-America or Asia (except Indonesia and Japan)

[154] The decrease in healthy life years is mainly caused by an increase in unhealthy lifestyle among women (e.g. increase in smoking and alcohol abuse and an unhealthier diet)

Since in-work poverty is very low in the Netherlands, there is a clear link between inclusion and employment policy. Policy initiatives mentioned in the NRP aimed at increasing the overall education level, reducing early school leaving and (re)activation of vulnerable groups increase both employability and opportunities for social inclusion.

As previously, the number of targets for the mentioned priorities is limited and targets are mainly formulated in general terms. In the report, specific gender-related issues and attention to different target groups are only mentioned under the objective of promoting (labour) participation. An omission in the report is the lack of analysis of the relationship between the three policy areas. Also, the NSR does not mention to what extent the Structural Funds will contribute to achieving the national priority policy objectives.

3. SOCIAL INCLUSION

3.1. Key trends

10% of the Dutch population lives on a disposable income below the at-risk-of-poverty line. The at-risk-of-poverty threshold is an annual income of €10.924 for a one-person household and €22.941 for a household consisting of two adults with two dependent children. In-work-poverty risk after social transfers is low (4%), while unemployed persons face a high risk of poverty (27%). Unemployment traps remain high. Especially lone parents are affected: in 2007 they faced an income loss of 8.75% when accepting a job at minimum income level. In 2008 the situation improved for families with children when the tax discount for children was converted into a child allowance.

Despite progress in recent years, ethnic minorities continue to lag behind with respect to educational attainment, labour market performance and housing conditions. Due to the large number of flexible contracts among ethnic minorities, their unemployment rate is more volatile over the economic cycle. Their labour market performance is therefore projected to deteriorate with the current economic slowdown.

The youth education attainment level is below the EU average (76.2%; EU: 78.1%) and the EU benchmark of 85% by 2010. The situation is worse for boys (71.9%) than for girls (80.5%). Despite falling from 15.5% in 2000 to 12% in 2007, early school leaving is still far above the national target of 8% set for 2012. Ethnic minorities are overly represented among early school leavers. Also, the educational attainment gap between natives and non-Western ethnic minorities is high (2005: 53% against 67%). Early school leaving and low educational attainment are considered to be main causes of the low employment rates of non-Western ethnic minorities.

Despite an intense policy focus, low levels of literacy remain a severe problem. Although the number of 15 year-olds who are low-achievers in reading literacy is one of the lowest in the EU, their number has grown rapidly from 9.5% in 2000 to 15.1% in 2006. Also, it is estimated that approximately 1.5 million people lack the necessary reading and writing skills to participate fully in society. Another concern is the relatively low participation of poorly-qualified and unemployed people in lifelong learning.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

For the period 2006-2008, the government put forward four policy objectives:

- Promote participation through employment, training and/or unpaid social activities;
- Combat poverty and promote participation among children and young people;
- Promote the use of existing provisions;
- Address over-indebtedness.

The 2008-2010 NSR gives detailed information on the progress towards the targets for these four policy objectives. For instance: the growth in employment picked up from 1.8% in 2006 to 2.6% in 2007. However, the report does not mention to what extent this progress can be attributed to the favourable economic situation. Two particularly noteworthy and unfavourable trends are the steep increase in the number of disabled young people (+17pp since 2004) and the increase in the number of applications for support in debt settlement.

Due to the election period, 2007 has been relatively quiet in terms of actual implementation of new policies affecting income and social inclusion. On the other hand, several measures have been or will be implemented in 2008 and 2009 to enhance the participation of under-represented groups in the labour market. These measures should help to meet the challenge put forward in the 2007 JR to promote integration of ethnic minorities, single parents and older people into the labour market.

The 2007 JR mentioned that it was disappointing that the NRS did not put forward any new policies for tackling inactivity and low-wage traps. The NSR 2008-2010 makes reference to the (planned) adaptation of several measures that should point financial incentives in the right direction.

The challenge to continue developing an adequate evaluation and monitoring framework for assessing the employment and social measures has still to be met. Since the government is not playing a central role in implementing social inclusion policy as part of a decentralising and deregulation operation, it is important to closely monitor developments in this area. According to the NSR, efforts are being made to synchronise existing data systems and reports so as to monitor targets and indicators for risk groups in mainstream employment and social measures. This should reduce the number of policy monitors by 25%.

3.3. Key challenges and priorities

The government has maintained the same four policy priority objectives as for the period 2006- 2008. These objectives reflect the current key trends and the challenges presented in the 2007 JR. However, the issue of adequate evaluation and monitoring of employment and social measures, identified as a challenge in the 2007 JR, is not addressed in the 2008-2010 NSR.

The selected priorities are relevant, although the focus is broad and objectives and outcome expectations could be made more specific. Since poverty was a growing problem during the last economic downturn, there is a need for vigilance with regard to the effects of the current economic crisis on the situation of the most vulnerable. The Netherlands was not confronted with the effects of the financial crisis until after the NSR was written, therefore possible difficulties in meeting policy objectives in view of the current economic downturn are not addressed.

3.4. Policy measures

The first priority is well elaborated: tailored policies are being developed to increase participation of various target groups. Under the policy of decentralisation, local governments are now primarily responsible for the re-integration and participation of disadvantaged groups. Although the number of benefit recipients has fallen by 19% since the introduction of the Social Assistance Act in 2004[155], municipalities have mainly been successful in helping those who are relatively easy to place. Evaluation shows that municipalities are not successful in re-integrating the hard core of long term benefit recipients. To make it easier for municipalities to pursue a more coherent participation policy, the existing budgets for re-integration, civic integration and adult education will be combined from 1 January 2009.

Specific programmes have been launched to increase the participation of target groups. For example, the government aims to help 50.000 migrant women find their way to voluntary or paid work by 2010, to guide an additional 200.000 people at the lower end of the labour market into work by 2011 and to realise 30.000 extra work-study programmes for unqualified young people. This is relevant given the disadvantaged status of these groups, but it is difficult to forecast the effects of these programmes.

To encourage people (especially women) to work – and work longer hours – the government announced a review of the 2005 Child Care Act and introduced fiscal measures, such as the phasing out of the transferability of the general tax credit. Estimates indicate that the full phase-out would have a significant impact on female participation. However, since the transition will take 15 years and there are several exemptions, this measure is insufficient for tackling the high marginal effective tax burden on second earners in the short run. Given the importance of increasing the labour supply, it is disappointing that transferability is not being eliminated more rapidly and without exemptions.

In the field of social inclusion of immigrants and ethnic minorities, policy measures focus on acquaintance with the Dutch language and culture and combating discrimination. The NSR highlights the importance of the Dutch integration policy in improving the social inclusion of immigrants. To better prepare immigrants, thereby also helping to prevent exclusion, the integration system has been drastically overhauled with the 2007 Civic Integration Act and the Deltaplan Inburgering (a master plan for integration).

Changes will be made to the Sheltered Employment Act (WSW) and the scheme for those Disabled from an Early Age (Wajong) to better assist people with disabilities, who are capable of working, in finding a suitable job that enables them to work independently as far as possible. This could lead to better opportunities for re-integrating these people.

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155 An important aspect of the Social Assistance Act is the change in funding of municipalities. Instead of claiming all welfare expenses directly from the central government, local governments get a fixed budget to cover all welfare expenses. The idea is that this will lead to a more efficient implementation of the welfare case load

As regards the second priority, arrangements have been made with municipalities to combat poverty among children from poor backgrounds. From 2009 municipalities will have more scope for giving extra financial support to families that have been on a low income for several years. In addition, families on low incomes with school-going children will receive more assistance in the form of provisions, such as computers and sport club memberships. Because of the direct impact education has on the risk of poverty, there is a strong focus on preventing early school leaving. To encourage sustainable labour participation and prevent benefit dependency, youngsters between 18 and 27 will no longer be entitled to social assistance benefits. Municipalities are obliged to give young people applying for benefits a personal offer consisting of work and/or training.

The remaining two priorities are concerned with reducing the number of households at the minimum income level. With regard to preventing the non-use of income support, the government is continuing its existing policy measures, in line with the principle of individual responsibility: trying to reach beneficiaries through advertising, merging the databases of different institutions and simplifying application forms. To halve the number of people with problem debts in 2011, stricter rules on advertising will come into force for credit providers, plus higher fines for violation of those rules. Also, the government wants to improve the quality of debt relief assistance and to cut waiting lists. Although these measures could have favourable effects, the individual responsibility approach may be too one-sided to reduce the number of minimum income households.

3.5. Governance

There has been an extensive process of consultation for the preparation of the NSR which has involved, among others, municipalities, social partners, organisations in daily contact with the high poverty risk group (e.g. the municipal credit bank and social housing corporations), as well as NGOs and people from the high poverty risk groups themselves. The results of the consultation are summarised in the appendix of the NSR. The results are also visible throughout the report e.g. in the themes 'child poverty' and 'encouraging the use of income support'.

The civil society dialogue has resulted in agreements between the government and other stakeholders on the scope of NRS-related topics, e.g. in the areas of promoting participation, fighting illiteracy and dealing with problematic debts.

4. PENSIONS

4.1. Key trends

In the Netherlands, all residents from the age of 65 are entitled to a universal flat-rate public pension (AOW)[156]. In addition, around 90% of the active population is covered by supplementary occupational pensions. The third pillar of the Dutch pension system is relatively small and comprises individual, voluntary pension plans. In 2006, the first pillar accounted for 50% of total net retirement income and the second pillar for almost 40%. Although the relative importance of the secondary pension income is increasing, the first pillar will remain an important source of income for older people. In 2030, the AOW will still account for 44% of total net retirement income.

[156] Precondition for a full first pillar pension is to be a resident in the Netherlands without interruption between the age of 15 and 65. Non-residents who pay income tax in the Netherlands are also insured

The contribution rate to the public pension scheme was 6.8% of GDP in 2004. This share is projected to decrease slightly over the next couple of decades, while public spending on pensions is expected to increase from 7.7% to 11.2% of GDP in 2050. According to ISG projections, the net theoretical replacement rates will increase with 8 percentage points between 2006 and 2046, reflecting the defined benefit design of statutory and occupational pensions in the Netherlands.

4.2. Key challenges and priorities

The 2007 JR acknowledged that the Dutch system ensures adequacy. It also highlighted two challenges: strengthening incentives for older workers to remain in the labour force and increased participation of women and part-time workers in occupational pension schemes.

The first pillar is financed according to the PAYG system; the ageing of the population has put pressure on this system of financing. The Dutch strategy for the first pillar relies on an ambitious goal of achieving budgetary surpluses over a long period, supported by intensified employment policies and discouraging early exits from the labour market. Recent reforms of tax law and regulations affecting early retirement have successfully raised the average exit age from 61.6 years in 2005 to 63.9 years in 2007. Nevertheless, the employment rate gap of 37 pp between the 55-59 age group and the 60-64 age group (EU average: 28.2 pp) demonstrates that older workers still make up a large proportion of the unused labour supply in the Netherlands. Therefore, in order to deal with the financial pressure of ageing, efforts should be continued to expand participation of older workers and to further delay the average exit age until at least the State pension age of 65 years.

No specific measures are taken to increase the participation of women and part time workers within the occupational pensions sphere. The NSR states that, since the Netherlands has strict regulations for equal treatment between men and women and between full time and part time workers as concerned company pension systems, this challenge will be automatically met by focussing on increasing labour market participation and average hours worked.

4.3. More people in work and working longer

The employment rate of people aged 55-64 has increased significantly in the past decade. However, beyond the age of 60 the participation rate is still low (31.1% in 2007). There are large gender differences: 80.4% of men aged 55-59 and 39.8% of men aged 60-64 still have a job, while the corresponding figures for women are 55.7% and 22.2%.

To bring about the necessary increase in the effective exit age, disability and unemployment benefits have been reformed to prevent these schemes from being used as early retirement routes. Also, the fiscal treatment of early retirement and pre-pension schemes has been changed. To further raise the effective exit age, new measures are to be introduced in 2009: employees who stay employed after the age of 62 will receive a bonus for each year they continue working and people will have the opportunity to voluntarily delay claiming their state pension. Delaying retirement benefits after the age of 65 years will be rewarded with a higher pension later on[157]. Unfortunately, national studies show that it is unlikely that the proposed new financial incentives will successfully influence older worker's behaviour[158].

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[157] It should be noted that workers are often not able to keep working after the age of 65. In most cases labour contracts legally end at 65 by collective agreement. In addition, the demand for workers over 65 is weak since firms must pay employees' wages during sickness absence for a period of up to two years. For workers over 65 they cannot insure against this risk

[158] E.g. Netherlands Bureau for Economic Policy Analyses, *Effecten doorwerkbonus,* 17 October 2008.

Even though life expectancy has increased by more than six years, the age of eligibility for a state pension has remained unchanged since the scheme was established in 1957. Increasing the retirement age in line with life expectancy would have favourable effects on labour market participation and fiscal sustainability. However, the government wants to avoid an increase in the state pension age.

4.4. Privately managed pension provision

Around 90% of the active population is covered by supplementary occupational pensions. The number of households above 65 years that receive a supplementary pension will rise from 84% in 2006 to 95% in 2030.

In recent years, many pension funds have switched from final-pay schemes to average-wage plans[159]. Nowadays the typical occupational pension contract comprises an average earnings defined benefit pension in which only nominal benefits are guaranteed, but with the intention of providing wage indexation. As from 2005 a number of large companies introduced a new type of pension scheme, the 'collective defined-contribution scheme (CDC)', mainly with a view to limiting the company's financial risks. With the introduction of these CDC schemes, the risk of poor investment performance is shared between the employers and the members of the scheme. If buffers are too low, contributions are adjusted or indexation will be lower (or zero) for pensioners and putative pensioners, making them poorer in real terms in their retirement.

Supplementary pension funds are supervised by the Dutch central bank. Every fund has to fulfil obligations regarding financial reserves and sound financial policies. The financial position of the Dutch pension funds has been significantly affected by the problems on the international financial markets. The coverage ratios of the funds have decreased and several funds dropped below the minimum threshold of 105% or even below the 100% coverage rate. As a result, it is expected that most pension funds will not fully grant indexation for 2009 and that contributions will be adjusted. Pension funds with a coverage ratio below 105% have to submit a recovery plan to the Dutch central bank.

The third pillar is relatively small and only accounts for 10% of retirement income. The role of the government in the third pillar is confined to providing a fiscal and legal framework. There are two main forms of insurance in the third pillar, annuity insurance and capital insurance. Since the majority of self-employed persons can not participate in a second pillar scheme, the government offers them fiscal opportunities to save for a pension provision in the third pillar. Recently there have been doubts about the sustainability of third pillar pensions, as insurers have been calculating excessive costs, which lower the profitability of these pension schemes. Although this state of affairs is not the direct responsibility of the government, it may adversely affect the income position of pensioners.

Differences in income position among older people are mainly situated in the second pillar pensions. Women (especially older women) are lagging behind men with regard to pension accrual in the second pillar. National figures show that women aged 55 and above have entitlements to second pillar pensions that are 80% lower than those of men in the same age group. Entitlements of women aged 40-50 are 50% lower. The upward trend in pension accrual of women can mainly be explained by increased participation rates and finding better paid jobs.

[159] National figures show that between 2002 and 2007 the share of all active participants covered by an average-wage scheme jumped from approximately 25% to 84.5%

4.5. Minimum income provision for older people

In the Netherlands a statutory guaranteed minimum pension income in the form of the first pillar pension (AOW) applies. The amount of AOW depends on the minimum wage and the development of this amount can be linked to the development of wages in collective labour agreements. Such an indexation occurred in the period 2005 – 2008. People who are not entitled to the full AOW benefit and who have, together with other sources of income, a total income below the subsistence level (less than 70% of the legal minimum wage) are entitled to receiving social assistance.

The Dutch pension system is efficient at coping with old age poverty. People aged 65 and above enjoyed a living standard close to that of the general population (86%) in 2005: this represented a slight decrease compared to 2004 (88%). In 2007, the at-risk-of-poverty rate after social transfers for older people (65 years and over) was 10%, which equals the risk of the 0-64 population. It is noteworthy that the poverty risk for older people increased during the last couple of years (5% in 2005), while it decreased for the 0-64 population (12% in 2005).

4.6. Information and transparency

A new Pension Act was introduced with effect from 1 January 2007. It aims to modernise the pension system and adapt it to new developments in the pension area. An important element is improving transparency. Therefore, the Pension Act contains extensive instructions on providing information about the content of pension schemes and the way the pension scheme is administered (including indexation). The distribution of responsibility within the triangular relationship of employees, employers and pension providers has been clarified. The new Pension Act also introduced a new supervisory framework for pension funds - the Financial Assessment Framework (FTK). To make information on pensions more accessible, a pension register where people can access up-to-date information on their pension situation will be made operational by 2011.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

In 2006 the government implemented radical reforms in the health insurance system. The dual-funded and partly compulsory system was replaced with a mandatory universal system operated by private health insurers. A key idea of the reforms is to increase efficiency by promoting competition on the health insurance and health care provider market. These markets are supervised by the Dutch Care Authority (NZa).

To maintain solidarity, a mandatory basic insurance package is laid down by law for all citizens whereby health insurers are obliged to accept all applicants and to charge each applicant the same nominal premium for this basic package. The basic health insurance is financed primarily through nominal and income related premiums. The latter are redistributed according to a risk adjustment scheme that compensates health insurers for predictable differences in their medical expenditures. Additional private insurance can be purchased, but in such cases insurance companies can reject applications and the ban on premium differentiation does not apply.

A major aspect of the reform is the creation of a direct relationship between payment and care provided by hospitals. The diagnosis treatment combination (DBC) forms the basis of this new payment system: insurers pay a single price per case for the total care provided to one patient. This allows a better comparison of the price of treatments and enables insurers to improve their contractual arrangements with care providers[160].

The competition on the health insurance market is leading to mergers among insurers. At present, the Dutch health insurance market consists of four large concerns having a combined market share of around 90%[161]. Although larger insurers might be able to negotiate better conditions with health care providers, there is a danger that this will lead to greater market power and, hence, higher mark-ups. More recently, a large health care provider started negotiations with health care insurers to bring about a vertical merger. This can mitigate several types of inefficiencies, but it may also reduce competition in the market, e.g. if the vertical merger enables insurance companies to foreclose access of other insurers to the health care provider. Another issue that may impair the functioning of the health care market is the limited role of consumers. Due to the large information asymmetries, technical complexity and uncertainty about future needs, consumers are not able to make properly considered choices and, as a result, may not take sufficient care when it comes to switching insurers[162]. This brings the risks of reduced competition in the future.

5.1.2. Accessibility

The Netherlands has an accessible health care system. The compulsory basic insurance package includes essential curative care, for which premium differentiation is forbidden. The government pays the nominal premium for children up to the age of 18.

Although everyone is required to have insurance, approximately 1.5% of the Dutch population is not insured. In 2006, half of the uninsured were people in their twenties and thirties. First-generation migrants are far more likely to be uninsured (6.6%) than natives (0.8%), while second-generation migrants are only twice as likely to be uninsured (1.6%)[163]. Some people have insurance but fail to pay their premium. Benefits recipients and migrants are overrepresented in the group of defaulters. People on low incomes can apply for a health care allowance.

Out of pocket payments apply to certain services but are limited. Until 2008 insured individuals could obtain a refund of the basic rate premium up to a standard fixed amount in the absence of claims for care during the preceding year. Since the chronically ill were disproportionately disadvantaged by the no-claim system, this no-claim scheme was replaced in 2008 by a compulsory excess of €150 a year.

The percentage of people who said they did not receive necessary medical care was low in 2006 (0.4%). The self reported unmet need for medical care is highest for people on the lowest incomes (0.9%). While there may be minor differences in the quality of health care due to specialised institutions, there are no significant regional disparities. Waiting lists, which

160 Currently free pricing is possible for approximately 20% of all the medical actions in hospitals. The aim is to further implement performance costing to about 33% in 2009

161 In 2007 the health insurance market consisted of six large concerns and seven smaller companies.

162 In 2006 about 19% of the insured changed their healthcare insurer (due to the premium war started by insurers); in 2007 this percentage was only about 4.5%

163 People are first generation migrants if they and at least one of their parents were born abroad. Second generation migrants are persons who were born in the Netherlands and of whom at least one parent was born abroad. These definitions are not necessarily based on the principle of nationality, since people can obtain Dutch citizenship when at least one of their parents holds this at the time of birth

were seen as an unsatisfactory feature of the previous system, continue to exist, albeit at reduced levels.

5.1.3. Quality

Quality is safeguarded through supervision by the Health Care Inspectorate. Furthermore, the government has established three priorities to promote quality in health care (improving transparency and measurability, enhancing the influence of patients and clients and improving safety of care itself).

Primary health care is delivered mainly by general practitioners. They perform a 'gate-keeping' role for specialist and hospital care. Patients can choose and change their general practitioners at any time.

Personnel availability is a prerequisite for providing good quality and access to health care. It is projected that by 2020 there will be a shortfall of half a million care personnel. To tackle this expected labour shortage, the government will focus on increasing the inflow of new personnel, keeping existing personnel and enhancing innovation.

5.1.4. Sustainability

Total health care expenditure was 9.2% of GDP in 2005, which is slightly above the EU average. Total expenditure per capita was also above the EU average (3192 $PPP against 2454 $PPP). National figures indicate that the total costs of care have increased on average by 4.4% a year during the 2001-2006 period. Two notable cost increases occurred in 2006: in the freely negotiable part of hospital care, costs rose by about 12% and a new funding system gave rise to an unexpected increase in expenditure on general practice care of about 17%. The NSR does not reflect on these increases and the contradiction with the aim of the reforms in the health care system (namely creating incentives for the efficient use of resources).

The national report does not mention long-term sustainability as a challenge as such, and little attention is paid to the effects of ageing on the health care system. However, liberalisation of the health care purchasing market was introduced in order to address future sustainability problems. In addition, policy is focusing increasingly on prevention and on innovation to contain future health care costs.

5.2. Long-term care

5.2.1. Description of the system

The Exceptional Medical Expenses Act (AWBZ) is the national insurance for long-term care and high-cost treatments. It arranges the organisation and financing of long-term care for the elderly, the disabled and chronic psychiatric patients. On 1 January 2007 the Social Support Act (WMO) came into force. It transferred several responsibilities (e.g. home services and transport for elderly and disabled) to municipalities with a view to create a stronger local social support.

5.2.2. Accessibility

In order to receive care under AWBZ a valid statement of need from the Care Needs Assessment Centre (CIZ) is required. Within the framework of the WMO, the municipality is responsible for determining who is eligible to receive care and for providing these services. In most cases, personal contributions are required. These contributions are income-dependent and may differ from one municipality to another.

5.2.3. Quality

According to the NSR there are problems regarding the quality of long-term care and the position of the client in the health care system. Therefore, adjustments in the current organisation of the AWBZ are required.

Arrangements have been made with all long-term care sectors on methods of measuring responsible care. The government has developed instruments to measure the standard of the care provided by nursing homes and homes for the elderly and how that care is perceived by patients. Quality data for nursing, medical care and home care will become available in accordance with the quality framework of sound care ('*kwaliteitskader verantwoorde zorg*'). This should provide clients with more insight into the quality of care and allow them to make informed choices between care providers.

The person-related budget is another important scheme to encourage the freedom of choice for people who are dependent on care. Also, measures have been announced to create more freedom of choice and diversity in living, such as a further extension of the scheme making it possible to receive heavy care at home which is usually provided in an institution *('full home package')*.

5.2.4. Long-term sustainability

According to the NSR the manageability of the volume and cost development of the AWBZ is a serious problem. The main causes of this are the fact that the scope of care provided by the AWBZ has expanded enormously over the years, and the growing need for care due to ageing. To maintain sustainability and solidarity, the government aims at considerably improve the current scheme. In this regard, there are plans for several measures to cut expenditure by € 800 million by 2010. This involves, for instance, a better definition of the provisions in order to combat unintended and undesirable use. In addition, compulsory personal payments will be introduced for all AWBZ treatments. At the same time, € 2.5 billion will be invested in addressing the challenges of the AWBZ's core business over the next few years.

6. CHALLENGES AHEAD

- To continue efforts to improve educational attainment of young people so as to ensure that everyone enters working life with at least a minimum level of qualifications (including an acceptable level of Dutch language skills);

- To promote active inclusion into society and the labour market for the most vulnerable groups, in particular by further stimulating the labour market integration of ethnic minorities, young disabled, long term unemployed and single parents, tackling inactivity, addressing low wage traps and increase take-up of minimum income benefits;

- To ensure the quality of monitoring within the national objective to reduce the number of policy monitors by continuing the development of an adequate evaluation and monitoring framework for assessing the participation of, and outcomes for, at risk groups in employment and social measures;

- To continue efforts to increase participation of older workers and raise the effective exit age, and to continue pragmatic regulation of occupational pension schemes allowing stabilising mechanisms to operate fully;

- To monitor the medical, social and financial effects of the reforms of the health care system, especially the functioning of the health care markets. It is particularly important to monitor the impact of consolidation on competition and to address the large asymmetries on information and lack of transparency in order to increase the influence of consumers;

- To safeguard the quality of and access to long term care in the future by addressing shortages in the supply of personnel and by dealing with the growing lack of manageability of the long-term care budget (AWBZ).

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,9	134,3	**2000**	72,9	82,1	63,5	68,4	38,2	**2000**	2,8	2,2	3,6	5,7
2005	2,0	130,8	**2005**	73,2	79,9	66,4	65,2	46,1	**2005**	4,7	4,4	5,1	8,2
2008*f*	1,9	129,0	**2007**	76,0	82,2	69,6	68,4	50,9	**2007**	3,2	2,8	3,6	5,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	74,6	80,4	14,7	19,0	61,1	62,1	5,5	**1995**	8,3	71,0	n.a.		-
2000	75,5	80,5	15,3	19,2	61,4	60,2	5,1	**2000**	8,0	63,1	9,0	**2005**	0,5
2006	77,7	82,0	16,8	20,3	65.0b	63.2b	4,4	**2006**	9,3	64,9**	7.7**	**2006**	0,4

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	30,6	38,0	28,5	9,9	4,6	6,5	12,6
2000	26,4	42,4	29,3	5,1	4,6	6,8	11,8
2006	29.3p	41.4p	31.8p	5.0p	5.8p	7.5p	8.5p

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	21,8	20,9	7,7	6,1	0,5
2010	22,8	-0,3	-0,1	0,2	0,0
2030	40,0	3,8	2,9	1,0	0,3
2050	45,6	4,9	3,5	1,3	0,6

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	10	14	9	10	17p	18p	18p	10p	4,0p	**2005**	11
male	10	-	8	9	18p	-	22p	9p	-	**2006**	10
female	11	-	10	11	17p	-	18p	11p	-	**2007**	9

p: provisional

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	6,0	6,9	5,4	8,5
2004	7,0	8,0	6,7	9,3
2007	5,9	6,5	5,3	7,6

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female		Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	0,6	0,5	0,7	**2000**	15,5	16,2	14,8
2004	1,6	1,5	1,6	**2004**	14,0	16,1	11,9
2007	1,3	1,2	1,4	**2007**	12,0	14,4	9,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,83	0,84	0,84	***Aggregate replacement ratio***	0,42	0,49	0,54

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	Estimate of current (2002)	Assumption
8	5	2	DB	4	DB	100	91	7	9,8	11,5-12,5

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Austria

1. SITUATION AND KEY TRENDS

Austria's macro-economic performance has been strong, with real GDP growth at 3.4% in 2007 above EU average. The employment rate has risen above the Lisbon target in 2007 (71.4% - women: 64.4%, men: 78.4%). The employment rate of older workers, however, remains well below the Lisbon target of 50% in spite of a steep increase from 31.8% in 2005 to 38.6% in 2007. The strong employment growth has brought the unemployment rate down from 5.5% in 2005 to 4.4% in 2007 and a projected 4.1% for 2008, after a sharp increase recorded up to 2005. Youth unemployment has also decreased over the last two years, but at 8.7% still almost doubles the overall unemployment rate. The long-term unemployment has remained stable at a low level (1.3% in 2007).

However, as a result of the global financial crisis, growth has started to slow down in 2008 and is expected to fall to -1.2% in 2009. As job creation will not be sufficient to match the growing labour force due to increased inflow of migrants and rising participation rates of women and older workers, unemployment is expected to increase again in 2009 and 2010.

According to the latest available data, reflecting the income situation of households in 2006, the at-risk of poverty rate stood at 12%, with a higher risk for women than for men (14% vs. 11%). Without social protection transfers the at-risk-of-poverty rate would be twice as high. Social protection expenditure, as a percentage of GDP, amounted to 27.6 % in 2005, slightly higher than EU average. Out of total expenditure, pensions account for 48.6%, health for 25.5%, and social inclusion for 1.5%. Austria is projected to face similar demographic trends as most EU Member States in the coming decades: the old-age dependency ratio is projected to increase steadily from 23.6 in 2005 to 50.7 by 2060. Life expectancy at birth has risen substantially in the last decade, reaching 77.2 years for men and 82.8 years for women in 2006, which is above EU average.

Among migrants, employment is considerably lower than among Austrians, with a particularly pronounced gender gap: the employment rate of foreign women stood at 53.3% in 2007, compared to 74.5% for men. Unemployment, on the other hand, is more than twice as high for foreigners than for Austrian nationals (9.5% in 2007). This is closely linked to considerable gaps in education levels. The share of early school leavers among migrants is almost three times higher than the overall rate. Migrants are also affected by the risk of poverty to a much higher extent than Austrian nationals.

2. OVERALL STRATEGIC APPROACH

The key objectives of the Austrian strategy for the years 2008 to 2010 with view to social inclusion are to offer all children and young people optimal opportunities for development, to improve the employability and labour market integration of disadvantaged groups, and to reduce monetary poverty through a means-tested guaranteed minimum income. Regarding the pension systems, the strategy aims to provide social cushioning and to strengthen the incentives in the pension system for longer working lives. In the health sector, Austrian policies focus on the integration of health care services based on sustainable funding, the development of a binding quality framework, and further improvements regarding the accessibility and affordability of health care services. It is also a priority to enhance health promotion and prevention, as well as to improve care and support services for older people. Austria's social inclusion and social protection policies are closely linked to the Lisbon strategy for growth and jobs. Measures to fight poverty and to support integration into the

labour market are considered an investment in the people as well as the national economy, as they decrease the burden on the federal government budget and promote growth through a larger labour supply.

While there is overall continuity with the 2006-2008 Strategy Report, the new report adopts a more multidimensional approach towards social inclusion, and places more emphasis on social aspects in the pension system. The aims are defined in rather general terms, while quantified targets and concrete indications of financial means are largely missing. Good governance has been reinforced through a substantial and transparent consultation process of wide range of stakeholders. Although equal opportunities for women and men are addressed by some specific measures, a gender perspective throughout the strategy is missing. The European Social Fund in Austria contributes to a large extent to the social inclusion strategy. It supports the integration of disadvantaged groups into employment and helps to develop new approaches to support those furthest from the labour market.

3. SOCIAL INCLUSION

3.1. Key trends

Being poor in Austria means living on 911€ per month or less. The risk of poverty and inequality of income remained below the EU average in 2007. While the at-risk-of poverty rate - at 12% in 2006- has remained relatively stable over the last years, it is expected to increase due to rising unemployment. The situation of people living on low income is likely to get worse due to prices rising faster than available incomes since mid 2007. As a result of high food and fuel prices, non-profit organisations assisting the poor report that their clients are increasingly dependent on their assistance for covering basic needs. The groups affected most severely by the risk of poverty are unemployed (42%), mainly female pensioners in one-person households (24%), migrants from non-EU/EFTA countries (26%), lone parents (31%), as well as persons with disabilities (18%). Moreover, 6% of people in gainful employment have incomes below the poverty threshold, i.e. can be considered as 'working poor'. The at-risk of poverty rate for children and young people under 18 stood at 15% in 2007, and there is still some way to go to reach Austria's target of 10% by 2016. The intensity of poverty is less severe in Austria than on EU average, i.e. the gap between the median income of the poor and the poverty threshold is less pronounced (17% vs. EU average of 22% in 2007). Austria's performance regarding low educational attainment, which increases the risk of poverty substantially, has deteriorated over the last years. The percentage of low-achieving 15-year-olds in reading literacy went up steeply from 14.6% in 2000 to 21.5% in 2006, which is above EU average. The rate of early school leavers has also increased over the last years, to reach 10.9% in 2007, while the trend has been positive in the EU overall. The early school leaving rate is particularly high among migrants (28.9% in 2007), whose education outcomes do not significantly improve in the second generation.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Overall, Austria has succeeded in implementing the priorities in the field of social inclusion identified in the 2006-2008 National Strategy Report as planned, with the exception of the means-tested minimum income. Opportunities for disadvantaged children and youth have been improved, in particular through a new scheme to identify and address German language deficits of pre-school children, the reduction of class sizes and a guarantee for young people to get a vocational education. Furthermore, counselling and support for families in crisis situations as well as reintegration of young delinquents were part of the strategy. Progress was

also made regarding the employment participation of individuals furthest from the labour market and social inclusion of individuals with disabilities, thanks to increased national funds for active labour market measures and some innovative projects.

The 2007 Joint Report on Social Protection and Social Inclusion identified the intergenerational transmission of poverty as a major challenge. While the above-mentioned measures in favour of children and youth are important steps in the right direction, continued and enhanced efforts are necessary to improve education outcomes of vulnerable youth.

Furthermore, the 2007 Joint Report also referred to the active inclusion of women, especially of single mothers, older female workers and pensioners. Considerable progress was achieved by the introduction of a minimum wage through collective agreements, the implementation of social security coverage for a-typical employment, the flexibilisation of the child care allowance facilitating a faster re-integration into the labour market, and the allocation of additional funds for child care facilities. However, further measures seem warranted to reduce the high poverty risk of single mothers and female pensioners. Minimum wages remain to be implemented in contracts not covered by collective agreements. The lack of child care facilities, as well as after school care facilities for the 6-14-year olds needs to be further addressed. Furthermore, it would be important to adopt a comprehensive approach aiming at improving career opportunities and incomes for women, including improved availability of qualified part-time jobs and counselling for young women with regard to career choices.

3.3. Key challenges and priorities

Austria's priorities for social inclusion policies are to enhance development opportunities for children and young people; to improve employability and labour market integration; to implement a means-tested guaranteed minimum income. These priorities are largely a continuation from the previous National Action Plan on Social Inclusion. The additional priority on integrated measures in other policy areas expresses a more comprehensive approach to address the multi-dimensionality of poverty and social exclusion. While the defined priorities are all very relevant, the strategy could further benefit from complementing the universal approach by additional targeted measures to combat poverty and social exclusion of vulnerable groups, most notably of lone parents and individuals with a migrant background. Also, against the background of high inflation, it might be relevant to consider not only income but also consumption poverty.

3.4. Policy measures

Policy measures targeting children and young people aim at reducing child poverty to 10% by 2016, from the current 15%. They are mainly a continuation of previously launched initiatives. A new measure is the launch of a pilot project for a common school for all 10-14-year old. This is a relevant step to break the links between educational opportunities and socio-economic background; although concrete plans beyond the pilot phase 2008/09 are missing. Some new measures are foreseen to improve the quality of education for pupils with special needs. It would also be important to enhance non-formal education as a tool for social inclusion of young people.

With a view to fostering labour market integration, active labour market measures will be implemented for the long-term unemployed, recipients of social assistance, older workers (55+years), women, people with disabilities, persons with a migration background and the low qualified. The increased level of funding for measures of the Public Employment Service since 2006 will be continued beyond 2008. The effectiveness of the active labour market measures could benefit from a more integrated approach for particularly disadvantaged groups, involving cooperation with organisations specialised in providing targeted support for those groups.

Another priority of the Austrian strategy is to implement the recently launched means-tested minimum income, with the aim of making the current social assistance scheme more effective for the prevention of poverty. The currently relatively high non-take-up rate shall be reduced, and social assistance recipients shall benefit from active labour market measures implemented by the Public Employment Service. Although the minimum income has been fixed just below the poverty threshold, this new scheme has the potential to make a substantial contribution to reducing poverty, and it should therefore be a priority to implement it. Important challenges will be to provide the necessary additional resources for the Public Employment Service, including appropriately qualified staff, and to ensure a coherent approach for the labour market integration of unemployed persons and of social assistance recipients.

Integrative measures in other policy areas comprise social housing, assistance to homeless people, facilitation of cultural participation for low-income earners, as well as disability equality legislation and the support to victims of violence. Some measures in support of migrants, refugees and asylum seekers are also included, but a more comprehensive and far-reaching approach to foster their social inclusion is warranted. The strategy also addresses over indebtedness, which is a newly emerging problem in Austria, having increased steeply over the last years. In all these areas, it will be important to ensure adequate regional availability of social services.

3.5. Governance

Governance has been strengthened in the preparation of this year's Strategy Report through a substantial consultation process with a wide range of stakeholders. Transparency was ensured by the publication of all comments on the website of the Federal Ministry of Social Affairs and Consumer Protection. It would be important to continue with this approach also in the future. Moreover, there is a long-standing tradition of social partners' active involvement in the full policy cycle, in which NGOs are, however, less involved. Provisions for monitoring have been strengthened by the development of additional national indicators for social inclusion, but a comprehensive evaluation scheme is missing.

4. PENSIONS

4.1. Key trends

Pensions in Austria are based on a statutory pension system with defined benefits, which is organised on a pay-as-you-go basis. In 2007, older people (60+) enjoyed a living standard very close to that of the general population (93% relative median income ratio and aggregate replacement ratio of 0.61%, both well above the EU25 average). However, the poverty risk among older people (14%) is slightly higher than for the population below the age of 65, and most importantly, it shows significant gender differences (10% for men, 18% for women).

The pension system underwent important structural reforms in the years 2000, 2003 and 2004. These reforms have helped to improve long-term financial sustainability, although they have long transition periods. They foresee that the retirement age for women will gradually be increased to equal the retirement age for men, i.e. from the current 60 years to 65 years between 2024 and 2033, the annual accrual rate will be reduced stepwise from 2% in 2003 to 1.78% by 2009, and the assessment period will be increased to life-time earnings (from the best 15 years) by 2028. At the same time, a loss limit of 10% for pension entitlements gained from the unreformed system was introduced. The pension system was harmonised through the introduction of a uniform pension law for all professions, pension benefits were indexed to consumer prices and the link between contributions and benefits was strengthened. Early retirements due to reduced capacity to work and due to unemployment were abolished. A "bonus-malus" system for deferred and early retirement was introduced, which was however weakened by the reduction of the discount rate for early retirement from 4.2% to 2.1% in 2007, a very low rate by international comparison. For persons whose first pension contributions start after 1st January 2005, and for invalidity pensioners, the discount rate for each year of early retirement remains at 4.2%. Early retirement is still possible on the grounds of disability, of long-term insurance contributions (45 years for men, 40 years for women), and of physically hard work. Furthermore, a sustainability factor was in discussion, which was intended to function as a mechanism for adjustment of the system to longer life expectancy.

4.2. Key challenges and priorities

In its 2006 Sustainability Report, the European Commission assessed Austria as a low-risk Member State as regards the sustainability of public finances. According to the 2005 projections of the working group on ageing populations of the Economic Policy Committee, Austria is expected to face low pressure on its public finances from an ageing population. While Austria's spending on public pensions is currently among the highest in the EU, it is projected to decrease from 13.4% in 2004 to 12.2% in 2050. However, forecasts on pension expenditure are based on relatively optimistic assumptions and do not include expenditures for the so-called "equalisation supplement", a top-up payment for pensions below the minimum income level, nor expenditures on public subsidies to the voluntary, private funded pillar. This might entail unforeseen increases in future pension expenditure. The level of pensions is projected to remain on a relatively high level over the medium term, but will have to be closely monitored.

The main challenge for Austria, as identified in the 2007 Joint Report on Social Protection and Inclusion, is to ensure both the adequacy and sustainability of future pensions by significantly increasing the employment of older workers. While the employment of older workers has been a focus of active labour market policies, there has been limited progress in further strengthening incentives to work longer in the pension system. Moreover, respective plans are missing in the Strategy Report 2008-2010. Recent measures, such as the reduction of discount rates for early retirement and the prolongation of early retirement due to long insurance contributions give the wrong signals. The mechanism for adjustment of the system to longer life expectancy has been subject to revision and it is not yet clear if and how it will be implemented.

The high poverty risk of female pensioners remains another important challenge. Significantly lower life-time earnings, combined with the fact that the 2004 reform foresees a very long transitory period for women's retirement age to be raised to the same as that of men (from 60 to 65 years), imply that pension outcomes for women will still lag behind in coming decades.

4.3. More people in work and working longer

The employment rate of older workers aged 55-64 years stands at 38.6% in 2007, well below the EU average of 44.7%, although it has been on a steep increase over the last years. Unemployment among older people is relatively low (3% for 50+ years in 2007). The effective retirement age has hardly increased since the start of the pension reforms in 2000. It was 59 years for men and 56.9 years for women in 2006, remaining well below the statutory retirement age (currently 65 years for men and 60 years for women). There has been a decrease in early exits from the labour market as consequence of the pension reforms, but 72% of all new pensions were still below the statutory retirement age in 2007. The abolition of early retirement due to reduced capacity to work in the year 2000 was to some degree de facto substituted by the instrument of invalidity pensions. These accounted for approximately 35% of yearly access to pensions in 2007. Invalidity pensions can not generally be considered an "easy going" early exit from the labour market, as life expectancy at the age of 60 of persons in invalidity pension is lower than life expectancy of people in normal direct old-age pension (4 years for men and 3 years for women). There is, however, scope for reforming the disability pension scheme, notably by enhancing health prevention at the work place. A working group has already developed proposals for a reform, and the Strategy Report announces plans to develop prevention and health care at all levels.

4.4. Privately managed pension provision

Private pensions are still much less important in quantitative terms in Austria than the public pay-as-you-go system, although their volumes have increased rapidly in recent years. The coverage of all dependent employees by occupational schemes has reached 15% in 2008, while the importance of the staff provision scheme introduced in 2003 (new severance pay scheme) seems to remain limited with view to old-age provision. This scheme is based on the legal obligation for employers to pay monthly contributions for each employee to a staff provision fund set up especially for this purpose. Employees have the option to withdraw their savings in case of termination of a work contract (if specific preconditions are fulfilled) or keep them until retirement age. The latter option, however, does not seem to be widely used at the moment. The number of individuals acquiring rights to draw pensions from private funds is increasing, however, mainly among those with higher incomes and education levels. An important incentive is the public subsidy available since early 2003 for the premium-aided pension savings scheme. In 2006, 15.3% of the population under 60 had a contract in the framework of this scheme.

4.5. Minimum income provision for older people

A means-tested minimum pension is available in Austria for individuals who are entitled to old-age pension. Although minimum pensions have been increased over-proportionally in the last years, they still remain below the poverty threshold. Persons without individual or derived pension entitlements can claim means-tested social assistance benefits administered by the federal states, which are also below the at-risk-of poverty threshold in most cases. The poverty risk of older people (65+) is higher than for the overall population, affecting women in particular (18% vs. 12% overall), although the gap between available income and the poverty threshold is relatively low (13% vs. 15% overall). Pensions for the disabled are also very low on average. The means-tested minimum income – if implemented as planned- will create a universal means-tested minimum pension, which would be an important improvement for older people without any pension entitlements. If raised slightly to the poverty threshold, it could substantially reduce the at-risk-of poverty rate for older people.

4.6. Information and transparency

Although information on the statutory pension system is generally available, transparency could be further enhanced. Gradual and stepwise implementation of reforms adopted in 2004 and 2005, exceptional rules, rules on capping of losses, long transition periods and "parallel accounts" in the old and the new system, contravene the aim of transparency, originally intended when introducing "personal accounts" in 2005. Regarding the second and third pillar, there is a considerable lack of information.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The overall architecture of the Austrian health care system is a rather complex and fragmented one, entailing a decentralisation of powers and multiple financing instruments. The federal government is responsible for the health care system, with the important exception of hospital care. As far as the latter is concerned, the federal government only has the competence for general legislation, whereas implementation and enforcement are under the responsibility of the provinces (*Länder*). 46% of health care expenditure is financed by compulsory social health insurance, 30% by tax revenue and 24% by private households, including financing by supplementary private health insurance. Health services are provided by regional government-owned, private non-profit and private organisations or self-employed health professionals. The Austrian system is characterised by a relatively high use of resources, regarding both medical doctors and technical equipment, and a large hospital sector in international comparison. Austria had 6.1 acute care hospital beds per 1.000 population in 2006 compared with an OECD average of 3.9. The hospital admission rate is also relatively high (27.3% vs. EU average of 18.3% in 2005). In 2005, a major reform of the Austrian health care system was launched. Given the substantial structural changes it involves, this reform is still in the state of gradual implementation. Its objectives, which are confirmed in the 2008-2010 Strategy Report, are integrated planning, management and financing of the entire health system; assuring and improving quality in the health system throughout Austria; ensuring the long-term financial sustainability of the health system through measures curbing costs and boosting efficiency.

Life expectancy of 79.9 years in Austria is above EU average, having increased substantially over the last decades. Infant mortality has been decreasing and is below EU average. There are, however, significant socio-economic differences in health status and life expectancy.

5.1.2. Accessibility

The Austrian health system is characterized by an easy and generally equal access to all medical and therapeutic services, although social and regional inequalities in health status exist. The social health insurance, which is organised as a compulsory insurance, is the core of the system. It covers around 98.5% of the Austrian population. Individuals without insurance may have access to health care services via means-tested social assistance. However, continued efforts are necessary to ensure equality between social assistance recipients and persons covered by compulsory insurance. Apart from patients' co-payments applicable in a few insurance funds, prescription charges for pharmaceuticals, and a relatively low daily co-payment to hospital care (up to a maximum of 28 days per year), the social health insurance provides free access to health services. In addition to existing exemptions, a new ceiling was introduced to prescription charges for patients suffering from chronic

diseases or several diseases, notably 2% of the patients' income. Thanks to adequate staffing levels and equipment, there are no substantial waiting times or waiting lists for medical services in general. Waiting times do, however, exist for certain non-emergency surgeries. Supplementary private health insurance is mainly used to obtain better hospital accommodation and the doctor of one's choice, as well as to shorten the above-mentioned waiting times. The Austrian Strategy report identifies the need for additional measures to gradually remove the existing health inequalities of the Austrian population, in particular between eastern and western parts of the country. In some provinces, efforts are stepped up to improve the situation of individuals with a migrant background.

5.1.3. Quality

Several legal provisions adopted as a result of the 2005 health care reform have strengthened the framework for mandatory quality work in the Austrian health system. They aim at reducing the regional and sectoral disparities in the quality and availability of health care and at improving the overall quality of health care in Austria. The establishment of the Federal Institute for Quality in the Health System in 2007 has been a decisive structural improvement, although its real impact will only show in the years to come. The nation-wide implementation of quality guidelines developed at central level will remain a major challenge. It will also be important to ensure the best possible 'care path' from the patients' perspective (and not the institutions' perspective) involving smooth transitions between different types of care (hospital vs. outpatient care, health care vs. long-term care). The empowerment of patients is to be supported by setting clear standards. Initiatives to use evidence-based medicine and health technology assessment have been increasing in Austria over the last years. Furthermore, a number of initiatives were taken in the last years to strengthen health promotion and prevention in a system which has traditionally emphasised curative medicine. It will be important to implement the newly developed strategies and pilot projects on a wider scale.

5.1.4. Sustainability

Total expenditure on health care including long-term care rose from 8.4% of GDP in 1991 to 10.3% in 2004. Since then, it decreased slightly to 10.1% in 2006, which is still among the highest levels in the EU. Public health expenditure corresponded to 76.2% of total expenditure in 2006. The public share increased during the 1990's, but has been largely stable since 2000. According to the 2006 forecasts by the Economic Policy Committee and the European Commission, the share of GDP dedicated to public spending on health and long-term care is projected to increase by 1.5 percentage points over the period 2005 to 2050, while the OECD forecasts an even higher rise (2007). Reasons for the long-term increase in expenditure on health are to be found, as in many other countries, in demographic factors, technical developments in the health sector and rising price of health care. Irrespective of these long-term projections, it is also a challenge to safeguard the short-term financial viability of the social health insurance funds, some of which already have substantial deficits. Progress in implementing the planned measures to improve efficiency, including the intended further shift from inpatient to outpatient care, has been slow, although some pilot projects of integrated care (e.g. for diabetes) were implemented and small outpatient centres were introduced. Measures to contain the cost of pharmaceuticals have not had any long-term effect, and no concrete new initiatives are announced in the Strategy report. The main challenge remains to ensure integrated and efficient planning, monitoring and financing within a complex system of financing mechanisms and competences split between federal and regional level.

5.2. Long-term care

5.2.1. Description of the system

The Austrian system for long-term care has two main components: the universal needs compliant long-term care benefit (introduced in 1993) and ambulatory, outpatient, semi-outpatient and inpatient care services organised by the *Länder*. Up to 80% of people in need of long-term care are cared for in their own homes by family members, specific outpatient services or by privately engaged carers. At present, around 5% of the Austrian population receive long-term care benefits. A working group has been established to tackle a number of issues which remain challenges for the future: long-term financing, adaptation of care benefits, and a further expansion and improvement of social services.

5.2.2. Accessibility

All individuals in need of long-term care, are legally entitled to a care benefit irrespective of income or wealth, which is calculated on the basis of the actual care need. In addition, they have access to social services, for which financial contributions have to be paid according to the financial situation of the beneficiary. Institutional care is predominantly provided by provinces and municipalities, or by religious and other non-profit organisations. Home-care services are provided by non-profit organisations or by private carers. A major step taken to safeguard access to long-term care has been the creation of a legal framework for 24-hour care at home and the introduction of an additional benefit to cover extra costs arising from social insurance coverage of the - now legally employed - care staff. These new provisions are an important improvement, although they only affect a relatively small number of persons with care needs. Care services in general have not yet been sufficiently expanded to eliminate the marked regional differences in availability, and the need for new flexible models for ambulant and semi-ambulant care has not yet been addressed.

5.2.3. Quality

In the last years, efforts to enhance quality in long-term care were continued. With the harmonisation of social care professions (implementation finalized in 2008) and the introduction of a uniform job profile for "home helpers", a major challenge concerning the provision of qualified care staff has been addressed. Measures to support care-giving family members include the expansion of a scheme of home visits through qualified nursing staff to provide information and counselling, subsidies for substitute care, and improvements regarding social security coverage. It will, however, be important to further strengthen support to informal carers and to ensure the quality of informal care. Evaluations to monitor the impact of the measures and further research into regional and sectoral inequalities are likewise needed.

5.2.4. Long-term sustainability

According to the 2006 projections by the Economic Policy Committee and the European Commission, public long-term care expenditure is projected to increase by 0.9 percentage points of GDP by 2050 due to population ageing. Expenditures include those for benefits in kind in the social services sector, as well as cash benefits. Both are covered from the budgets of the Republic of Austria, the *Länder* and – to a minor extent- the local authorities, and not through social insurance. A major challenge for the financing of long-term care lies in demographic developments leading to an increased need for care services. New strategies are therefore needed to ensure long-term financial sustainability. A working group has been established to develop proposals as a basis for future political decisions.

6. CHALLENGES AHEAD

- To further reinforce efforts to break the intergenerational transmission of poverty; in this context enhance education opportunities and outcomes for vulnerable youth;

- To enhance efforts to reduce the above-average risk of poverty for women, in particular single mothers and pensioners, as well as for migrants. To this purpose, reinforce measures to improve life-time earnings of women, enhance the reconciliation of family and work, and raise the retirement age for women. Furthermore, a more forceful and comprehensive approach aiming at fostering the social inclusion of migrants is needed;

- To ensure both the adequacy and sustainability of future pensions by significantly increasing the employment of older workers;

- To quickly re-establish the financial viability of the health insurance funds and to also ensure the long-term financial sustainability of health care by improving efficiency, notably through a stronger integration of health care planning and financing, a shift of priority from hospital to outpatient care and enhanced health promotion and prevention. It will also be important to contain the increasing costs of pharmaceuticals;

- To continue to develop quality standards for health and long-term care and ensure nation-wide implementation;

- To further improve the access to information, guidance and training for informal (family) carers and develop strategies to address the increasing need for professional care staff.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,7	131,4	**2000**	68,5	77,3	59,6	52,4	18,8	**2000**	3,6	3,1	4,3	5,3
2005	2,9	124,8	**2005**	68,6	75,4	62,0	53,1	31,8	**2005**	5,2	4,9	5,5	10,3
2008*f*	1,7	121,5	**2007**	71,4	78,4	64,4	55,5	38,6	**2007**	4,4	3,9	5,0	8,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	73,3	79,9	14,9	18,6	60,0	n.a.	5,4	**1995**	9,7	72,6	17,0		-
2000	75,1	81,1	16,0	10,4	64,6	68,0	4,8	**2000**	9,9	75,8	16,8	**2005**	0,5
2006	77,2	82,8	17,3	20,7	58.4b	60.8b	3,7	**2006**	10,1	76,2	16,5	**2006**	0,5

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	28,8	46,3	25,6	5,8	11,3	1,4	9,7
2000	28,4	48,0	25,6	4,9	10,8	1,1	9,7
2006	28,5	48,6	25,5	5,8	10,4	1,5	8,2

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	25,4	25,4	13,4	5,3	0,6
2010	26,0	-1,0	-0,6	0,2	0,1
2030	38,1	0,8	0,6	1,0	0,4
2050	48,3	0,1	-1,2	1,5	0,9

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	12	15	11	14	17	19	21	12	**3,8**	**2005**	12
male	11	-	9	10	19	-	23	12	-	**2006**	13
femal	13	-	12	18	16	-	20	12		**2007**	13

People living in jobless households

	Children Total	% of people aged 18-59* Total	Male	Female
2001	4,1	7,9	6,2	9,6
2004	5.6 i	8.8 i	7.6 i	10.0 i
2007	5,3	7,1	5,9	8,4

Long Term unemployment rate

	% of people aged 15-64 Total	Male	Female
2000	1	0,9	1,2
2004	1.3 b	1.3 b	1.4 b
2007	1,2	1	1,4

Early school-leavers

	% of people aged 18-24 Total	Male	Female
2000	10,2	10,7	9,6
2004	8.7 i	9.5 i	7.9 i
2007	10,9	10,2	11,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,93	0,98	0,91	***Aggregate replacement ratio***	0,61	0,62	0,68

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
5	1	1	DB	/	-	100	/	22,8	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Poland

1. SITUATION AND KEY TRENDS

Economic growth reached 6.7% in 2007 but is projected to slow down to around 5% in 2008. High GDP growth positively influenced the labour market and has helped reduce poverty. Employment rate grew to 57% in 2007, but is still one of the lowest in EU, particularly for women aged 15-64 (50.6%). Employment growth is projected to slow down significantly over the next two years. The unemployment rate fell by over 4 percentage points since 2006, and reached 9.6% in 2007 (9% for men and 10.4% for women). The reduction of unemployment over the last few years refers particularly to women (19.1% in 2005 and 10.4% in 2007) and young people (36.9% in 2005 and 21.7% in 2007), but still remains high in relation to the EU averages. Although the unemployment in 2008 tends to decrease, it is expected that over 2009-2010 will increase and reach 9.6%.

At 17%, the at-risk-of-poverty rate fell from 21% in 2004, but still continues to be above the EU average (16%). Children are particularly affected by poverty (24%), although the rate has decreased by 5 p. p. since 2004; by contrast the poverty rate of older people at 8% is one of the lowest in the EU (6% for men and 9% for women). Total social expenditure reached 19.2% of GDP in 2006, with 61.2% of expenditure related to pensions, 20.4% to healthcare, and 9.3% to disability. Only 1.8% was spent on housing and tackling social exclusion, but there has been increase since 2000 (1.5%). The age-related expenditure is forecast to decrease by over 6 p. p. until 2050.

Between 2005 and 2006, life expectancy at birth slightly increased (70.9 years for men and 79.7 years for women). It is still below the EU average (especially for men), but has consistently risen over the last decade (67.6 and 76.4 in 1995). Although the infant mortality rate is steadily decreasing (down from 12.2‰ in 1996 to 6‰ in 2006), it is among the highest in the EU. In comparison with other countries, healthy life expectancy in 2006 was high for women (62.5 years), whereas for men it was rather average (58.2 years).

Poland is projected to face demographic trends that are similar to those of other EU Member States: the elderly dependency ratio will grow from 19% in 2010 to 27% in 2020 and to almost 56% by 2050 (slightly more than the EU-27 average of 50%).

Given negligible immigration (e.g. in 2007 the share of the population aged 15-64 born in Poland was 99.6%) the social inclusion of migrants has not been among the main challenges for social policy. The group of third country nationals most exposed to the risk of poverty and social exclusion are Chechnyans. The employment gap between people born outside/inside Poland is 21.7%, although the employment rate of migrants has increased, especially in relation to third country nationals (from 30.1% in 2005 to 38.7% in 2007).

2. OVERALL STRATEGIC APPROACH

The overall strategic approach of Poland is to promote social cohesion and equal opportunities by ensuring adequate and stable social protection systems and implementing effective social inclusion policy. The importance of investing in human capital and modernising social policies is emphasised in shaping conditions for greater employment activity. The National Strategic Report (NSR) stresses the necessity of increasing the supply and productivity of labour by reducing access to early retirement and developing effective educational and active labour market policies. To achieve this, the NSR identifies a broad range of priorities and specific measures in the area of social inclusion, social protection, and health care. However, the information on the linkages between these fields is limited.

To a large extent the NSR priorities correspond to the areas defined in the NSR 2006-2008. The goals in focus are: addressing inequalities in education, developing labour market services, policy coordination, strengthening social services and continuing the pension reform process.

The NSR (mostly under the NAP-Inclusion) provides information on ESF support for various actions. Separate measures for Governance are planned and the representatives of various bodies were involved in preparing the NSR. To some extent, efforts have been made to define indicators for the NAP-Inclusion, but some outcome targets are missing. The gender dimension is covered, but with limited visibility (especially in health and long-term care strategies), and the multidimensional approach to people with disabilities is underdeveloped.

The links between the NSR and the National Reform Programme (NRP) are visible especially in relation to measures aimed at: supporting the social economy, reforming early retirement schemes, and reconciling family and work life. New measures in education, e.g. reforming curricula and lowering the age for entering primary education, may contribute to both economic growth and social inclusion. Nevertheless, the broader social dimension of pro-employment measures envisaged in the NSR could be better presented and the links between some NSR and NRP actions (e.g. aimed at broader access to IT) could be more developed.

3. SOCIAL INCLUSION

3.1. Key trends

Despite sustained economic growth, Poland still faces weak employment and unemployment indicators compared with other EU Member States. The risk-of-poverty rate slightly decreased, but still affects 18% of men and 17% of women. Poverty and exclusion are mainly associated with being out of work, hence significant drops in youth unemployment (almost double since 2002) and long-term unemployment rates are worth mentioning. Around 45% of the unemployed face poverty and the share of people living in jobless households, although decreasing (from 14.4% in 2006 to 11.6% in 2007) is still above the EU average. Nevertheless, access to work is not a full remedy as the level of in-work-poverty is high (13% in 2006). The groups particularly affected by poverty and social exclusion are children (24%), the disabled and people living in rural areas. There is also a high correlation between the risk of poverty and the number of children in the household. In 2007, the rate of extreme poverty[164] in households with 3 to 4 children was 10.5%, whereas for households with more children it rose to 25.4%.

[164] Extreme poverty (national indicator) refers to a "market basket" of goods including those needs, whose satisfaction cannot be postponed in time and consumption lower than defined by this level leads to biological deterioration

Poland had a high poverty rate before social transfers (27% in 2006). The strongest effect of social transfers on poverty reduction is observed among people over 64 (mainly due to pensions), whereas for children it is relatively low. Dispersion of regional unemployment is decreasing (4.5, EU: 11.1) but intra-regional discrepancies are growing, especially in the most developed regions. In 2007, early school leavers accounted for only 5%, which was relatively low in comparison to other Member States. Access to education still remains difficult for some groups, e.g. people with disabilities. There is a need to improve equal access to the education system, especially in relation to the differences between urban and rural areas.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The priorities of the NAP-Inclusion 2006-2008 were mainly focused on: support for families with children, inclusion by activation through developing the social economy and active inclusion, as well as mobilisation and partnership by reinforcing social assistance institutions and strengthening their cooperation with labour market institutions.

Progress made in implementing the above-mentioned priorities varies: some remained in the planning phase, others are underway or started recently. Nevertheless clear progress can be seen in areas corresponding to the NAP's priorities. Between 2005 and 2007, the relative poverty rate of families with children has been reduced, although the scale of decrease is less visible in families with more children. New legislation on tax allowances for families was adopted and numerous projects targeting children from poor families were implemented. The visible increase in the employment rate of women with children under 6 years of age (by almost 6 p. p. since 2005, reaching 55.5% in 2007) and the increase in family benefits for families with several children also contributed to a decrease in poverty rate. In addition, over the last few years, many pupils benefited from different subsidies, social grants and other forms of assistance (e.g. free meals at school). Support to children at risk of exclusion is also provided by socio-therapeutic centres: until the end of 2007, over 115 of such centres were created.

Although coverage of the Active Labour Market Policy has increased, projects implemented by the Public Employment Services (PES) reach socially excluded people to a limited extent, and joint projects of the PES and social assistance institutions are not very common. Thanks to ESF assistance and new legislation, the role of the social economy in active inclusion has been enhanced, but demand for this type of support still exceeds available capacity.

3.3. Key challenges and priorities

The social inclusion strand of the NSR focuses on three key priorities: the fight against poverty and social exclusion of children (Priority 1), inclusion through activation (Priority 2) and the development of high quality social services (Priority 3). These priorities are relevant for the current situation in Poland and correspond to the common OMC objectives. The priorities also respond, to a large extent, to the specific challenges identified for Poland in the 2007 Joint Report. The strategy combines a continuation of current policies with new initiatives. Some long-term measures that could have a significant preventive effect on social exclusion (i.e. affordable housing, development of care services) are still at an early stage of implementation. Several changes in relation to the NAP 2006-2008 are visible in the approach to the issue of child poverty: it is now a priority, while previously being tackled from the perspective of assistance to families. The lack of measures aimed at better cooperation between PES and social assistance institutions is not explained, although better coordination between employment and inclusion policies remains a challenge for Poland. New measures

aimed at social inclusion of people returning from abroad are planned. The expected contribution of ESF and the links with the ESF 2007-2013 Programme for Poland are presented in detail and refer especially to developing the social economy, introducing active inclusion tools, assisting people with disabilities, and improving the system of vocational education.

3.4. Policy measures

The first priority, to combat poverty and social exclusion of children and young people, focuses on three issues: improving the income situation of families with children, developing child care services, and ensuring equal educational opportunities. The plan is to improve the income situation of families by combining income support policy with labour activation of parents. The development of child care services is among the most crucial challenges, both in the context of ensuring equal educational opportunities and vocational activation schemes for parents. Introducing mandatory pre-school care for children aged 5 is one of the actions envisaged with the potential to produce positive results, if properly implemented. However, the NAP does not specifically address the important issue of day care centres in rural areas and providing care for children with disabilities. The approach to ensuring equal educational chances is comprehensive, but the issue of segregation in schools could be further explored.
Active inclusion plans under Priority 2 will be implemented by developing the social economy and active inclusion instruments. The social economy will be supported by creating regional centres offering assistance for social economy initiatives, supporting employment in social cooperatives and introducing new legislation facilitating the participation of such institutions in public tenders. Broader use of social contracts and local activating contracts is planned together with new active labour instruments for the long-term unemployed. A specific measure targets dedicated to people with disabilities. Poland still has to address the lack of a comprehensive and multi-dimensional policy for this group. Nevertheless, the planned mix of schemes including creating a system of benefits which support activity, developing vocational advisory actions, implementing rehabilitation programmes and counteracting discrimination should help increase the employment rate of this group which is one of the lowest in the EU (13.7% in 3rd quarter of 2007).

Most of the measures under Priority 3, Access to *High Quality Social Services*, were already included in the previous NAP, though they are now revised and updated. The planned changes in the programme to combat family (domestic) violence can bring improvements to the situation of victims. New initiatives also address the modernisation of vocational education, which should help eliminate the major causes of youth unemployment. Their implementation is ensured by the relevant statutory regulations and financial mechanisms and supplementary measures planned under Priority 1. The ongoing civil advisory service programme focuses on ensuring access to legal aid for poorer people. In relation to the social housing programme, the proposed change is to speed up the construction of social housing. Nevertheless, the shortage of financial resources will remain the fundamental problem here.

The new objective to develop services for older people responds to the challenges related to an ageing population. However, the concept of improving access to services for lone elderly people, or services to support their careers should be further developed. The document contains some statistical data broken down by gender, but this is not consistent across the strategy and promoting gender equality per se is not an explicit goal.

3.5. Governance

The drafting and consultation process for the NSR involved representatives of relevant ministries, local and regional authorities, social partners, NGOs, and experts. Although an effort was made to encourage major stakeholders to take part in the process, it seems that the NSR is still not the subject of broad public debate. The NAP includes some measures for improving communication among the main stakeholders, but the development of mechanisms to improve cooperation between the authorities at various levels still remains a challenge. Progress in involving NGOs in working together is evident and the NAP provides numerous initiatives fostering this cooperation. The development of a consolidated system to monitor progress in social inclusion is planned, particularly with regional authorities maintaining the involvement of regional social inclusion observatories.

4. PENSIONS

4.1. Key trends

The statutory pension system consists of two elements, both of which are mandatory and universal (there are special schemes for farmers and some civil servants such as the military personnel, police, judges and prosecutors): a pay-as-you-go notional defined contribution (NDC) scheme, administered by the Social Insurance Institution (ZUS) and a fully funded scheme, managed by independent private investment companies (open pension funds – OPFs), supervised by the State. The financial crisis resulted in a strong decline in OPFs' assets which may particularly affect the small group of those pensioners who are to retire soon. This is backed-up by a deteriorated perception of the OPF in society and may result in a significant decrease in the inflow of people willing to open voluntary individual retirement accounts.

The statutory pension is based on the defined contribution principle, dependent on the accumulated capital in ZUS and the OPF and on the average unisex life expectancy at the age of retirement. The statutory scheme is financed by the old-age pension contributions (the contribution rate is equal to 19.52% of gross salary) collected by ZUS and divided by the contribution for the NDC pensions and for the statutory funded scheme (ZUS transfers 7.3% of gross salary to OPF). An additional contribution is paid for disability and survivor pensions (10% of gross salary in the second half of 2007 and 6% since 2008).

The statutory retirement age is 65 for men and 60 for women, but the effective retirement age is still much lower and in 2007 equalled 57.5 years for women and 61.4 years for men. In 2005 the poverty rate of people aged 65+ was one of the lowest in the EU (8%) but still higher for women (9%) than for men (6%). The aggregate replacement ratio was 0.58 according to 2007 SILC data (EU-25 average: 0.49). Since 2004, over 915 000 people have opened voluntary individual retirement accounts which provide opportunities for tax-free savings to supplement future pensions.

4.2. Key challenges and priorities

The AWG's 2005 projections show a considerable drop in public pension expenditure from 13.9% to 8.0% of GDP over the period 2004-2050 (pension expenditures decrease to 9.3% of GDP in 2050 when the mandatory funded tier is taken into account). Nevertheless, the pay-as-you-go tier is projected to remain in deficit until the mid-2030s due to transition costs. According to ISG projections, the net theoretical replacement rate would gradually decline (by 19 percentage points till 2046) unless the balance between the years in employment and retirement is improved. This decline is amongst the highest in the EU. To maintain the future

adequacy of pensions the government needs to promote supplementary pension provision and to encourage more people to work longer.

According to projections, Poland's demographic profile will follow the EU average and it is expected that the old age dependency ratio will rise from the current level of 19% to over 55% by 2050. The employment rate of older workers is one of the lowest in the EU-27, especially for women (19.4% according to 2007 data). Furthermore, the reforms of the farmers' pension scheme are delayed which results in keeping the flat rate based contributions, unrelated to the income generated and requiring significant assistance from the state budget. In light of the recent reductions in contributions, existing early retirement schemes for miners, and new mechanisms of pension indexation introduced, (through *inter alia* partial indexation on wages) it will remain a challenge to ensure a financially sustainable pension system.

The overall approach presented in the NSR in general repeats the objectives set in previous Strategies and reflects the challenges identified in the 2007 Joint Report. It covers introducing the bridge pension system that will limit the (currently large) number of professions entitled to early retirement and reforming pension schemes to enhance the employment of the disabled. In addition, there are plans to develop new mechanisms for farmers pension schemes by linking the values of contributions with the income generated. Currently, the link between the values of contributions and pensions is not visible and planned mechanisms, if properly created and implemented, may also have a positive impact on the regional dispersion of employment and agricultural restructuring. Finally, the NSR envisages completing the conversion of funded pension savings into safe annuities. These measures will by supported by schemes to increase employment rates among various groups and to develop a system to equalise the retirement age of men and women.

4.3. More people in work and working longer

The planned reform of early retirement schemes, which constitute a major route to an early labour market exit, has been delayed and the rules for the miners pension scheme have been changed back to the old system. Although some increase in the employment rate was observed, it is still almost the lowest among all age groups in relation to other EU Member States. In 2007 the indicator was 57% (63.6% for men and 50.6% for women) which still puts Poland far below the EU average (65.4%). A very slight increase was noticed in the group aged 55-64 (from 28.1% in 2006 to 29.7% in 2007) and here particularly among women (19.4% in 2007 as result of only 0.4 p. p. increase in relation to the previous year) where 4 out of 5 women do not work. In light of the ageing society the call for an increased participation in employment remains valid and should in principal include reforming early-retirement schemes, the farmers' pension scheme and disability pensions, which also influence the financial stability of the system. This should be supported with measures to increase public awareness of the links between contributions and benefits.

Acknowledging this situation, and in addition to the planned changes to the pension system, the government plans to implement the "Solidarity between generations" programme which will be aimed at achieving the Lisbon target in the employment rate of people aged 55-64. Increasing employment among all age groups is one of the main strategic goals of the labour market policy, and the NSR correlates the need for higher employment among older population with the goal of maintaining sustainable economic growth in Poland.

4.4. Privately managed pension provision

Since the 1999 reform the OPF constitutes an integral part of the insurance system. It has separate assets and is managed by private general pension societies. The cash and securities accounts of the OPF are maintained by depositaries (banks), fully independent from the societies and their shareholders. The legislation focuses on avoiding conflicts of interest between members of the OPF and shareholders of pension societies. Debt securities (bonds and treasury bills) issued by the State Treasury constitute the majority of OPF investment portfolios. The maximum levels of contribution fees charged by the OPF provide the following: until the end of 2010 fees can not exceed 7% of the contribution and this threshold will be gradually decreased to reach 3.5% in 2014. The first pension benefits from funds collected by the OPF will be paid in 2009. Given this fact, the government has recently introduced a bill in parliament on the pay-out phase of the mandatory funded scheme, proposing two kinds of payments: life annuities and temporary funded pension benefits (for women aged 60-64). In light of the recent sharp declines in the value of the OPF assets, it is positive that the government considers adopting the life cycle design in the mandatory funded scheme (an investment approach where the investment risk is gradually reduced as the person nears retirement). The mandatory character of the life cycle design should be taken into account.

4.5. Minimum income provision for older people

The guaranteed minimum pension is paid if the total pension amount - paid within the statutory system – is below the legal minimum of the pension (equal to 56% of the minimum wage). Between 2005 and 2007 the value of the minimum pension was around 23% of the average wage. The poorest pensioners may also benefit from social benefits granted under the social assistance system. The government, together with the social partners, will work to develop mechanisms to ensure that pensions will sufficiently prevent the risk of poverty among older people. Currently the influence of social transfers' on poverty reduction is quite significant, especially for men over 65, for whom the risk of poverty is diminished by approximately 30% (for women it is around 25%).

The aggregate replacement ratio is above the EU average and the poverty risk among older people is significantly lower than that of the population below the age of 65, but is around a third higher for women than for men. Partial wage indexation was recently introduced. Nevertheless, following the projected decline in the theoretical replacement rate, the adequacy of pensions may become an issue in the future, notably for those with short careers, predominantly women. The government thus needs to encourage more people to work longer and to promote supplementary pension provision. Moreover, equalising the legal retirement age for men and women would help reduce the gender gap in pension entitlements and would contribute to increased employment rates.

4.6. Information and transparency

Each person insured receives annual information about the contributions collected, both in ZUS and OPF accounts; this system is to be extended by adding more information on the value of future pensions. The standardised system of information contributes to increasing people's awareness of their future incomes and helps plan other forms of savings (e.g. opening voluntary retirement accounts). Setting up a new institution is intended to enable conducting regular forecasts on incomes and expenditures of the pension system and management of the scheme's funded pensions.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The compulsory health insurance scheme administered by the National Health Fund (NHF) and 16 regional branches provides universal coverage to insured persons (with a list of excluded services). Primary health care (PHC) is provided in the form of private individual and group practice, in private clinics and public healthcare units. Family doctors act as gate-keepers for specialist and hospital care. Specialist outpatient care is based on private medical practices or specialised health centres. Inpatient care is provided predominantly in public hospitals. The system is financed mostly by insurance contributions with state, regional, county and local budgets financing some groups (e.g. unemployed people). Private voluntary (supplementary) insurance is negligible but an increasing trend is visible. Some companies offer accident and health insurance packages (mostly outpatient care) to their workers. The National Health Strategy aims until 2013 to enhance health promotion and healthy living, increase the effectiveness of services, achieve a better value for money and reduce the health status gap in relation to the EU average.

The situation as regards reforming healthcare policy has not progressed since 2006, although some planned measures were implemented e.g. improving the medical rescue system. The new legislation on healthcare system reforms is not yet adopted. Increasing shortages of medical staff (of particular specialisations) due to mobility outside Poland have been found.
Life-expectancy continues to increase, but indicators for Poland (75.3 years) are still among the worst in the EU, especially for men (70.9 years).

5.1.2. Accessibility

Though population and service coverage is high, there are significant regional discrepancies in care availability (lack of certain specialists and equipment) and thus in access to health care. The increasing number of private hospitals does not improve the situation significantly, since - as commercial entities - they are located in richer and better developed areas. The level of self-reported unmet needs for medical care is three times higher than the EU average. Patients out-of-pocket payments are high (25.6% in 2006 of total health spending) due to co-payments and the use of private sector services, adversely affecting vulnerable groups. Waiting lists and times for some services are extensive. This follows limited access and forces patients to opt for the private sector, where they have to pay the full cost of care. The number of GPs is rather low by EU standards and the waiting list management system is ineffective. The authorities plan to develop a list of guaranteed health services to be covered by the public health insurance scheme and to introduce new insurance schemes, covering additional, not-guaranteed services. This will result in increased coverage and additional resources for the system. Further measures aimed at improving the functioning of the national medical rescue system are planned. The government also plans to introduce new formulas of running healthcare entities to improve economical stability and delivery. Further actions aimed at improved access include developing a better system of health information.

5.1.3. Quality

The Centre for Health Care Quality Monitoring (CHQM) provides independent accreditation on the basis of a published set of standards. Quality requirements, national guidelines and standards are to be developed based on independent expertise. Further schemes include developing a better system to evaluate services. The use of technology assessment will increase, leading to evidence-based contracting of services.

5.1.4. Sustainability

Total health care expenditure (6.2% of GDP and per capita PPP$910 in 2006) is low in comparison to other EU Member States. Per capita expenditure has increased over time and in real terms. Public health expenditure represents almost 70% and private around 30% of total health expenditure (2006). According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.4 p. p. of GDP by 2050 due to the population ageing. Increased demand for care is straining the financial sustainability of the system with a high, albeit constantly declining degree of indebtedness of care providers. To provide extra funding, the NHF contribution rate has been increased from 7.5% in 2000 to 9% in 2007. Further work is underway to secure more funding for the healthcare system. Additionally, efforts to improve the effectiveness and efficiency of provided services, such as setting new rules for running healthcare entities and reforming the health insurance system are underway. The total number of acute hospital beds has decreased lasting recent years. Further restructuring is necessary: the PHC needs to be strengthened and outpatient contacts need to increase vis-à-vis unnecessary and expensive specialist and hospital inpatient care. With regard to staff, the number of medical professionals is low: the constant decrease in the number of physicians employed in healthcare units per 100.000 inhabitants (229 in 2003 to 199 in 2005) and still low number of nursing staff should be particularly addressed. Wages are low although authorities have started the process of increasing them to tackle staff mobility. In addition, responding to shortages identified in particular specialisations (especially of anaesthesiologists and specialists for intensive therapy), more attention should be given to training and educating medical staff (the use of ESF funding is planned for such measures). The NSR gives also specific consideration to early identification and treatment of cancer diseases. Investment in modern equipment is planned to ensure the proper level of assistance along with ERDF funding support.

5.2. Long-term care

5.2.1. Description of the system

The long-term care (LTC) system operates within both the health and social care sectors. Under universal insurance coverage, LTC can be provided in residential or nursing units or as home care. Care services for lower-income groups can also be provided in social welfare centres. While care is funded by the NHF, food and accommodation is partly funded by patients (as co-payment). The central budget pays for vulnerable groups, people with severe problems and chronic diseases, on a means-tested basis.

5.2.2. Accessibility

Social assistance is provided in welfare houses which pay additional costs of health care that are not covered by the NHF. Local authorities test the conditions for receipt of social assistance. They means-test according to household size and income, comparing that level to healthcare costs. Broader involvement of non-public institutions, especially in providing palliative care and increased public awareness of the challenges related to LTC is visible. In light of growing demands for LTC, the scope and availability of services are deemed

insufficient. Although in most of the regions the number of LT and palliative care centres has increased, their distribution across the country is still uneven and waiting times between regions vary significantly. Ensuring well qualified staff is one of the challenges for LTC in Poland, therefore a new profession of "care assistant" has been introduced and the first assistants have started work.

5.2.3. Quality

The government plans to better focus on monitoring the services provided within the LTC entities following the conclusions of recent (2007) audits conducted by the central administration. The respective changes in legislation are under preparation. The issue of quality is also strictly correlated with introducing training programmes on palliative care in the curricula of medical studies and training for nurses.

5.2.4. Long-term sustainability

According to the 2006 EPC/EC projections long term care expenditure is set to increase by 0.1 p. p. of GDP by 2050 due to the population ageing. The financial shortages follow the risk that growing demands for care, typical for an ageing society, will not be met. This will be partly addressed by the introduction of a compulsory nursing insurance, which will provide additional resources for financing the system. Increasing the number of medical and nursing staff and developing the social infrastructure in rural areas remains a challenge.

6. CHALLENGES AHEAD

- To promote active inclusion by tackling inequalities in the education system, implementing active labour market instruments, particularly for the disabled, women and older workers, implementing policies to make work pay for recipients of various forms of social transfers and providing the social services needed to support integration in employment, especially for large families,

- To continue strengthening the administrative capacity of social assistance and labour market institutions with a better focus on developing mechanisms to improve the coordination of policies and measures at different levels and between various stakeholders,

- To continue pension system reforms (especially farmers and disability schemes) and to consider equalising the legal retirement age between men and women in order to address the future gender gap in pension entitlements, while raising the employment rate of older workers and people with disabilities and promoting supplementary pension provision,

- To review the mandatory funded scheme by finalising the legal base for converting funded pension savings into safe annuities and by ensuring that the Open Pension Funds adjust the investment risk over the life cycle, in order to guarantee that sufficient resources for adequate pensions are available;

- To ensure equal and better access to healthcare and Long Term Care services by reducing regional discrepancies in supply (notably Primary Health Care), patients direct financial burden of care and long waiting times, by increasing public health expenditure to address under-financing, counteracting shortages of medical personnel and improving care purchasing and the administration of purchasing entities;

- To improve system efficiency by strengthening Primary Health Care, outpatient care and day-case surgery vis-à-vis inpatient care, and by developing clear national guidelines and standards to evaluate the quality of healthcare services and Long Term Care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	*Employment rate (% of 15-64 population)* 15-64 Total	Male	Female	15-24	55-64	Eurostat	*Unemployment rate (% of labour force)* 15+ Total	Male	Female	15-24
2000	4,3	48,2	**2000**	55,0	61,2	48,9	24,5	28,4	**2000**	16,1	14,4	18,1	35,1
2005	3,6	51,3	**2005**	52,8	58,9	46,8	22,5	27,2	**2005**	17,7	16,6	19,1	36,9
2008*f*	5,0	54,3	**2007**	57,0	63,6	50,6	n.a.	29,7	**2007**	9,6	9,0	10,4	21,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	*Life expectancy at birth* Male	Female	*Life expectancy at 65* Male	Female	*Healthy life expectancy at birth* Male	Female	*Infant mortality rate (2007 instead of 2006)*	WHO - OECD	*Total health exp %GDP*	*Public health Exp % of THE**	*Out-of-pocket payments % of THE*	EU-SILC	*Unmet need for health care % of pop*
1995	67,7	76,4	12,9	16,5	n.a	n.a	13,6	**1995**	5,5	72,9	27,1		-
2000	69,6	78,0	13,6	17,5	n.a	n.a	8,1	**2000**	5,5	70,0	30,0	**2005**	9,9
2006	70,9	79,7	14,5	18,8	58,2	62,5	6,0	**2006**	6,2	69,9	25,6	**2006**	9,3

s: Eurostat estimate; p: provisional — **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	*Total expenditure * (% of GDP)*	*Old age and survivors*	*Sickness and health care*	*Unemployment*	*Family and children*	*Housing and social exclusion*	*Disability*
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	19,7	55,3	19,6	4,6	5,0	1,5	14,0
2006	19,2	61,2	20,4	3,0	4,4	1,8	9,3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	*(2008) Old age dependency ratio Eurostat*	*Expenditure (% of GDP) Level in **2004** and changes* Total social expend.	*Public pensions*	*Health care*	*Long-term care*
2004	18,9	23,7	13,9	4,1	0,1
2010	19,0	20,2	-2,6	0,3	0,0
2030	36,0	14,4	-4,7	1,0	0,0
2050	55,7	13,7	-5,9	1,4	0,1

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	***At-risk-of-poverty rate*** Total	Children 0-17	18-64	65+	***Poverty risk gap*** Total	Children 0-17	18-64	65+	***Income inequalities*** S80/S20	***Anchored at-risk of poverty***	Total - fixed 2005 threshold
Total	17	24	17	8	24	26	25	14	**5,3**	**2005**	21b
male	18	-	18	6	25	-	25	15	-	**2006**	16
femal	17	-	17	9	23	-	24	14	-	**2007**	13

	People living in jobless households Children Total	% of people aged 18-59* Total	Male	Female
2001	n.a.	13,8	12,9	14,7
2004	n.a.	15,8	14,8	16,8
2007	9,5	11,6	10,4	12,7

	Long Term unemployment rate % of people aged 15-64 Total	Male	Female
2000	7,4	6,0	9,1
2004	10,3	9,6	11
2007	4,9	4,6	5,4

	Early school-leavers % of people aged 18-24 Total		Male	Female
2000	n.a.	n.a.	n.a.	n.a.
2004	5,7		7,7	3,7
2007	5,0		6,4	3,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	1,04	1,12	0,99	***Aggregate replacement ratio***	0,58	0,64	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046) *Net* Total	*Gross replacement rate* Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	*Assumptions* Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-19	-16	-16	NDC/DC	/	-	77	/	36,9	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Portugal

1. SITUATION AND KEY TRENDS

The Portuguese economic activity expanded at a gradually faster pace in more recent years, with GDP growth reaching some 1.9% in 2007. However it has decelerated in 2008 and is estimated by the interim forecast to have been 0.2% in 2008, due to the global financial crisis. While activity rates, both for men and women are above the EU average employment rates have been broadly stagnant, registering the same value in 2007 and 2004 (67.8%), which is however above the EU average. Unemployment has doubled, reaching 8.1% in 2007 (2000: 4%), affecting more women (9.7%) than men (6.7%). Youth (16.6%) and the older generations (6.5%) are more exposed to unemployment than the EU average. Also long-term unemployment is increasing (3.8% in 2007) and is above EU average. Improving the education system is paramount to improving economic performance, given that early school leaving (36.3% in 2007) and the attainment level (54.3%) are far below EU levels. The vocational training system is also under reform, in order to adapt to labour market needs.

Despite the some improvements, poverty levels and inequality of income distribution constitutes serious structural problems. Portugal has one of the highest degrees of unequal income distribution in the EU (Gini coefficient: 38 and S80/S20 ratio: 6.5 and the poverty levels (16% for the overall population in 2006) are also an important concern. Regarding demography, life expectancy at birth has improved considerably (men: 75.5; women: 82.3 in 2006), which is above the 2004 EU average[165]. The Portuguese population lives almost ten years longer now than it did 30 years ago. Conversely, the healthy life expectancy has been fallen over the last decade. Due to the projected faster ageing, Portugal's old-age dependency ratio will increase from 26.6% in 2010 to 53% in 2050, above the EU average (25.9% and 50.4%). Consequently the total public spending, that represented 23.8% of the GDP, is expected to rise by 9.8%, representing the second highest increase in the EU25.

2. OVERALL STRATEGIC APPROACH

The National Strategy Report (NSR) for Social Protection and Social Inclusion 2008-2010 will be implemented through two (2) strategic priorities and six (6) strategic objectives. One strategic priority regards the impact of demographic changes and is composed of three strategic objectives: (i) to support the birth rate and infancy, (ii) to support the reconciliation of professional, personal and family life; (iii) to promote quality active ageing and to prevent and support dependency. The second strategic priority considers the promotion of active inclusion and the reduction of disparities, implemented by through three strategic objectives: (iv) to promote active social inclusion, (v) to improve living conditions in vulnerable territories, (vi) social inclusion of specific groups, such as the disabled, immigrants and ethnic minorities, and the homeless.

The current Portuguese NSR shows progress since the previous 2006-2008 report, since the priorities and objectives are now more focused and targeted to the factors undermining social inclusion and social protection. Nevertheless this new strategy does not cover all existing problems, but it seems to identify the correct priorities.

The three strands have listed concrete measures. The National Action Plan for Inclusion is backed by more detailed measures, identifying financial resources, quantified targets and monitoring indicators. Measures related to the autonomous regions of Madeira and Açores are

[165] EU average of 75,2 and 81,5 for males and females, respectively.

described. The alignment with the National Strategic Reference Framework (NSRF) 2007-2013 is demonstrated, and most measures will be implemented through the support of Structural Funds.

The overall strategic approach identifies links with the Lisbon Strategy. The NSR includes several measures with a direct impact on the *jobs and growth* strategy for the period 2008-2010 (active ageing, pension reform, active inclusion and flexicurity). Regarding governance, the previous governance model is kept. The following were found to be particularly useful: the political coordination among ministers, strong articulation of the three strands of the OMC, involvement of civil society and stakeholders, and adequate information to population. As regards the gender dimension, the main national body responsible for gender equality actively participated in the preparation of the report.

3. SOCIAL INCLUSION

3.1. Key trends

The Portuguese economic and social situation remains fragile, reflecting structural imbalances and deficiencies in human capital. The unemployment rate peaked at 8.1% (2007), affecting mainly women (9.7%) and young people (16.6%). Although overall employment rate has remained constant, the rates for women (61.9%) and older workers have increased (50.9%) and are both above the EU average. But youth employment has decreased considerably (2001: 42.3% to 2007: 34.9%).

All main indicators prove that social inclusion is a critical concern. The at-risk-of-poverty rate after social transfers is among the highest in the EU (PT: 18%, EU: 16%), affecting mainly children (PT: 21%, EU: 19%) and the elderly (PT: 26%, EU: 19%). Although employment is a key policy in promoting social inclusion, employment *per se* is not enough. Indeed the "working poor" are sizeable (PT: 11%; EU: 8%), which reflects low wages paid and creates a widespread social problem. The in-work poverty is highest for part-time workers (29%), compared to full-time workers (9%), reflecting high labour market segmentation.

Regarding education performance, progress has been made on early school leaving, which decreased by almost 3% (2006: 39.2%; 2007: 36.3%), its lowest level in a decade. For the first time in a decade, youth attainment exceeded 50%, (2006: 49.6%, 2007: 53.4%). Yet the disparity *vis-à-vis* the EU average is still very wide (which are 14.8% and 78.1% respectively).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

It is welcomed that an evaluation of the NSR 2006-2008 is currently ongoing and was promised to be disclosed in early 2009. However the current NSR would benefit from such analytical underpinning. The NSR simply recalls the main measures set out for the period 2006-2008. No concrete evidence of the achievements and no assessment of the final targets' results are given. Though an interim evaluation was conducted involving the stakeholders, this allowed to update the process and also enabled the definition of priorities for the NSR 2008-2010. One of the major improvements of the NSR 2006-2008 was the definition of concrete objectives with quantified targets, thus a final assessment of these targets is of utmost relevance.

The response to the challenges lacks sound argumentation and barely mentions how they were addressed. On the challenge "to closely monitor and evaluate the impact of the measures relating to the minimum income scheme, ensuring effective social integration of groups at risk", the NSR mentions the reinforcement and consolidation of the insertion component of the Social Insertion Income (SII). The SII was subject to a regular monitoring and assessment exercise involving different entities and stakeholders. Also the evaluation of the minimum income scheme has proved that the insertion component of the SIII shall be a central priority for the new cycle.

With regard to the challenge *"to ensure that groups furthest from the labour market benefit from mainstream measures to raise the qualifications levels of the population, with a particular focus on the large numbers of unskilled working poor and early school leavers",* the political priority to upgrade the qualifications of young people and adults is restated, through the comprehensive *"Novas Oportunidades"* initiative. It has been addressed the structurally low educational level of the population through investment in pre-school expansion, consolidation of universal basic education, an extension of steps to diversify education and training at secondary level and improvements to the quality of the education system, as well as reinforcing professional pathways. Measures to facilitate the labour integration of the groups furthest from the labour market were implemented through specific intervention programmes, targeted namely to the disabled and unemployed immigrants.

3.3. Key challenges and priorities

The promotion of social inclusion, the prevention of poverty and social exclusion, and tackling demographic trends are two fundamental key challenges for the new period. To this end the NSR 2008-2010 identifies three priorities to: (i) fight child and elderly poverty, by ensuring their basic rights of citizenship, (ii) correct the disadvantages in education and training/qualification, and (iii) overcome the discrimination and strengthen the integration of specific groups, namely the disabled, immigrants and ethnic minorities.

These priorities are consistent with the current social situation and represent continuity with the previous period. Focussing on a smaller number of priorities can render the NSR more operational. The explicit concern regarding the need to invest in structural changes and simultaneously prioritise specific initiatives, *vis-à-vis* specific groups, is consistent with the challenges faced by Portugal as regards poverty and social inclusion. This continuity reflects the need to keep on tackling the challenges identified in the 2007 Joint Report.

The selection of the NAP Inclusion 2008-2010 objectives definitely contains some positive features, namely considerable emphasis on cross-cutting measures (between the three strands of the NSR, but also the thrust of the NRP 2008-2010); reinforcement of policy areas that had formerly been under-developed (such as housing), a considerable set of new measures, incorporation of measures from Madeira and Açores. It is also important to highlight the links with the National Strategic Reference Framework (NSRF), and the contribution of the Structural Funds. The ESF co-funded Operational Programme "Human Potential" (OPHP) is expected to play a key role in financing several measures.

Globally the NAP Inclusion addresses the social inclusion strand objectives. The NSR assesses gender issues through a cross-cutting approach. The social inclusion strand contains specific measures which seek to include more women into the labour market. The legal possibility of greater sharing of family responsibility by the parents, coupled with the increasingly compulsory nature of this time can make a difference.

3.4. Policy measures

The scope of the measures included under the **first priority** has widened, which plans to *"fight child and elderly poverty, through measures ensuring their basic rights of citizenship"*. Significant structural issues were taken into account such as: income (gradual increase of the National Minimum Salary and income support during pregnancy) and housing (housing costs and a housing programme for the elderly). These measures will have an overall broader impact, and not only focus on children and the elderly, it is undeniable that measures such as direct income support will have substantial added-value in a country where the minimum wage is still very low and the proportion of working poor remains high. Furthermore, measures such as investment in social infrastructures will lead to increased female participation in the labour market. It is positive that the wide range of measures covers many aspects: income, housing, integration into the labour market, education, provision of social equipments and services. There is a description of all measures, identifying the body responsible, the beneficiaries an indicator for evaluation. The budget allocated to the measures is mostly given.

Under the **second priority**, which plans *"to correct the disadvantages in education and training/qualification"*, most measures are closely linked to the National Employment Plan and the *"Novas Oportunidades"* initiative. Previous measures have clearly stabilised (the network of pre-primary school infrastructures, alternatives curriculum paths, *"Novas Oportunidades"*), while the main new feature is the introduction of measures in the field of Information and Communication Technologies (Technological Plan for Education, broad-band networks and a School Portal). More systematic measures include the increased coverage of pre-primary education, the creation of alternative curriculum paths, more education and training courses for the young people and Education Areas of Priority Intervention. There is a clear focus on pre-primary education and on raising the qualification levels of young people (through the double-certification courses) and adults (through the recognition, validation and certification of competences). Some measures provide access to ICT for disadvantaged groups, mainly at school or in the special inclusion centres (Centres for Digital Inclusion). There are plans to include people at risk of exclusion in vocational training schemes. Special attention was also paid to the disabled. Nevertheless it appears that the gender dimension has not been fully considered, especially as regards young women from disadvantaged social backgrounds.

The **third priority** to *"overcome discrimination and reinforcing the integration of specific groups, namely the disabled, immigrants and ethnic minorities"* presents specific measures for the disabled, immigrants, ethnic minorities and the homeless. Most measures targeting the disabled, constituting a coherent set of measures (on education, qualification, health, labour market integration, accessibility, and legal advice) and are in line with the previous NAP. Measures on immigrants stem mainly from the existing Plan for the Integration of Immigrants (PII), in force since 2007, and refer to integration centres, language courses, and entrepreneurship support. The recent approval of the Plan to Combat Human Trafficking and the creation of an Observatory in this field are welcome. Also new risk groups have been included in the NAP, such as the Roma and the homeless.

3.5. Governance

The preparation of the NSR was coordinated by the Ministry of Labour and Social Solidarity, through an inter-ministerial group (representing fourteen ministries), the Government of the Autonomous Regions of Madeira and Açores and the Non-Governmental (NGO) Forum. The Non-Governmental Forum for Social Inclusion and the Local Social Networks gave

stakeholders an opportunity to contribute to the process from the design stage. This improvement is highlighted in the NAPIncl 2008-2010 Assessment Report produced by the Non-governmental Forum for Social Inclusion.

Implementation of the NSR 2008-2010 will be monitored by a network of Focal Points (which will replace the former Inter-Ministerial Commission for Follow-up the NAP 2006-2008 and the Working Group of the Ministry of Labour) and by a platform of coordinators of different plans, composed of sixteen coordinators of national plans in diverse domains (such as Immigrants, Health, Culture, Drugs, Housing, etc). Regarding the Focal Points, a network involving sixteen ministries, the representatives of Madeira and Açores and from the municipalities will be created. The involvement of local actors was given a special attention and the main national representatives of the local authorities are now taking part in the governance structure, providing thus a stronger local perspective.

The creation of the national network of experts for promoting knowledge on poverty and social exclusion is important, and would add value to the whole NSR. As regards monitoring and evaluation this NSR should have given more attention to an effective and operational mechanism to monitor, assess and evaluate this ambitious strategic plan.

4. PENSIONS

4.1. Key trends

The Portuguese pension system is characterised by a statutory regime, which is a general scheme mandatory for the private sector. Occupational schemes also exist in particular for civil servants. Pension spending has been a major driver of rising government expenditure in Portugal since the mid-nineties. Quickly maturing old-age pension schemes caused by the significant growth in the number of pensioners and average pension outlay due to the longer career contribution of new retirees are responsible for the increased spending on pensions. According to AWG's 2005 projections, public spending on pensions is set to rise from 11.1% of GDP in 2004 to 20.8% in 2050. However in October 2007, the Portuguese pension reform was submitted to a peer review of the AWG, and the projections were positively revised (expected value in 2050 is 16%). In this context, Portugal was downgraded from a high-risk to a medium-risk country. A revision of these projections is currently ongoing; consequently the updated projections are foreseen to be completed this spring.

Pension reform was then at the core of the fiscal consolidation programme. The aim was to control spending and improve the efficiency of the public sector, as well as to reform public administration. Following an agreement with the social partners, a general reform of the social security was passed in January 2007 and the reform of the pension system entered in force in May 2007.

The relative median income ratio for people aged 65 years and over relative to the income of the age group 0-65 was 0.79 in 2007, the same as the year before. The aggregate replacement ratio was 0.47 in 2007. The average retirement age was 63.1 years in 2005, which is above EU average of 61. The gross replacement rate for Portugal in 2006 was 75 (91 for net replacement rate). The gross theoretical replacement rate is expected to change by -19 % between 2006 and 2046 (-20 % for net replacement rate)

4.2. Key challenges and priorities

The main challenge facing Portugal is the fully implementation of the pension reform adopted in 2007, particularly by converging the public servants regime with the general scheme, promoting longer working lives, establishing a comprehensive active ageing strategy and reducing the poverty risk of the elderly.

The 2007 Joint Report identified the "*implementation of the pension reform*" as a major challenge for the future. Portugal has responded positively with the 2007 reform. The main measures include extending the assessment period to cover the entire career (instead of just considering the best 10 out of the last 15 working years)[166], financial penalties for early retirement (up from 4.5% to 6% on an annual basis) and incentives for postponing retirement. Other measures included a new formula to calculate pensions which would benefit persons on lower salaries; the introduction of a "sustainability factor" that automatically adjusts benefits to changes in residual life expectancy and a new indexation rule *"Indexante de Apoios Sociais"* that considers real GDP growth and consumer inflation.

As regards sustainability, the core measures are extending the assessment period to cover the entire career and the new "sustainability factor"[167]. Other important steps taken include measures to encourage births, a penalty for early retirement and benefits for working longer, the new legislation regarding unemployment protection[168], the new indexation rule (that no longer considers the minimum income wage), a new Contribution Code that adjusts the contribution basis (also for the self-employed), the strengthen mechanism to fight fraud and a new model of finance.

Portugal has clearly addressed the need of curbing public expenditure through the pension reform. However future gaps in the contributory social security system may appear. The NSR sets out the National Active Ageing Strategy (through incentives to work longer) and increased incentives for the disabled as important measures to address the future adequacy of pensions, but it remains to be seen whether this will be sufficient. It is of utmost importance that regular review and adjustment mechanisms be developed.

4.3. More people in work and working longer

Although the reform of the general pensions system introduces flexibility in the age of retirement, it also penalises early retirement (before 65 years). This penalty also acts as an incentive to remain in workplace, and is a clear measure to retain more people at work. The penalty has risen from 4.5% to 6% per year. The public administration sub-system, under which the legal pension entitlement age used to be 60, is now converging to the general regime. For the first time a distinction was made for the disabled between "absolute invalidity" (with the minimum pension guaranteed) and to a "relative invalidity", in which case the pension can be topped up by a job income.

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[166] This rule applies from 2007 onwards to the general pensions system; however it will only be extended to civil servants in 2015. In 2005, **changes to the pension scheme for government employees** were adopted, resulting in its convergence to the less generous general scheme for private-sector workers. This will be accomplished through step increases until 2015 in the retirement age and eligibility periods as well as changes to the benefit formula.

[167] That involves multiplying the pension formula by a penalty factor equal to the ratio of life expectancy at age 65 in 2006 and life expectancy at age 65 in the year before retirement

[168] In force since 1st January 2007, the unemployment benefit scheme has been improved by strengthening activation mechanisms, reducing the unemployment period and helping people return to the labour market. Also the access to early retirement following unemployment has changed from age of 60 to 62, having the beneficiary at the date of unemployment at least 57 years old.

4.4. Privately managed pension provision

The NSR does not provide much information about privately managed pensions. However in the banking and telecommunications sectors occupational schemes substitute the general scheme. Companies also provide complementary retirement benefits for employees. Occupational schemes cover roughly 3.7% of the labour force. The liabilities for future pensions are covered by independent pension funds, whose assets currently amount to 14% of the GDP. A major liability of these occupational schemes is the prevalence of defined benefit pension plans. Losses in the value of pension fund portfolios, due to the current financial crisis, could seriously damage these schemes.

4.5. Minimum income provision for older people

The poverty risk for older people is currently 26%, significantly above the overall rate (18%). A specific monetary income compensation for the old-age pensioners, called the Solidarity Supplement for the Elderly (SSE)[169] was established in 2006, benefiting around 200.000 elderly people. Additional health benefits for those eligible for the SSE were created in 2007, which allow for an extra reimbursement of health expenses.

4.6. Information and transparency

The National Council of Social Security was created in 2007 in line with a Government pledge. It is the body which consults social partners and promotes the tri-party monitoring of the economic, social and financial sustainability of social security system. Additionally it is responsible for defining its objectives and following up the implementation. The NSR acknowledges the importance of a monitoring system, but gives no precise information on the development of such monitoring and evaluation mechanisms, although it is mentioned in the report on the on-line web application and the annual report on social security sustainability. On transparency, an on-line web application was created, which allows citizens to consult their contributively career and be informed about the reform in due course. An annual report on social security sustainability is annexed to the Government's budget proposal, which is presented to the Parliament. Social service centres are being modernised and access for the disabled will be improved. The social security call centre is planned for 2009.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Portuguese Health System covers the entire population and is organised by the National Health Service (NHS), with some responsibilities delegated to regional bodies. The internal organisation of the ministry is being restructured in the context of a general reform of public administration in the country. The NHS is managed by the Ministry of Health. Overlapping with the NHS there are certain special public and private insurance schemes for certain professions (called "health subsystems"). Primary health care is provided through a network of health centres, outreach services and non-profit organisations that provide care for NHS users. In the NHS general practitioners operate as gate-keepers by referring patients to hospitals for specialist care. Hospital care is provided by hospital departments of the NHS complemented, when deemed necessary, by private and social entities with established

[169] Accession is progressive: in 2006 it was available for those above 80 years old, in 2007 for elderly above 70, and in 2008 pensioners above 65 years old can require (by means-test) this income supplement.

contracts with the Ministry of Health. The system is funded by general taxation and supplemented by public and private insurance schemes and out-of-pocket payments. Co-payments apply to pharmaceuticals, consultations, hospital care and home care, but 50% of the population is exempt. The improvement in key health indicators, such as life expectancy at birth and low infant mortality is attributable to the NHS. The National Health Plan 2004-2010 focuses very strongly on enhancing effective promotion and prevention activities at all levels of health care. This Plan has prioritized four strategic programmes (cancer, HIV, cardiovascular diseases and mental health).

The total public expenditure on health care (as percentage of THE) is 70.6% (2006), and represents 10.2% of total government expenditure. Private expenditure on health care is approximately 3% of GDP (2006), while private expenditure on health compared to total health care expenditure is 30.3%, which is well above the EU average of 24.1%, and may represent a financial burden on more vulnerable groups. Policy measures to counteract this situation include the promotion of greater access, namely through the integrated management lists for surgery and medical appointments. The fact that some groups with their own social insurance scheme (like ADSE for civil servants and SAMS for the banking sector) can access both the NHS and other providers means that some sections of the population are allowed to choose their providers, while others are restricted to the NHS.

5.1.2. Accessibility

A key challenge is to reduce waiting times, both for primary and hospital care. Although waiting times are still perceived as being too long in many hospital specialities and despite the regional disparities, Portugal has achieved significant strides in recent years. In four years the waiting time for all surgeries has decreased by 50%. Improving access to hospital care is a top political priority, as is equal access for all citizens. The main measures include adopting integrated nationwide systems to manage waiting lists for surgery and to manage access to hospital medical appointments (timely access programme for hospital speciality consultations). Both systems were designed to assure that people receive health care according to their needs and take into consideration their clinical situation. These two information and management systems show the need for specific intervention programmes, like to the current ophthalmology or the obesity programmes. With regard to redistribution of services and the regional disparities in the access and supply of those services, there is an ongoing plan covering different areas of the country including mobile care units. Services must be redistributed to improve access in some geographical areas and to enhance efficiency in others.

Measures under the health chapter include implementation of the "e-agenda (facilitating appointments and complementary diagnosis and therapeutic means through multi-channel technological platforms, 24h counselling helpline and a health portal), the revision of agreements/contracts with the private sector to improve the access for beneficiaries of the NHS, campaigns to promote health for specific groups, reorganisation of psychiatric emergency assistance are some of the other projects which will be set up. The NHS exempts from any fee or co-payment patients suffering from chronic diseases (e.g. diabetes, oncologic and neuromuscular) and vulnerable groups (such as pregnant women, children and elderly benefiting from the national minimum wage). Also special programmes have been implemented on dental care for those vulnerable groups, given the NHS shortages in this field. The policy on pharmaceuticals also contains important elements regarding access, namely stepping up incentives to prescribe generics, revising medication subsidies and access to pharmaceuticals.

5.1.3. Quality

The government ensures quality standards for public and private institutions, through a system of audit, inspection, national accreditation and the qualification of infrastructures. The main measures to enhance quality include implementing an experimental model of integrated disease management, implementing and developing national programmes to prevent and control non-transmissible diseases, and reorganization of maternity services. There will also be measures aimed at guaranteeing the accreditation/certification of hospital rules and procedures, the development of the National Programme to Qualify Health Centres, the preparation of national guidelines about good practices, the development of internal and external clinical audit in order to progressively improve the quality of health care, and the progressive qualification of human resources.

An important aspect of quality in the health care system is human resources. Portugal has experienced staff shortages and has had to overcome them by, for instance recruiting foreign staff from Spain and Eastern Europe. This has been occurring across the staff grades (too few GPs, nurses and dentists). To this end, two new medical degrees have started at universities and a specific allocation from the ESF is available to health care professionals for the period 2007-2013 through the OP Human Potential.

5.1.4. Sustainability

The sustainability of the health care system is largely dependant on the consolidation of public spending, and on overall economic growth. Health expenditure continues to grow faster than the GDP (1995: 7.8%, 2006: 10.2%). This is the result of the complexity of the process coupled with increased demands on the health budget because of new technologies, new pharmaceuticals and new services. However the health authorities have implemented reforms to curb the high costs associated with health care, in particular through efficiency programmes, reducing the costs of pharmaceuticals and general reforms of the NHS (concentration of hospitals centres, the creation of ten new Public Corporate Entities/"enterprise-hospital", primary health care reform, network of integrated continuous care). These measures highlight a tight control over the expenditures in health system, which made possible to reach the objectives and targets within the budgetary allocation, avoiding the need to resort to corrective budgets.

Similarly to the pension system, the health care system is at the core of current fiscal consolidation efforts. Control spending on health care and the new "enterprise-hospital" management model had important implications for the fiscal sustainability. Reforms in the health sector are having a positive impact, such as the creation of a central purchasing unit (thus more economies of scale), the adoption of a contracting model on the basis of activities and performance, the revision of NHS agreements and update of co-payments for access to NHS.

5.2. Long-term care

5.2.1. Description of the system

Until recently there were only limited long term care services available. Only the *"Misericórdias"* and a few non-profit organisations provided of long term care facilities such as, day care and nursing care for the elderly and for those living in situations of dependence. In 2006 was approved the National Network of Integrated Continuous Care, which aims to provide all levels of integrated continuous care (convalescence, mid, long-term and palliative care). This network is a partnership between the Ministry of Health and the Ministry of

Labour and Social Solidarity, and also involves the "social sector" (*"Misericórdias"* and charity institutions) and the private sector. It aims to promote the continuous health care and social support for all citizens who dependant on others either temporarily or permanently. Moreover, this measure is designed to have a major impact on the reconciliation of family and professional life of women, helping them remain/return to labour market. Geographical functioning seems to have been properly addressed and to this end three levels of coordination (central, regional and local) have been established.

5.2.2. Accessibility

Although the scope of the National Network of Integrated Continuous Care should be seen as an initial step, the NSR 2008-2010 has established measures to be implemented regionally and locally with the view of creating convalescence units[170], medium-term and rehabilitation units[171], long-term and maintenance units[172], palliative units and day-care units.

This network will be an important step forward for the elderly above 65 years old. It will also be important for those who are dependant. In addition it will have the major added-value of getting closer the goal of the full participation of women in the labour market.

5.2.3. Quality

A training plan for long-term care professionals, a systematic and continuous process of results assessment, an evaluation of the degree of users satisfaction and a system of feedback and complaints are all implemented.

5.2.4. Long-term sustainability

The National Network of Integrated Continuous Care will be implemented over a framework period of ten years (2006-2016) to ensure its sustainability. A programme to fund this network was created in May 2008 to back up this political priority with appropriate financial means.

6. CHALLENGES AHEAD

- To tackle child poverty, by adopting comprehensive strategies to provide better support for family incomes and facilitating labour market integration.

- To ensure that the groups furthest from the labour market benefit from mainstream measures to raise the qualification levels of the population, with a particular focus on the large numbers of unskilled working poor and early school leavers.

- To closely monitor and evaluate the impact of measures of the National Action Plan for Inclusion, in particular measures relating to the minimum income scheme, in order to ensure the effective social inclusion of groups at risk.

- To further develop and regularly review the monitoring mechanism of adequacy for future pensioners.

[170] 810 beds by 2008 and 1446 beds in 2009

[171] Expected to rise from 1100 beds in 2008 to around 1500 in 2009

[172] Foreseen to reach 7000 beds in the National Network of Integrate Continuous Care by 2009

- To improve equity and efficiency (notably by reinforcing primary care, adjusting hospital capacity and controlling pharmaceutical expenditure) and implement comprehensive all-ages promotion policies to improve health status and reduce health inequalities.

- To enhance the provision of long-term care and reduce geographical disparities of care supply.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,9	78,0	2000	68,4	76,5	60,5	41,1	50,7	2000	4,0	3,2	4,9	8,8
2005	0,9	76,9	2005	67,5	73,4	61,7	36,1	50,5	2005	7,6	6,7	8,7	16,1
2008f	0,2	73,7	2007	67,8	73,8	61,9	34,9	50,9	2007	8,1	6,7	9,7	16,6

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	71,7	79,0	14,7	18,1	59,6	63,1	7,5	1995	7,8	62,6	n.a.		-
2000	73,2	80,2	15,4	18,9	60,2	62,2	5,5	2000	8,8	72,5	22,2	2005	4,7
2006	75,5	82,3	16,6	20,2	59.6b	57.6b	3,4	2006	10,2	70,6	22,8	2006	5,0

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	21,0	41,1	36,2	5,3	5,2	0,4	11,8
2000	21,7	44,7	32,0	3,7	5,4	1,4	12,7
2006	25,4	49,1	29,2	5,5	5,1	1,2	10,0

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	25,9	23,8	10,5	6,7	n.a.
2010	26,6	0,4	1,4	0,1	n.a.
2030	36,6	4,2	3,4	-0,1	n.a.
2050	53,0	9,8	5,5	0,5	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	18	21	15	26	24	26	27	19	6,5	2005	n.a.
male	17	-	14	24	24	-	27	14	-	2006	n.a.
femal	19	-	16	27	24	-	27	22	-	2007	n.a.

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	3,6	4,3	3,7	4,9
2004	4,3	5,3	5,0	5,7
2007	5,1	5,7	5,3	6,1

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	1,7	1,4	2
2004	3	2,6	3,4
2007	3,8	3,2	4,5

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	42,6	35,1	50,1
2004	39,4	30,6	47,9
2007	36,3	30,4	42

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,47	0,50	0,48	***Aggregate replacement ratio***	0,47	0,5	0,48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	pensions Assumption
-20	-20	-20	DB	/	-	81	/	33	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Romania

1. Situation and key trends

The macroeconomic performance of Romania has improved significantly since 2000. The growth rate of real GDP for 2007 was 6% and the latest forecast for 2008 was 7.8%. The immediate effect of the current financial crisis will be a fall in economic growth in the forthcoming period. The latest forecast from the European Commission for 2009 is only 1.8%. The GDP per inhabitant in PPP[173] represents only 43.6% of the EU average. Despite the registered growth in GDP, the employment rate has been relatively constant since 2002. Following a slight increase in 2006, the employment rate in 2007 stabilised at around 58.8%. Employment in agriculture, characterised by very low monetary income, and therefore a source of poverty, still accounts for quite a high proportion of jobs. The labour force participation rate in 2007 was 63%, and was higher for men. The female employment rate (52.8%), the youth employment rate (24.9%), and the rate of employment for older workers (41.4%) remain lower than the European average. The unemployment rate fell to a record level of 6.4% in 2007, lower than the European average. However, owing to the financial crisis, we can expect an increase in 2009. This is a worrying development for young people, despite recent decreases (20.1% in 2007).

The strategy identifies a poverty risk of 19%, with higher values for the rural population, the Roma, children, the unemployed and elderly women. From a demographic point of view, the population of Romania is decreasing steadily as a result of intra-Community mobility, the low fertility rate (1.31 in 2006), life expectancy at birth being one of the lowest in the EU (69.2 years for men and 76.2 years for women in 2006) and a relatively high rate of mortality at birth. The rate of mortality at birth is still one of the highest in the EU, although there was an improvement (12%) in 2007. The projected demographic dependency ratio is estimated at 21.3% for 2010 and 54% for 2050. Welfare expenditure represents 14.2% of GDP (2005), one of the lowest levels in the EU (27.2% of GDP).

2. Overall strategic approach

The general objectives set in the new strategy are directed at continuing efforts to create a society of inclusion, solidarity and prosperity based on equality and social justice for everyone, in accordance with the objectives of the open coordination method for protection and social inclusion, the Lisbon Strategy and the sustainable development strategy. For the new period, the focus will be on active inclusion. The modernisation of the social protection system continues to be the central issue in social policies, with a particular focus on avoiding dependence on the system and encouraging active inclusion. The strategy attaches importance to the implementation of reforms which have already been initiated in the field of social protection. Overall, the strategy can be described as ambitious, but, owing to a lack of quantified objectives, it risks simply being a declaration of good intentions on a rather general level. One of the important objectives is to develop integrated policies and ensure the effective implementation of sectoral strategies. The strategy outlines the implementation difficulties and the need to develop monitoring and assessment instruments and procedures aimed at increasing the effectiveness of policies. The ESF is mentioned as the instrument which can help to attain the strategy objectives (for example, measures to increase the participation of vulnerable groups in the labour force, the strengthening of administrative capacity at both local and central level, and the supply of efficient, high-quality services on a decentralised basis). The strategy sets the priority of developing a common understanding and

[173] Purchasing power parities (PPP)

raised awareness among citizens and professionals of the concept of active inclusion, in order to improve efficiency in the design and implementation of social policies. However, few actions have been taken so far to materialise this declaration. Little reference is made in the strategy to the issue of child poverty, although this is a constant priority on Romania's social agenda and a national strategy on the protection of children's rights was adopted for the period 2008-2013; the matter of children whose parents have left to work abroad is not even mentioned, despite it being a widespread phenomenon. The strategy tackles the gender dimension: actions will continue to be adopted to foster equal opportunities on the labour market and reconcile work and family life. The strategy covers disabilities in the context of the reduction of discrimination, social integration, employment and long-term healthcare.

3. SOCIAL INCLUSION

3.1. Key trends

The poorest social categories are the Roma, the rural population, children, elderly women, single-parent families, households with three children or more, single people and women in long-term unemployment. As regards regional distribution, the north-east region is the poorest (26.2%), followed by the south-east and south-west regions (24.2% and 23% respectively). The poverty rate remained relatively constant in the period 2004-2007, at around 18-19%. However, the risk of poverty is higher among children, young people under the age of 25 and women over the age of 65. The number of children living in jobless households is falling steadily (10% in 2007 compared with 11.1% in 2004). Trends in the 18-59 age bracket remain unchanged. The rate of long-term unemployment is also falling, with a value of 3.2% in 2007 (3.6% for men; 2.7% for women). Youth unemployment remains a source of concern (20.1% in 2007). The percentage of young people leaving school early remains high in relation to the European average (19.2% in 2007). In rural areas, this phenomenon is even more pronounced. The situation is still very worrying among the Roma, for whom a low school attendance rate is noted. The strategy indicates that 9% of Roma enter secondary education and only 2% go to university. The illiteracy rate remains very high (28%). For almost 40% of the Roma population, the main sources of income are welfare benefits and the minimum guaranteed income. Participation in the official labour market remains low, with most Roma working on the parallel labour market.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The strategy and the progress report give a rather descriptive view of the programmes and projects targeting vulnerable groups, and fail to provide a sufficient analysis of the results. Progress has been made, but the figures presented are misleading because there is no overall evaluation of the impact of the measures. Even though connections between the projects presented and the existing sectoral strategies/programmes of national interest doubtlessly exist, the wording of the strategy does not make this very clear. Furthermore, the lack of quantified objectives for the short-, medium- and long-term makes it difficult to compare past, present and future situations. Progress in terms of employment (objective 1): this section contains information on the programmes aimed at increasing employment in the various vulnerable population groups. The increase in the number of employed people in vulnerable groups is a positive aspect, but employment does not cover all the social aspects of inclusion: an integrated approach is necessary. Progress relating to access to rights and services (objective 2): measures have been taken in the social assistance sector to achieve the objective of reducing poverty by implementing policies to support people on low incomes and providing services for the various vulnerable groups. The strategy provides statistical figures

which indicate a fall in the number of people claiming various types of social benefits. It is unclear whether the numbers have decreased owing to the effectiveness of the policy or for other reasons (such as limited access to information, complicated procedures, etc.). There is no reference in the current strategy to the objective of the previous strategy to ensure equal, high-quality access to education for all. Given Romania's somewhat disappointing performance in the field of education (for example, a percentage of early school-leavers which remains high, low participation of adults in lifelong learning measures), this should still be a central objective for the future. Improving the situation of the Roma (objective 3): the information contained in the section on progress makes little reference to the strategy itself. Some information is provided on job exchange centres for Roma and the employment caravans, but the results seem to be rather modest. The report does not mention developments as regards identity papers, a major source of social exclusion for this category. As with previous objectives, not enough information is provided to evaluate the success of the programmes undertaken.

3.3. Key challenges and priorities

The priority objectives for the period 2008-2010 are still to meet the challenges identified in the JIM and in the strategy on inclusion and social protection for 2006-2008. Progress has been noted on social inclusion (for example, legislative and institutional developments, strategies and action plans, programmes of national interest), but the objectives set in the former strategy will be carried over as priorities for the new period, as many efforts have been made to find solutions to emergency situations or to meet new needs, and it has not always been possible to stick consistently to the initial plan. As regards pensions and health, the priority of continuing with the respective reforms remains.

3.4. Policy measures

The three priorities chosen by Romania are detailed below.

The aim is to increase the level of employment in the most vulnerable population groups, promote integrated family policies, and continue with efforts to improve the living conditions of the Roma.

– *Increase the level of employment of disadvantaged people.* In the new strategy, emphasis is laid on developing the social economy sector. The disabled are specifically targeted by these social economy measures, although they can also benefit other vulnerable groups. A certain number of crucial points still need to be addressed: lack of accompanying support services, a generally low wage level, a difference in income levels between women and men; disparities and imbalances between rural and urban areas, inconsistencies between training provision and available jobs; a low rate of participation in lifelong learning, etc.

– *Promote integrated policies (packages of measures, benefits and social services).* The measures under this priority are aimed at continuing efforts to ensure a reasonable income for all members of society and providing better access to resources and high-quality services. The strategy comprises a more integrated approach which combines financial aid and social services. Romania's priority here is to develop childcare facilities and reach an adequate level of social allowances.

– *Continue with efforts to improve the living conditions of the Roma.* In the presentation of this objective, there is some confusion between the objectives and the measures envisaged. Little indication is given as to how the problem of premature school-leaving/illiteracy will be reduced or how the participation in education of the Roma will be improved. Romania

will continue in its endeavour to improve access to the health services, and will also continue the programmes to train health/school mediators, develop national programmes to encourage the Roma to participate in the official labour market, and promote anti-discrimination policies. The commitment to implement the monitoring and evaluation system for programmes and policies to help the Roma population is a positive factor, as is the collection of the data needed to develop suitable policies. However, the weak point remains the lack of quantified objectives. The strategy will have to focus more on the situation of Roma women.

The objectives and measures seem to be realistic and correspond to needs, but in the absence of quantified objectives, they may amount to no more than a declaration of good intention at a rather general level which would be difficult to assess.

3.5. Governance

While the development of the strategy for 2008-2010 proved to be a high-level exercise which remained virtually invisible for certain actors in the field of social inclusion, in daily practice, there has been some improvement as regards the creation and strengthening of the capacity of the relevant competent institutions, and the participation of the social actors, particularly with regard to the social dialogue. Nevertheless, a clearer division of roles and responsibilities should result from a consultation process between all parties concerned at all levels. Many non-governmental organisations, local authorities, and individuals (including journalists and politicians) were not informed of the development of the current strategy. Their potential contributions remain an untapped resource in the search for solutions to eradicate poverty and the fight against social exclusion. For each priority objective, the strategy identifies the institutions responsible for implementation. Romania's efforts in relation to the new period will focus on consolidating the national mechanism to foster social inclusion, to make it the framework for the coordination and development of social policies. This objective will be achieved through the implementation of a programme financed by the ESF as of 2009.

4. PENSIONS

4.1. Key trends

Like most EU Member States, Romania must face significant demographic challenges in both the short and the long term.

The early retirement systems adopted over the first decade of transition have considerably increased the number of pensioners (80% between 1990 and 2003). The early retirement policy designed to solve the problem of growing unemployment resulted in a fall in the average age of pension entitlement. Consequently, the number of contributors per retired person fell from 3.43 in 1990 to only 0.79 in 2003, while pension expenditure as a percentage of GDP decreased from 7.2% to 6.5% over the same period. In order to cover the growing deficit in the pension funds, the government increased contributions by 49.5% in 2005. Owing to high employee taxation (around 50% of gross earnings), the government has decided to reduce this contribution to 40.3% by the end of 2008. The Romanian pensions system has undergone numerous reforms in recent years (particularly with the introduction of a private component in 2007). The new pensions system has three entirely functional pillars: pillar 1 (public, financed entirely and run according to the PAYG system, earnings-related, compulsory, DB), pillar 2 (private, financed entirely and run by private funds, compulsory for those under the age of 35 and optional for those aged 35 to 45) and pillar 3 (private, optional), which is mainly intended for the self-employed and farmers, but is also open to public- and private-sector employees. Pillar 1 (public, compulsory, succeeding the old PAYG system),

was introduced in 2000 with a contribution rate of 29% of gross earnings (shared between the employer and the employee) and has 5.5 million contributors from a total working population of 8.8 million. The number of pension points was increased several times, mainly in 2007, to reach 37.5% of the average salary, and there are plans to further increase it to 45% of the average salary.

4.2. Key challenges and priorities

Romania is facing considerable challenges in relation to the sustainability of the pensions system in both the short and the long term. On the one hand, it must confront short-term collection problems and, on the other, problems due among other things to the relatively low number of contributors to the system in comparison to the number of beneficiaries, the still low level of employment among older workers (41.4%), the substantial percentage of work which is not declared (around 20-50% of total employment according to the definitions used), and resources which are still insufficient. National data indicate an expenditure level of 7.3% of GDP for 2008, which is still lower than the European average. One significant challenge in terms of sustainability lies in the introduction of the pre-financed component of the first pillar, with consequences on the reduction of funds available for today's pensioners and also on the deficit of the PAYG system.

The Romanian government has taken a series of measures to deal with these challenges (for example, increasing the minimum contribution period from 10 to 15 years, increasing the minimum retirement age from 57 to 60 years for women and from 62 to 65 years for men by 2014, measures to encourage the employment of older people, etc.). In the near future, the reform priorities will focus on including farmers and self-employed workers in a contribution scheme, reducing differences between pensions, and increasing the number of people on the labour market in order to maintain the financial sustainability of the first pillar. Attention should continue to be focused on improving the collection of contributions and combating undeclared work.

4.3. More people in work and working longer

Romania has an ageing population, which raises the question of system sustainability. The figures who that the employment rate is lower than the European average (58.8%, in comparison to 65.4% in 2007). Over the most recent period, the rate of employment of older workers has remained relatively stable (41.4%), lower than the European average (44.7%), and with significant differences between men (50.3%) and women (33.6%), despite the growth registered by Romania in recent years. The minimum period of contribution to the pensions system is 25 years for women and 30 years for men. The strategy also mentions the possibility of establishing equal contribution periods for men and women, but no precise information is available concerning the date of the discussions. The number of people receiving a disability pension is a cause for concern: these are actually early retirement pensions (in 2005, this rate was abnormally high and represented almost 14% of the total number of retired people). The objective of pensions policy in the years ahead will be to establish a financially viable system which can offer adequate pensions for everyone. In order to achieve this objective, the Romanian government has made a number of political decisions to lessen the burden of ageing, at least in the short term (for example, through an increase of the minimum contribution period and the retirement age, measures to encourage older people to stay in work after the retirement age, strict limitations on early retirement introduced recently in order to discourage this common practice, the establishment of a national programme to promote the employment of older people for the 2008-2011 period, etc.).

4.4. Privately managed pension provision

Two pillars corresponding to the private pensions system were introduced in 2007: pillar 2 (regulated by Act 411/2004) and pillar 3 (regulated by Act 204/2006). Pillar 2 (private, incorrectly referred to as the "*pilier 1bis*" [pillar 1a]) is compulsory for everyone up to the age of 35. Contributions are optional for those aged between 35 and 45. Pillar 2 (or "*pilier 1bis*") is the pre-financed component of the first pillar, as a portion of social security contributions is mandatorily channelled into privately-managed pension funds. The contribution rate over the first year is 2% of gross income and will rise to a maximum of 6% by the end of 2016. The number of contributors registered in this system was 4.15 million (March 2008). Pillar 3 (private, voluntary), is intended mainly for self-employed workers and farmers, but is also open to public- and private-sector employees; contributions are limited to 15% of gross monthly income, and employers may participate in this contribution. The first contributions started in May 2007. One year later, 88 000 contributors were registered (80% of them in urban areas). The authority responsible for regulating and monitoring private pension funds is the CSSPP (Monitoring Committee for the Private Pensions System), established in 2005, as an independent body accountable to the Romanian Parliament. A pensions fund can function with a minimum capital in RON equivalent to 4 million euros; over the first three years, the fund needed to attract at least 50 000 contributors.

4.5. Minimum income provision for older people

The data indicate that the risk of poverty among older people is approximately the same as for the total population of Romanian (19%), but with significant differences between men (13%) and women (22%). The Romanian social welfare system offers guarantees for the most underprivileged. Romanian legislation does not set a minimum pension level because the level depends on the contributions paid. Nevertheless, retired people with insufficient pensions are covered by various social assistance schemes, the most important one being the guaranteed minimum income. According to one study, the impact of the guaranteed minimum income is greater among older people: the rate of poverty in the population aged over 65 has decreased from 22.2% to 19.1%.[174]

4.6. Information and transparency

In 2007, a national campaign was conducted to inform the population of the recent changes in the pensions system. The results of the survey which followed this campaign show that 78% of Romanians are well informed about the private pensions system, 52% know that the private pension is correlated with the policy of investment in a pensions fund, 78% are aware of the existence of the CSSPP and 88% have a positive opinion of this institution. Whereas 61% of the people interviewed have no confidence in the public pensions fund, 60% are in favour of private pensions, and 73% of them are well informed about the third pillar of the system.

[174] Zaman and Stanculescu, 2006

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Eurostat figures indicate a rather precarious state of health for Romanians in comparison to other EU countries: they have one of the lowest life expectancies at birth in the EU (69.2 for men and 76.2 for women in 2006), and one of the highest maternal and infant mortality rates in the region despite recent improvements. The most common causes of death in Romania are cardiovascular diseases (62.1%), cancer (17.6%), digestive illnesses (5.5%) and respiratory illnesses (4.9%). The Roma have the worst health record. The results of a survey carried out in 2000 show that only 34% of Roma have sickness insurance. In general, the Romanian health system is perceived by the population as one of the most corrupt elements of society. [175]

Major reforms in the field of healthcare aim to transform the centralised system into a decentralised, pluralist system based on contractual relations between the health insurance funds as purchasers and healthcare providers. It operates on the principle of insurance, with compulsory participation correlated to the status of employee. Contributions are a percentage of income and are paid by the employer and the insured person. Private practices are authorised although hospitals are mainly state-owned.

The aim of this strategy is to improve the health conditions of the population and help to create a modern, efficient health system which is compatible with the health systems of the EU. In the medium term, the Romanian government is trying to improve access to basic medical services and service quality. A certain number of strategies have been developed to achieve this, the most important of which are linked to the development of infrastructure and of preventive medicine. Preventive medicine is currently an essential priority for the government, given the results of the national programme recently established to evaluate the health of the population. According to the conclusions of this evaluation, around 37% of the Romanian population is at risk of illness.

5.1.2. Accessibility

For certain categories, there is the issue of accessibility to medical services: a) people without sickness insurance (around 5.7% of the population), b) people living in remote rural areas (who must travel large distances between their homes and the nearest health institution) and c) insured people who are living in poverty and are unable to pay for related services (for example, medicinal products, services not covered by insurance). Access to healthcare is particularly low in the case of the Roma minority. Differentiated access to services is also due to the heterogeneous territorial distribution of hospitals, hospital beds and medical staff. Access to care has recently improved, above all as regards universal access to pre-hospital/hospital emergency services for insured and non-insured persons alike. For example, in the pre-hospital sector between 2007 and 2008, 2 420 ambulances and 71 vehicles to transport traumatised patients were purchased, while in the hospital sector, 167.7 million euros were invested in modern equipment for 313 hospital units to deal with emergencies). Access to health programmes (e.g. oncological treatment, diabetes, programmes for mother and child, etc.) is also provided for non-insured persons to the same extent as for insured persons. The report presents a series of measures envisaged to improve the accessibility of healthcare in the near future. Among the objectives set for the new period, the government intends to build 28

[175] Study carried out by Transparency International, 2006

new hospitals, renovate 15 emergency hospitals, purchase 1 520 ambulances, and recruit 500 community medical assistants per year and 50 Roma mediators per year.

5.1.3. Quality

In 2007/2008, considerable investments were made in the purchase of medical equipment in hospitals. However, not enough medicinal products are available as the most expensive medicines are the first choice in medical prescriptions. Obstacles to improving quality are posed by poor distribution and the low salaries of medical staff. It is customary to pay health staff "under the table". According to certain estimates, illicit payments to medical staff amount to around 285 million euros per year. Efforts have been made to channel resources into the best health establishments and eliminate hospitals and specialised centres of lower quality. The purchase of equipment is problematic in general. Certain measures are set out in the strategy in this respect, but there are no quantified references, without which the strategy could simply remain a declaration of good intentions, with overly general objectives. Attention should continue to be focused in Romania on the regional disparities in the purchase of equipment.

5.1.4. Sustainability

In 2004, Eurostat estimated total health expenditure at around 5.5% of GDP. In 2004, public health expenditure represented 66.1% of total health expenditure, which is increasing, while non-reimbursed payments accounted for 31.7% of total health expenditure. Furthermore, like the pensions system, the health system is based on a system which functions according to the contribution principle. Demographic trends and the fall in the number of contributors will threaten financial stability. The use of supplementary sickness insurance, provided by private institutions, could be a solution, but access to this service will remain limited to people on high incomes. Financial sustainability looks highly insecure when we compare health expenditure in Romania to the EU average. Human capital is one of the concerns relating to the sustainability of the system: Romania faces high intra-Community mobility of medical staff, who prefer to work in other EU Member States where the pay is higher. Romania must therefore envisage a suitable human resources strategy to improve the quality of their employment conditions, and also encourage them to stay in Romania to work. As regards training, Romania must use the support offered by the ESF in this field.

5.2. Long-term care

5.2.1. Description of the system

According to the strategy, the beneficiaries of the system are older and disabled people, a large majority of whom are assisted by their families or live alone. Only those who need permanent medical care are included in the system. Reforms in this field of long-term care have shifted responsibilities from the central budget to the local authorities and the regions. The financing of the system is mixed and combines resources from the national and local budgets. Cuts in community-based services are continuing and, despite some progress, the system is still underdeveloped and NGOs play an important role in terms of organisation and funding. The National Authority for Disabled People is responsible for developing the social services system for the disabled. Progress has been made (an increase in the number of social services, the adoption of a strategy for disabled persons for the period 2006-2013, the development of an assessment tool to identify and analyse social service needs), but efforts must continue, above all in relation to quality.

5.2.2. Accessibility

The number of establishments providing long-term care has increased. The number of retirement homes for the elderly has risen from 19 in 2005 to 68 in 2007 (financed by local budgets) and 38 other institutions have been created since 2005 (financed by the NGOs). Nevertheless, the strategy does not give indications as to their geographical distribution. With regard to the second category of long-term healthcare beneficiaries, namely the disabled, the government has tried to develop the capacity of specialised institutions by converting over 140 residential health establishments into institutions for the disabled. The majority of these institutions were retirement homes or hospitals for the chronically ill, but almost no special alterations have actually been made to adapt the establishments to patients' needs.

5.2.3. Quality

The improvement in the quality of long-term healthcare and in the living conditions of the beneficiaries of residential long-term healthcare remain a priority for the Romanian authorities, as does the development of a network of social workers and the improvement of both sanitary conditions and the qualifications of staff working in this sector. Measures are envisaged, but the strategy must set indicators which will be useful for subsequent evaluations. The strategy also includes a commitment to encourage home care for dependent people. Measures envisaged include the possibility of paying and properly training family members involved in the care.

5.2.4. Long-term sustainability

The strategy does not give many indications on this subject: it refers only to the fact that, in order to be sustainable in the long term, the system must be reformed (payment of services by the "customer"; on the one hand, state intervention for those who cannot afford this expenditure and, on the other, sufficient guaranteed resources for the local authorities).

6. CHALLENGES AHEAD

- To continue efforts to break the cycle of poverty among the most vulnerable (above all children in vulnerable situations), with emphasis on the effective implementation of sectoral strategies and the development of the instruments necessary for adequate follow-up.

- To ensure that strategies in the field of social inclusion and employment dovetail. To continue efforts to increase the participation of everyone concerned in the development of suitable policies and in their implementation.

- To pursue efforts to improve the capacity of local authorities to better identify and implement priorities in the social domain, so as to increase the quality and efficiency of services on a decentralised basis, and reinforce local/regional administrative capacity to ensure better use of European funding in this sector.

- To continue efforts to improve the situation of the Roma (with particular emphasis on increasing their participation in education, training and the official labour market, solving the issue of identity papers and combating all forms of discrimination).

- To strengthen the functioning and sustainability of the current and future pensions system, in the short term through improved collection of contributions and in the longer term by

increasing the number of contributors to the system and the general rate of employment (particularly among older workers), in parallel with a decrease in undeclared employment. Efforts must continue to reduce the inequalities which persist for a large category of people.

- To continue efforts to solve the problems of the accessibility of healthcare and of good quality, long-term care, and above all to reduce geographical disparities and tackle the issue of high private expenditure on healthcare and pharmaceutical products.

- To pursue efforts to develop a decentralised, functional social health system which is capable of ensuring long-term financial sustainability and the efficient use of resources. A human resources reform must be envisaged in order to meet the challenge posed by the intra-Community mobility of medical staff and the problem of corruption.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	2,1	25,9	**2000**	63,0	68,6	57,5	34,0	49,5	**2000**	7,2	7,8	6,4	20,0
2005	4,2	35,0	**2005**	57,6	63,7	51,5	24,9	39,4	**2005**	7,2	7,8	6,4	20,2
2008*f*	7,8	44,3	**2007**	58,8	64,8	52,8	24,9	41,4	**2007**	6,4	7,2	5,4	20,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	65,3	73,1	12,6	15,1	n.a.	n.a.	21,2	**1995**	n.a.	n.a.	n.a.		-
2000	67,7	74,6	13,4	15,7	n.a.	n.a.	18,6	**2000**	4,6	74,1	25,9	**2005**	-
2006	69,2	76,2	13,6	16,5	n.a.	n.a.	12,0	**2006****	5,5	70,3	25,3	**2006**	-

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	13,2	48,5	25,6	7,7	10,0	0,4	7,9
2006	14,0	45,0	34,8	2,7	8,9	1,2	7,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	21,3	n.a.	n.a.	n.a.	n.a.
2010	21,3	n.a.	n.a.	n.a.	n.a.
2030	30,3	n.a.	n.a.	n.a.	n.a.
2050	54,0	n.a.	n.a.	n.a.	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	19 (p)	25 (p)	17 (p)	19 (p)	23(p)	26 (p)	23 (p)	19(p)	5,3 (p)	**2005**	n.a.
male	18 (p)	-	17 (p)	13 (p)	23 (p)	-	23 (p)	17(p)	-	**2006**	n.a.
femal	19 (p)	-	16 (p)	22 (p)	24 (p)	-	23 (p)	20(p)	-	**2007**	n.a.

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female		Long Term unemployment rate (% of people aged 15-64) Total	Male	Female		Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	6,8	8,7	7,7	9,6	**2000**	3,5	3,6	3,4	**2000**	22,3	23,3	21,3
2004	11,1	11,1	10,4	11,7	**2004**	4,5	5,2	3,6	**2004**	23,6 (b)	24,9 (b)	22,4 (b)
2007	10,0	10,4	9,3	11,5	**2007**	3,2	3,6	2,7	**2007**	19,2	19,1	19,2

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,89 (p)	n.a.	n.a.	***Aggregate replacement ratio***	n.a.	n.a.	n.a.

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net	Gross replacement rate					Assumptions: Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
52	39	39	DB/DC	/	-	n.a.	/	29	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Slovenia

1. Situation and key trends

The positive macroeconomic context and strong performance recorded over the last couple of years boosted the employment rate and brought down unemployment to a low level. However, inflation in Slovenia was 6% in August 2008, the highest in the euro area. The Slovene economy experienced a 6.8% growth in GDP in 2007 and 1.9% in the first quarter of 2008 (EU 0.6%, Eurostat). However, partly as a result of the global financial crisis, growth has started to slow down. It is forecast to reach 4.0% in 2008 and 0.6% in 2009, as a result of a broad-based deceleration in investment activity. Unemployment is forecast to reach 4.5% in 2008 and 5.2% in 2009.

GDP per capita reached 88.8% of the EU average in 2007. Although the employment rate is slightly above the EU average (67.8% in 2007), and the unemployment rate is one of the lowest (4.9%), the labour market is characterised by low employment of elderly workers (33.5%), especially elderly women (22.2%; the employment rate of older men was 45.3%). Although this is improving, this indicator is still one of the lowest in the EU and considerably lags behind the Lisbon target of 50% by 2010. The labour market is also characterised by a relatively high youth unemployment rate (10.1% compared to the 4.9% average in 2007). The GDP spent on social expenditure is estimated at 24.2% for 2004-2010, with 12% of the population at the risk of poverty in 2007 (10% of men and 13% of women), which is below the EU average. The shares of social expenditure as a percentage of total benefits were spent on pensions (45.4%), followed by healthcare benefits (32.1%), 8.6% on family and children (benefits linked with pregnancy, birth, adoption, child rearing and care for other family members), 8.5% on disability, 3% on unemployment and 2.5% on housing and social exclusion. Slovenia is expected to face similar demographic trends to most EU Member States in the coming decades: the old-age dependency ratio (23.9% in 2006) is estimated to more than double (to 59.4% in 2050). Life expectancy at birth has risen substantially in the last decade, reaching 82 years for women and 74.5 years for men in 2006. Slovenia had the eighth lowest birth rate in the EU in 2007 that is 0.98%.

2. Overall strategic approach

The general strategic approach of the NSR 2008-2010 is based on the thrust and substance of Slovenia's Development Strategy, which functions as an umbrella strategic national document for the period until 2013. The NSR recognises that globalisation, competitiveness and the ageing of Slovenian society require adjustment and modernisation of the social protection systems to promote a sustainable social state. On the other hand, strengthening individual responsibility and awareness of the need for constant personal development, education and training is essential.

The key social inclusion priorities of the NSR are to provide adequate income support to vulnerable groups to prevent social exclusion, to raise the potential of an inclusive labour market in combating poverty and social exclusion and to provide access to social services of general interest. The NSR recognises that demographic trends, changes in the labour market and globalisation affect the pension system and the link between employed insured persons and retirees. Regarding the health sector, the strategy concentrates on reducing overall regional and population differences in health status, by improving access to and quality of services and by raising awareness of individual responsibility for one's health. These priorities largely correspond to the country's specific challenges. There is an overall continuity with the 2006-2008 strategy report and the objectives and the priorities correspond sufficiently to three newly defined priorities.

However, gender and disability issues are not systematically mainstreamed into policies.
Social inclusion and social protection policies are closely linked to the Lisbon Strategy for growth and jobs. Unfavourable demographic trends require further steps to boost employment, especially for the elderly and for young people. Measures to fight poverty and to support integration into the labour market are considered an investment in people as well as in the national economy, as they ease the burden on the government budget and promote growth by increasing the supply of labour.

The ESF is partly involved in achieving the key challenges, especially for social inclusion. €41 million from the structural funds is due to be invested in promoting social inclusion for vulnerable groups and €30 million in social infrastructure for the period 2007-2013.

3. SOCIAL INCLUSION

3.1. Key trends

In 2006, 12% of the population was at the risk of poverty, still among the lowest in the EU. However, this figure was high among certain groups of population, such as single person households (39%), women above 65 years (25%), the unemployed (36%) and single parents with at least one child (29%). The intensity of poverty in Slovenia is less severe than the EU average, which is reflected in the relative median at-risk-of-poverty gap of 19% in 2006, one of the lowest in the EU. Poverty in Slovenia is defined as living on €466 per month or less in 2006.

Due to the high employment rate and one of the lowest unemployment rates, only 6.5% of adults lived in jobless households in 2007, while the EU average is 9.3%. More women than men lived in jobless households. The situation has improved, since 8.2% of adults lived in jobless households in 2001. The trend is also positive for children, since the figures fell from 3.8% in 2001 to 2.2% in 2007 living in jobless households (compared to the estimated average for the EU27 of 9.4%). Moreover, 5% of people in gainful employment had an income below the poverty threshold and can be considered as 'working poor' in 2006, compared to the EU25 average of 8%.

The inactivity trap for single persons with no children was 71% in 2006. The unemployment trap in Slovenia is the highest in the EU-27 and increased from 80.5% in 2001 to 94.09% in 2006 (EU27 average: 75.39% in 2006). The indicators on education and skills are good: in the academic year 2007-2008, 48.2% of the population aged 19-23 attended post-secondary vocational training or higher education and the share of early school leavers was low at 4.3% in 2007. Nonetheless, 41% of welfare recipients had a low education level (according to national data), pointing to the need to ensure access to education and training.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Overall, Slovenia has made progress on the objectives set in the NSR 2006-2008. However, some indicators had no quantified target or were not reported on, and it is therefore difficult to assess their implementation. Regarding the challenge to increase the active inclusion of people depending on social assistance, progress has been made as the number of beneficiaries receiving cash social assistance has decreased and nearly 1000 beneficiaries of assistance have found permanent employment. However, in October 2008, the number of social aid assisted increased by 51.18% (from 1061 to 1604), which is presumably due to the initial impact of the economic downturn. In terms of the priority to provide housing to vulnerable groups, progress has been made regarding the number of places for individual vulnerable groups and for temporary residence. Regarding the fight against discrimination and the social inclusion of migrants into society, the NSR reported on measures taken (including an anti-discrimination campaign, research project, etc.), but not on the indicators defined in the NSR 2006-2008 report.

The fourth priority on social protection for the elderly is closely linked to the HLTC and the indicators achieved.

The challenge set in the 2007 Joint Report '*to strengthen the active inclusion of people depending on social assistance, especially young long-term unemployed persons, by ensuring proper accompanying measures and adequate incomes to ensure that those furthest from the labour market are not marginalised further*' is addressed in the NSR report on implementation. However, it is not clear whether regional differences were taken into account. The second challenge of social inclusion '*to undertake with all relevant stakeholders, a thorough analysis of the extent and nature of the discrimination and adapt the suitable strategy*' was only partly addressed. The "Roma Community in the Republic of Slovenia Act" has been adopted. Nevertheless, it is not clear whether a suitable strategy has been adopted.

3.3. Key challenges and priorities

The general strategic approach of the NSR 2008-2010 is based on the thrust and substance of Slovenia's Development Strategy document.

The main quantitative objectives to prevent poverty and social exclusion by 2010 are to: reduce the at-risk-of-poverty rate from 11.7% to 11%, reduce the at-risk-of-poverty rate of people older than 65 from 20% to 18%, reduce the unemployment rate to 3–4% by 2013 with an interim goal to reduce registered unemployment to 6.3% by 2010 (currently 7.4%); reduce unemployment among disabled people to the average rate for Slovenia; reduce waiting periods for integrating persons with disabilities into vocational rehabilitation to under three months. These targets seem ambitious, particularly given the current economic downturn.
The priorities identified in the Report are, to some extent, a reformulation of previous priorities to: (i) provide adequate income support to vulnerable groups in order to prevent social exclusion; (ii) realise the potential of an inclusive labour market in the fight against poverty and social exclusion; and (iii) provide access to social services of general interest in order to prevent social exclusion. These priorities globally correspond to the three pillars of the active inclusion approach. Compared to the 2006-08 period, additional importance is given to child benefit.

However, more attention should be given to employment conditions, especially for young

people, and their housing problem, since 66% of young people aged 16-24 years work with fixed-term contracts (of which 76% are women). Most banks do not grant loans or mortgages to employees with such contracts. The discrepancy between salaries and real estate prices is also growing. This is the start of a vicious circle of a low permanent employment rate of young people, housing problems, consequently low birth rate and high budgetary pressure on pensions.

To tackle the expected rise in unemployment, special emphasis should be placed on the efficiency of employment services to allow quick redeployment measures for those made redundant. Flexicurity, upgrading skills, matching these to labour markets and maintaining household's income are vital under the current circumstances. In addition, the effectiveness of active inclusion policies in cushioning the impact of the financial crisis on vulnerable groups should be examined.

3.4. Policy measures

The Report sets a number of targets, although target values are not defined for all indicators. The first priority objective, which aims *to provide adequate income support to vulnerable groups in order to prevent social exclusion* includes a number of existing social benefits, such as child support, subsidies for kindergartens (to reach a 90% kindergarten attendance rate for children in the second age group and to maintain the current rate of children in the first age group - this target does not seem very ambitious), subsidised school meals, scholarships and income support for persons with disabilities. It also includes support for the elderly, a basic amount of minimum income and cash assistance as a consequence of price changes and the fact that social support may not be adequately indexed to meet these changes. Most of these benefits already exist, therefore the priority measures are not considered to be very ambitious. The NSR does not mention the ESF contribution, even though it is used in some measures, i.e. scholarships. No mention is made of gender differences.

The second priority's objective *to realise the potential of an inclusive labour market in the fight against poverty and social exclusion* will be implemented through a number of ESF measures, including access to employment and training for vulnerable groups, promoting equal opportunities and social inclusion among young persons, and raising public awareness of equal opportunities as a positive social value. The focus is on people with disabilities, migrants and their children, Roma, refugees and their children, women, youth, reconciling family and professional life, social entrepreneurship and innovative ideas for new approaches to employment for the vulnerable groups.

The third priority's objective *to provide access to social services of general importance in order to prevent social exclusion* is tackled via a number of measures to improve access to housing, access to social assistance services (help at home, institutional care of the elderly, occupational activity centres) and access to kindergartens. The measures include increasing the number of places available in various care institutions. Targets for better access to services are: to involve 36% of persons with disability status in day care programmes in occupational activity centres under the Act on Social Care of mentally and Physically Handicapped persons; to increase the capacity of maternity homes and shelters for women to a total framework capacity of 350 places; to increase the capacity of admission centres and shelters for the homeless to a total framework capacity of 250 places; to increase the capacity of the therapeutic programme network providing psychosocial assistance to children, adults and families to achieve full coverage (approximately one expert providing psychosocial assistance per 50 000 inhabitants) and to include vulnerable groups or persons with special needs in

social assistance services, with a special emphasis on developing innovative or alternative forms of service.

3.5. Governance

Good governance is promoted by involving stakeholders in the preparation of the NSR. The Ministry of Labour, Family and Social Affairs coordinated the preparation of the report, which was prepared by a working group split into four subgroups according to subject. The NSR was also presented and discussed at a public consultation event organised for the general public, representatives of interest groups, local communities, NGOs, social partners, providers of the social assistance services, state administration and experts in specific fields. However, closer cooperation with ESF departments would further improve the quality of the preparation of the NSR, given the fund's substantial contribution to social inclusion.

Governance of the social OMC would also be improved by extending the use of quantified targets and establishing appropriate monitoring mechanisms to measure progress. This would also facilitate the work of the evaluation group, which is due to be established by the end of 2008 and will prepare two interim reports.

4. PENSIONS

4.1. Key trends

Low birth rate and prolonged life expectancy puts increasing pressure on the Slovenian pension system. Similarly to EU trends, the ratio between employees and retired people fell from 2.3 in 1990 to 1.7 employees per one retired person in 2007 (national data). In addition, Slovenia still has a low employment rate of older workers (55-64 years), although it rose from 29.0% in 2004 to 33.5% in 2007. In 2007, the average retirement age of men was 61 years and 10 months, and 57 years and 7 months for women. The effective labour market exit age was 59.8 years in 2006, which is one of the lowest in the EU27 (average 61.2 years).With long careers and some years spent caring for children the minimum pensionable age for women and men is 56 and 58 years respectively in 2008 (national data).

The at-risk-of-poverty rate for people over 65 years stabilised between 2004 and 2006 at 19 %. However, the gender gap persists and is widening, as the breakdown in 2006 was 25% for women and 11% for men. The at-risk-of-poverty rate before social transfers is 35% for women and 23% for men. Pensions are indexed to salaries. The relative median income ratio for the age group 65+ in 2007 is 0.86%.

A mandatory earning-related scheme financed on a PAYG basis covers the risks of old-age, disability and survivors. All employees and self-employed persons are covered, and specific categories of inactive persons may join the system voluntarily. The total contribution rate is 24.35% of gross wages. Employees pay 15.5% and employers pay 8.85%. Compensatory contributions for people absent due to unemployment, temporary sickness or caring duties are paid by the general state budget. In the year 2000 a comprehensive pension reform was introduced with a transitional period until 2024. It implies that the pensionable age for women will be gradually raised to 58 years and at least 38 years of pensionable service, while for men a precondition of 58 years and 40 years of pensionable service is already in force. The reform also introduced a fully funded, voluntary supplementary pension scheme.

4.2. Key challenges and priorities

The 2007 Joint Report stated that the challenge ahead is to address financial sustainability and to ensure the adequacy of pensions, notably by considering a further pension reform and by taking complementary measures to increase the employment rate of older workers. During the period 2006-2008 no major reforms of the pension system were undertaken but improvements promised in the NSR for 2006-2008 were introduced, including the One-off Pension Allowance Act (2008), the Minimum Pension Support Act (2008) and the social state pension for people without entitlements. The basic aims of these were to reduce the high pressure caused by rising living costs, especially for pensioners with low pension income, and to ensure a minimum income for older people. In the absence of an agreement with the social partners and sufficient political consensus in 2006, proposals for further changes to the pension system to increase sustainability have been left pending. It remains to be seen whether it becomes part of the new government programme.

Budgetary pressure due to age-related expenditure is higher in Slovenia than in most other Member States. The old-age dependency ratio is projected to double - from 23% in 2008 to 59.4% in 2050. According to an AWG forecast in 2005, public pension expenditure is due to increase to 18.3% of GDP in 2050, a rise of 7.3 percentage points of GDP from 2004. Without policy changes, overall government debt, currently contained at 29.1% of GDP, would rise to about 287.2% of GDP by 2050. The net theoretical replacement rate is projected to rise by 2 percentage points 2006-2046 for an average wage earner retiring at age 65.

According to the NSR, Slovenia aims to have a pension system which not only protects against old age poverty but also maintains pensioners' standard of living. Supplementary pension insurance was introduced to partially compensate for the planned long-term reduction in pension levels under mandatory insurance. In 2007, the ratio of pension/salary was 61.5% and it is predicted to fall to 56.33% by the end of the reform transitional period in 2024 (national data). The at-risk-of-poverty rate for people over 65 at 19% is almost twice as high as the figure for 18-64 year olds (10%). On average a person over 65 has 86% of the average income of a person up to that age.

Changes to the pension system are needed in order to achieve both long-term sustainability and adequacy. In particular, change should focus on promoting longer working lives and reforming the pension system (higher pensionable age, longer contribution periods etc.). However, longer working lives must be supplemented with measures enabling older workers to find suitable employment. Not much has been done in this respect in Slovenia, despite the awareness of the need to achieve higher employment rates among older workers. An active ageing strategy was announced in 2005 but has still not been adopted. Reducing early exits from the labour market and encouraging and enabling older workers to continue working longer, coupled with major changes to the pension system, would be key to ensuring future adequacy and sustainability.

4.3. More people in work and working longer

The employment rate of older workers (55-64) has gradually risen (from 2005 to 2007 by 2.8%) but at 33.5% it is still one of the lowest in the EU, reflecting a long tradition of pensionable ages below 60 and insufficient measures to encourage and enable people to work longer. Currently only 17.7% of all pensioners have a working career lasting more than 40 years, of which 34.2% are men and 5.3% are women (national data).

Existing pension and employment legislation does not provide effective incentives for staying longer on the labour market. Moreover, there is a lack of employment opportunities for the elderly. Therefore an overall active ageing strategy composed of coherent measures targeting both individuals and organisations is essential.

4.4. Privately managed pension provision

Supplementary pension insurance organised by licensed, privately administered pension funds was introduced as part of the pension reform in 2000. Of those covered by supplementary insurance, only 5.48% are on individual schemes, the rest being insured by collective schemes. 55.19% of people covered by statutory pension and disability insurance are also members of a supplementary pension scheme. On the basis of past trends, contribution rates and the return on investments will not be sufficient to compensate for the planned reduction of replacement rates in statutory pensions; this was the case even before the financial crisis. The problem is recognised under the NSR 2008-2010, but no policy response is given. This is another issue where reforming the pension system is much needed.

Supplementary pension insurance is compulsory for persons whose employment is particularly challenging, harmful to their health or those employed in professional activities which cannot be successfully performed after a certain age.

4.5. Minimum income provision for older people

In 2006, the at-risk-of-poverty rate for women over 65 is 25%, for men it is only 11% and the total stands at 19%. The at-risk-of-poverty rate is much higher for older women than men, also according to data before social transfers (for women over 65 it is 35% and 23% for men). The problem of a high risk-of-poverty for older people has been recognised by the government, which aims to reduce it to 18%.

A large share (22.1%) of retired people receives pensions of between €300 and €400 per month, with only 18.3% of pensioners receiving pensions of over €700. However, the amount of average net pension is similar to the minimum wage, which was around €513 in 2007 (national data).

People without sufficient entitlements under the mandatory scheme may claim a means-tested state pension. In 2007 the average monthly state pension was €158.69. In the same year, state pension recipients represented 3.2% of pensioners under mandatory insurance.

6. Information and transparency

The level of financial literacy regarding the supplementary pension insurance system (voluntary part) is rather low and the NSR mentions the need to increase ‘financial literacy’, especially concerning the supplementary pension insurance system.

General information is provided on the Institute of Pension and Disability Insurance (IPDI) website. However, this is not the most effective channel, given the low level of internet usage (20%) among the age group 55-64. Another way to access this information is directly from the IPDI. Since the number of people interested in this information is growing but the number of staff employed at the IPDI remains the same, the response time is becoming longer. A new information mechanism is therefore needed to ensure high quality information.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Slovenia has an insurance-based compulsory healthcare system, financed by the social contributions paid by employees and their employers. A public-private partnership funding model is operated by the Health Insurance Institute of Slovenia and insurance companies. Public funds include compulsory health insurance and state and community budget funds. Private sources include voluntary health insurance funds, part of accident insurance company funds, direct payments from individuals for healthcare services, medicinal products and medical devices, as well as funds of various companies, charity organisations and donors. Statutory health insurance covers almost the entire population (98.7%) and provides a wide range of benefits.

Healthcare provision is delivered by public institutions and private undertakings holding a concession for performing an activity financed by public funds. The municipalities are responsible for capacity and organisation at primary level while secondary and tertiary level healthcare provision is the responsibility of the state. Primary-level provision is seen as insufficient to meet the needs of the ageing population.

The fifth priority of Slovenia's Development Strategy (SDS) and related Action Plan on 'Health as Part of the Quality of Life' sets the framework for the Slovene health strategy. During the last 12 months several acts (Mental Health Care Act), amendments to acts (amendments to Health Care and Health Insurance act) and resolutions (Resolution on National Plan of Health Care 2008-2013) were passed to help improve the efficiency and quality of healthcare. Amendments to the Health Care and Health Insurance act provide a significant contribution to greater social inclusion by providing funding from the national budget for co-financing health services up to their full price for the socially disadvantaged.

Regarding health status, many schemes focused on promoting a healthy lifestyle, prevention and individuals' own responsibility for their health. However differences persist between regions and population groups, although most respondents declared themselves to be in good or very good health. Life expectancy at birth is on the rise (78.3 years in 2006) and is higher for women (82.0 years) than men (74.5 years). Infant mortality is decreasing (3.4 ‰ in 2006), which is among the lowest in the EU-27.

5.1.2. Accessibility

Accessibility is improving. According to OECD data, 98.7% of the population was covered by health insurance in 2005. Those not covered include refugees, asylum seekers, former prisoners and foreigners with temporary residency. In 2006 self-reported unmet needs for total medical and dental care are well below the EU average (SLO 0.2; EU 3.1). Equal access is provided to all citizens at primary level with evenly distributed basic primary and hospital-level healthcare capacity (with the exception of some remote rural areas). Access to specialist outpatient hospitalisation services is not so even and is mainly concentrated in towns and major cities. Differences between regions exist and therefore a minimum level of coverage of the public health service network should be established to ensure more equal access to care.

Compulsory health insurance covers 100% of the costs of treatment only for certain groups of people (children, pupils, students) or for certain services (diagnoses and conditions). For other groups of persons and services, co-payment is requested. The share of out-of-pocket payments (payments for pharmaceuticals and services excluded from the benefits package and access to physicians on a private basis) has increased since 2002. It represented approximately 11.6% of expenditure on health in 2004 and exceeded 12% in 2005. The insured persons pay for these services out of their own funds or take out voluntary supplementary health insurance. This arrangement is in part unfavourable for those without income or in a low income family and may represent a serious financial burden for people in lower socio-economic groups.

Waiting periods have been shortened to some extent but still remain long for orthopaedics, orthodontics, open-heart, cataract and goitre surgery as well as for some more demanding diagnostic tests. The waiting period increased for vascular surgery. Slovenia aims to cut waiting periods to below the maximum permissible periods for closed treatment of primary diseases, with regard to individual treatment groups, through the measures laid down in the draft Resolution on the National Programme of Safety and Health at Work.

5.1.3. Quality

In general, Slovenia is one of the EU-12 that can boast good quality healthcare. The Patients' Rights Act adopted in January 2008 ensures equal treatment for all. To improve quality, authorities introduced six indicators regarding the quality of hospital services to be monitored. Patients have a representative in the Assembly of the HIIS and participate in the management of health institutes. Another important institute is the Ombudsman for Patient Rights.
The introduction of new technologies represents a serious challenge due to a lack of economic evaluation. It is not evident from the NSR that Slovenia would use either the ESF or the ERDF to improve access.

5.1.4. Sustainability

Total expenditure on health (8.5% of GDP and 1.959 per capita $PPP in 2005) is below the EU average (9.0% and 2.454 $PPP) and expenditure as a share of GDP has not changed substantially in the past years. Compulsory health insurance funds accounted for 6.05% of GDP in 2007. An increase was found in private health expenditure. Social insurance contributions represented the main source of funding of health care (72%), followed by the health insurance institute (13%) and payments from households (12%).

As regards coverage of healthcare professionals, a certain deficit in physicians (primary level) and nursing staff (secondary and tertiary levels) has been noted in recent years. Slovenia had around 2.48 doctors, 0.65 dentists, 1.9 nurses (or 6.4 health care providers) and 4.76 hospital beds per 1 000 inhabitants in 2006 (national data).

Great emphasis is laid on carrying out and implementing health promotion programmes, early detection of risk factors for chronic and degenerative diseases and on educational and awareness-raising programmes to heighten citizens' responsibility for their own health.

5.2. Long-term care

5.2.1. Description of the system

Although preparation of the new law on long-term care had commenced in 2005, Slovenia still lacks a coherent system of long-term care. Services and benefits are provided by the system of health care, social security, pension and disability insurance and by special regulations governing the status of persons with disabilities and war veterans, but

coordination is poor. The main source of funding is compulsory health insurance. Providers, both public and private, provide different services under institutional forms of assistance and integrate healthcare and social areas, although assistance has not been integrated in the context of forms provided in the living environment. Some services are provided in the form of institutional health care as well as home care by close relatives. The current organisation of long-term care does not fully provide users with quality, equal and needed access to services.

5.2.2. Accessibility

As regards available capacity, the situation is improving, but demographic trends are not favourable and the current capacity available in the health and social security system does not cover actual needs. The waiting periods to receive a number of services are still relatively long, geographical coverage is uneven and there is a lack of doctors and medical nurses. Provision of home-care services is insufficient and underdeveloped. In addition, demographic changes and the reconciliation of work and family life mean that fewer and fewer families are able to take care of elderly family members at home.

5.2.3. Quality

The quality, rights and access to long-term care differ between individuals in institutional care and those cared for at home. While the former can get quite comparatively good treatment the latter is not ensured the same quality. Lack of capacity in institutional care and underdeveloped home care coupled with the lack of coordination are the main challenges to quality provision.

5.2.4. Long-term sustainability

More than half of the expenditure on social services for long-term care is funded from public sources, with the rest covered by private funds, comprising extra payment for lodging and food in homes for elderly and other types of institutional care. The draft Act Amending the Health Care and Health Insurance Act is expected to provide for more stable financing of health care, shaping healthcare programmes and services and their prices in partnership. The objective of the Act is also to improve the payment of contributions and to more effectively manage healthcare expenditure. New long-term care insurance is also due to be introduced, aiming to bring in personal co-payments and voluntary insurance for long-term care.

6. CHALLENGES AHEAD

- To promote social and labour market inclusion of young people and to address the barriers to accessing housing.

- To improve governance, particularly by extending the use of quantified targets, establishing appropriate monitor mechanisms to measure progress and enhancing cooperation with ESF departments.

- To reach agreement on and carry out major changes to the pension system in order to address the long-term financial sustainability and adequacy of pensions and to substantially step up efforts to increase the employment rate of older workers.

- To further improve access to the healthcare system, notably by further reducing waiting lists and improving access to new pharmaceuticals, while continuing to improve system efficiency.

- To establish a coherent and better coordinated long-term care system with sufficient capacity and services provided by trained personnel.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	4,4	79,8	2000	62,8	67,2	58,4	31,2	22,7	2000	6,7	6,5	7,0	16,3
2005	4,3	87,4	2005	66,0	70,4	61,3	34,1	30,7	2005	6,5	6,1	7,0	15,9
2008*f*	4,0	89,3	2007	67,8	72,7	62,6	37,6	33,5	2007	4,9	4,0	5,9	10,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	70,8	78,5	13,6	17,6	n.a.	n.a.	5,5	1995	n.a.	n.a.	n.a.		-
2000	72,2	79,9	14,2	18,7	n.a.	n.a.	4,9	2000	8,4	74,0	11,5	2005	0,3
2006	74,5	82,0	15,8	20,0	57,6	61,0	3,1	2006**	8,5	72,4	12,4	2006	0,2

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	24,2	45,2	30,7	4,3	9,2	1,6	9,0
2006	22,8	45,4	32,1	3,0	8,6	2,5	8,5

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	23,0	24,2	11,0	6,4	0,9
2010	23,9	-0,2	0,1	0,3	0,2
2030	40,8	4,4	3,4	1,2	0,6
2050	59,4	9,6	7,3	1,6	1,3

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	12	11	10	19	19	21	19	20	3,3	2005	12b
male	10	-	10	11	19	-	20	15	-	2006	11
femal	13	-	10	25	20	-	19	20	-	2007	10

People living in jobless households

	Children Total	% of people aged 18-59* Total	Male	Female
2001	3,8	8,2	7,1	9,4
2004	3,8	7,5	7,0	8,0
2007	2,2	6,5	5,5	7,5

Long Term unemployment rate

	% of people aged 15-64 Total	Male	Female
2000	4,1	4,1	4,2
2004	3,2	3,1	3,4
2007	2,2	1,8	2,7

Early school-leavers

	% of people aged 18-24 Total		Male	Female
2000	n.a.	n.a.	n.a.	n.a.
2004	4,2u		5,8u	2,6u
2007	4,3u		5,7u	2,7u

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,86	1	0,81	***Aggregate replacement ratio***	0,44	0,51	0,39

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046) Net Total	Gross replacement rate Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	*Assumptions* Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
2	-4	-4	DB	/	-	100	/	24,35	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Slovakia

1. SITUATION AND KEY TRENDS

Slovakia continued to register a high GDP growth rate - the highest in the EU in 2008 at 7.1% (forecast at 2.7% in 2009). GDP per capita increased by 5 percentage points (pp) to 68.4% and then to 69.1% of the EU average in 2007 and 2008, respectively. Strong growth was only partially reflected in better labour market performance in 2007, with total employment increasing by 2.1% to 60.7%, and female and male employment growing by 2.2% and 2.0% to 53% and 68.4% respectively. Despite the fact that the employment rate for older people (55-64 years) has been steadily increasing from 23% in 2002 reaching 36% in 2007 (men: 53%, women: 21%), mainly due to the raised minimum pension age, it is still one of the lowest in the EU. Since 2000, the employment rate for young people (15-24 years) has been among the lowest in the EU: in 2007 it stood at 27.6% (men: 30.9%, women: 24.1%). The unemployment rate, despite slowly but steadily decreasing from 18.8% in 2000 to 11.1% in 2007 (men: 9.9%, women: 12.7%), remains the highest in the EU. It particularly affected young people, at 20.3% in 2007, even if it fell dramatically from 37.7% in 2002. Significant regional employment and unemployment disparities persist.

The poverty risk rate was 11% in 2007, with a higher risk for children at 17%. By contrast, people over 65 faced a significantly lower risk at 8% (men: 3%, women: 11%). Infant mortality (6.1 in 2007) is the seventh highest in the EU although it has improved considerably over the years (10.2 in 1996).

The current and projected old-age dependency ratio 65+ is well below the EU average: it is set to increase from the present 16.6% in 2008 to 16.9% in 2010, 32.3% in 2030 and 55.5% in 2050. Total gross social protection expenditure in 2006 decreased by 3.5 pp. to 15.9% of GDP compared with 2000. Health and pensions represented the bulk of expenditure in 2006 (31% and 45.3% respectively).

The NSR does not mention that a significant proportion of the labour force is currently working abroad (ca 7%), which has a favourable impact on the employment, unemployment and poverty rates. The largest minorities are Hungarians (ca 10% of the population) and Roma. According to estimates, up to 380 000 Roma live in Slovakia, of whom 60% live integrated and scattered among the majority population.

The Slovak government announced in its Resolution from December 2008 a number of measures aimed to support the financial sector and real economy including labour market in the light of the current financial crisis. The cutting of public expenditures is necessary in order to reach the planned deficit of 1.7% in 2009; however, the Government declared that savings cannot be made in the social area, where an ambitious social package for 2009 had been approved. The Government does not envisage any tax increase or decrease and intends to continue in the fiscal consolidation. It appealed to social partners to keep the wage increase very modest in the coming period, and it will introduce a monitoring system for price development. The Government wants to support citizens endangered by massive redundancies also through ESF (counselling, education, and requalification) and support job creation, establishment of new companies and self-employment.

2. OVERALL STRATEGIC APPROACH

The new NSR outlines the same priority objectives as the NSR 2006-2008: this could be seen as an advantage, as continuity in the social inclusion area facilitates mobilisation of resources. On the other hand, it cannot go unnoticed that the text of sections devoted to priorities has been largely taken from the previous NSR, suggesting a 'time-saving' approach to drafting and reduced political importance assigned to NSR preparation. Main strategic messages identified in the previous NSR are no longer highlighted. NSR acknowledges its links to the Slovak and Renewed Lisbon Strategy, Modernisation Programme Slovakia 21, and NSRF. ESF co-financing is planned for all three policy measures although no concrete financial data are provided. The texts of both 2007-2013 ESF OPs plan projects to improve education for disadvantaged groups and marginalised Roma communities (MRC), further education for employees in the healthcare sector, support for employment growth through ALMP and modernisation of employment services, support for social inclusion through increased availability and efficiency of social care services and community work, and capacity building for the public service and NGOs. Gender equality is to be ensured through legislative activity and coordinated by the Slovak Government Council for Gender Equality. Disability is mainstreamed, but the approach is fragmentary and a commitment to ensure accessibility for disabled to public services is missing. In general, the NSR seems to be a compilation of existing and draft policies rather than a strategic planning document.

3. SOCIAL INCLUSION

3.1. Key trends

Since 2004, the risk of poverty, with a negligible gender difference, has dropped slightly (from 13% to 11%), as has the risk for children (from 19% to 17%), while the risk for people 65+ has risen a little (from 7% to 8%) compared to 2007 data. The share of adults and children living in jobless households has decreased since 2006 (9.6% and 11.8% respectively) to currently 8.9% (men: 8.1%, women: 9.6%) for adults (EU: 9.3%) and 10.6% for children (EU: 9.4%). The poverty gap is slightly below the EU average translating into 19% for the total population and 21% for children while people 65+ are better protected at 12%. In 2006, the poverty threshold stood at 1988 EUR in Slovakia which is 4 times less than EU25 average.

Full time in-work poverty at 5% is in 2007 below the EU average of 8%. An annual increase of 0.7% on average was recorded over last three years in the rate of early school-leavers, reaching 7.2% in 2007 (EU: 14.8%). The unemployment trap fell from 70% in 2003 to 44% in 2006 (EU: 75%), as well as the low-wage trap for 1 earner couple with 2 children from 124% in 2002 to 29% in 2006 (EU: 62%).

The gender pay gap (22% in 2007) placed Slovakia in the second highest position (EU: 15%). A survey of living conditions of Roma in Slovakia published by the UNDP in 2007 estimates that 10.5% of Roma men and 4.6% of Roma women of productive age are employed.
The SK report does not devote sufficient attention to some important trends, e.g. labour force migration outflows or regional disparities. Neither does it cover the question of the social protection system and a minimum income, despite references to 'state social benefits' in some parts.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Some progress has been recorded under all priorities. Positive developments towards targets set for employment and poverty rates in Slovakia are arguably attributable not to the social inclusion policy alone but inter alia to overall economic growth and intra- and extra- EU labour mobility. Nonetheless, it is important to note the fact that EU-SILC did not take into account Roma population living in marginalised communities (ca 100 000 people in mostly jobless households), which is not mentioned in the NSR. 'Reducing child poverty' priority is reported to be tackled by education policy and related financial support programmes, assuming that the new Education and Upbringing Act suffices to solve the problem of poverty of children in MRC, as no other positive and/or equalising measures are described. Most of the quantified indicators have been achieved, except the most important one, namely inclusion of Roma children in standard schools. 'Increasing inclusion' priority reports on the progress by describing several activities in the area of legislation, housing development, a scholarship grant programme, and cultural needs development, but without presenting a comprehensive picture with clear policy co-ordination. Quantified objectives were mostly reached: the availability of social services, quality of social protection, or availability of housing for vulnerable groups increased slightly. SK authorities dealt with 'Improving labour market access' priority primarily through the 2008 amendment of the Employment Services Act, which introduced new ALMP tools such as creating social enterprises or engaging municipalities. ESF projects have been implemented in order to create local social inclusion partnerships supporting the Roma minority. 'Governance' priority was greatly assisted by EU-SILC as regards the quality and reliability of data. Both rather ambiguous targets (creation of a webpage and ESF-supported local partnerships) were achieved.

3.3. Key challenges and priorities

Priority objectives of the 2008 NSR are identical to NSR 2006, with slightly expanded and adjusted indicators. These objectives are in line with the jointly defined 2007 challenges, although the social inclusion of vulnerable groups in particular MRC through e.g. housing measures is not sufficiently addressed. The contribution of the ESF is expected under all three priorities; exact financial allocations are not presented.

The text of new NSR suggests a lack of coordination in the inclusion policies and a tendency to narrow the aim of ensuring 'access for all' to legislative changes instead of comprehensive equalising measures. NSR formally deals with all seven EU key policy priorities; least emphasis is put on sustainable social protection schemes together with minimum income schemes and decent accommodation. For the first time, the NSR aims to strengthen the gender equality principle, through a new gender equality body and labour market measures, although work and family reconciliation is seriously neglected.

3.4. Policy measures

– Reduce child poverty and eliminate its inter-generational transmission by preventive measures, and support families with children.

Without presenting a coherent strategy, the NSR describes several multi-dimensional but not integrated measures in the field of education: equal opportunities in access to and quality of education, pre-school education, new Lifelong Learning Act; and social security: increasing child benefit and parental allowance with proper targeting and subsidiarity, and raising the quality and quantity of social work. Quantified targets have been set for reducing child poverty risk, improving access to education for low-income families, enhancing social inclusion of Roma children into education, and reducing the average length of stay of children

in children's homes. The NSR does not raise the legal problem of identifying Roma children: in Slovakia, ethnic data are based on self-declaration which precludes assessing the effectiveness of measures implemented.

– Raise inclusion and fight discrimination of vulnerable population groups by supporting the availability of public services, developing local solutions and raising participation of excluded groups in the life of society.

Improving social services (availability and quality, modernisation and variability) is seen as a key tool to reach this objective; other measures are providing support for affordability of housing, access to health care, and digitisation of the Slovak cultural heritage. The legislative framework will be further developed by a draft Act on financial benefits to compensate for severe disability and a Social Services Act. However, it is not clear what measures will be taken in the area of housing or health care. The main objectives of planned measures are to improve social services, raise the quality and effectiveness of measures for socio-legal protection and social guardianship, map the current social network, increase the availability of housing, improve access to health care, financial programmes, and untraditional forms of education for vulnerable groups.

– Improve access to the labour market and raise the employment and employability of groups at risk of exclusion.

Assuming that 'employment growth is the most effective means of economic growth in developing an inclusive society', Slovakia aims to address long-term unemployment through new active labour market policy measures (co-financed by the ESF), and a new Action plan for the prevention and elimination of violence against women, with particular attention to immigrants and ethnic minorities. Efforts of all stakeholders should be merged into establishing a comprehensive flexicurity approach. It is important to strengthen the role of education and training and participation in lifelong learning in raising the employability of persons at risk. Plans to establish social enterprises as a new tool for supporting employment of disadvantaged jobseekers could be seen as a positive step in the active inclusion of vulnerable groups. Quantified objectives are set for reducing the long-term unemployment rate, youth unemployment, share of people living in jobless households, and expanding social development programmes, etc.

In general, some indicators lack a baseline or normative direction, precluding the assessment of their achievement. Slovakia provided six examples of good practice but their presentation is rather formal and cannot serve as a learning experience for other MSs. Disability aspects have been taken into account by a fragmentary rather than a cross-sectional approach. Gender perspective is limited. A description of current situation is missing in many cases (housing, health care, child poverty), so policy measures do not logically follow from the analysis. Specific vulnerable groups other than Roma are not directly targeted. Mainstreaming of social inclusion does not seem to be achieved; the issue of elderly people is underestimated.

3.5. Governance

Preparation of the NSR, coordinated by a working group comprising representatives of the central administration and publicised on a new web site focusing on social inclusion, received no media attention. For the first time in the history of the OMC in Slovakia there were no consultations with NGOs or any other stakeholders, such as people suffering from poverty or

experts dealing with gender equality. No arrangements for stakeholder- involvement over the full policy cycle are envisaged. Although gender equality is proclaimed to be an important aspect of social inclusion, the gender dimension in the NSR is negligent. Current legislation is at a sufficient level but more efficient implementing mechanisms need to be developed. Implementation part of the NSR is limited to a description of monitoring mechanisms for ESF implementation, which is clearly insufficient. Monitoring and evaluation of the NSR is claimed to be ensured through an ESF project 'Statistical monitoring of living conditions of selected target groups, in particular Roma communities', as well as the creation of a new national database of indicators in the field of poverty and social exclusion. For this priority, no quantified objectives have been set.

4. PENSIONS

4.1. Key trends

The pension system in Slovakia consists of three pillars: a public DB PAYG scheme (mandatory pension insurance) operated by the Social Insurance Agency, a privately managed funded scheme on the basis of defined contributions (old-age pension saving, previously mandatory and recently made optional for new entrants to the labour market), and a voluntary supplementary privately funded pension scheme. The 2005 pension reform, resting on reshaped pension insurance and the introduction of a fully funded second pillar, made important steps to improve the long-term financial outlook of the pension system as regards the ageing population, low employment rates and disincentives to pay social insurance contributions. With almost 1.6 million entrants to the newly created pension savings scheme, transition costs exceeded projected expenditures needed to cover the shortfall in PAYG revenues.

The standard retirement age is set at 62 years for men and women; men at present retire at 62 years of age, while women will reach the uniform retirement age of 62 in 2024. The effective exit age from the labour force in 2005 was 59.2 years (men: 61.1, women: 57.6) and it even decreased in 2007 to 58.7 years. Persons who have joined the private scheme contribute 9% of their gross wage to the public pillar and 9% to the private scheme against 18% for persons taking part only in PAYG. Aggregate replacement ratio in 2007 is 0.54 in total.

According to 2006 ECFIN-EPC report, the projected increase in total pension expenditure is higher than EU25 average of 2.7 percentage points, rising by 4 pp of GDP between 2004 and 2050. Theoretical replacement rates for a worker retiring at 65 after 40 years of average earnings should remain stable over the coming decades, with the net rate increasing slightly from its present level (2006) of 63.1% by 1.9 pp until 2046 and the total gross rate from 49.4% by 1 pp until 2046.

4.2. Key challenges and priorities

The financial sustainability of pensions has become an urgent priority. This issue was pointed out also in 2006 Synthesis report on adequate and sustainable pensions, which stated that 'additional measures to reform the PAYG scheme further might be needed in order to avoid running into heavy debt'. According to DG ECFIN assessment, Slovakia overall appears to be at a medium risk with regard to the sustainability of public finances. However, NSR avoids discussing the deficit in the public pension fund. Another future challenge is the fact that employed people paying minimum social insurance contributions (low-income workers, self-employed) could be entitled to future pensions below the minimum subsistence level.

Slovakia tried to address 2007 challenges aimed at ensuring the long-term sustainability of public finances through several approved or soon to be approved legislative amendments of the second pillar. Facts presented suggest they contribute merely to a short-term alleviation of financial pressure in the public pension scheme without truly reforming it, largely at the expense of the second pillar. Changes to conditions in the pension system could be seen as controversial as they risk weakening the reliability of the whole system and undermining its long-term sustainability.

Some positive effects brought by 2006 reforms include greater solidarity on account of the merit principle bringing higher benefits for low-income insured persons. On the other hand, extension of the period of insurance necessary for claiming an old-age pension from 10 to 15 years may exclude certain groups of women. Currently, the actual average level of pensions is significantly lower for women (lower wage, less years worked), but by way of example no specific measures in case of divorce are envisaged.

Key challenge for Slovakia is first to ensure long-term sustainability and subsequently to bring stability to the pension system by creating a transparent and stable legislative environment. In order to strengthen the contribution base and allow people to accrue additional pension rights, it is necessary to raise employment rates for both men and women in general and older workers in particular and to lower unemployment.

4.3. More people in work and working longer

Employment rates of older workers have increased quite markedly in recent years (26% in 2004 compared to 35.6% in 2007) mainly due to a rise in the legal retirement age and increased work incentives introduced by the 2005 pension reform. Participation of women at 21.2% falls clearly behind that of men at 52.5% in 2007, as a consequence of the slower increase their in retirement age and probably also traditions.

As of 1 January 2008, the revised pension legislation tightened access to early retirement, namely early pensions can be claimed no sooner than 2 years before reaching official retirement age after at least 15 years of pension insurance contributions, reduced by 0.5% for every 30 days of early retirement. The legislation preserved the possibility for pensioners to concurrently receive a pension and a salary from employment.

The NSR does not mention the rising trend in economic inactivity of disabled people and the increasing number of recipients of incapacity benefit (up 6.7% in 2007 on 2006).

4.4. Privately managed pension provision

On 31 December 2007, 1.56 million savers had personal pension accounts in 6 pension management companies, representing 40% of the productive age population or 59% of the economically active population. The overhaul of the pension system effective from 1 January 2008 comprised a temporary opening of the second pillar (6 months period during which savers had the chance to leave or join the 2nd pillar – more than 104 000 persons left, and some 20 000 joined, reportedly on account of the financial crisis it was opened again from 15 November 2008 until 30 June 2009; measures to tighten limits on investments in different types of securities were also approved), an increase in the minimum saving period needed for pension entitlement from 10 to 15 years, and the 2nd pillar being made optional instead of mandatory for new entrants to the labour market (data from 2006/07 suggest that less than half of young people signed contracts with pension management companies). This change will immediately increase funds for public pensions in the 1st pillar, thus postponing the full positive effect of the establishment of the 2nd pillar.

4.5. Minimum income provision for older people

Act on Minimum Subsistence has increased as from 1 January 2009 the minimum subsistence level to 28.8% of the average wage in the economy in 2007. This change would represent a significant increase of the minimum subsistence level and a significant restriction of entitlements to an early pension. Pensioners whose income is below the effective minimum subsistence level are entitled to material need benefits.

The latest 2007 EU SILC data on risk poverty rates confirm that older people are the population group least under threat; only 13% of people 65+ (6% men, 17% women) before social transfers except old-age and survivor's benefits are threatened compared to 18% of the total population. Social transfers play an important role in preventing the risk of poverty: they reduce it to 8% for people 65+ and 11% for the total population. Relative median of the poverty risk gap for 65+ people is 12% (19% men, 11% women), compared to 19% for the total population.

The provisions for the minimum pension are not established. The material need allowance for a single person is ca 56 EUR and for a couple ca 97 EUR per month. In case of all types of pension benefits including old-age, early retirement and invalidity, the level of pensions received by men in comparison with women is on average by 36.5-59.7 EUR higher – men receive on average 236-331 EUR. The average period of pension insurance for newly-awarded old-age pensions is 5-7 years longer for men than for women. Slovakia suggests that positive improvements could be expected due to the coverage of pension insurance periods in case of defined situations such as caring for children, where pension insurance premiums and contributions for old-age pension savings have been paid by state since 2005.

4.6. Information and transparency

The amendment effective as of 1 January 2008 introduced the obligation for the Social Insurance Agency to allow every insured person passive access to information on changes to the balance of their individual account free of charge via its website (1st pillar), and for fund management companies to provide the National Bank of Slovakia every working day with information on transactions involving assets in the pension fund (2nd pillar).

NSR does not ascribe any role to social partners or other stakeholders. Provision of adequate information for personal pension planning remains highly important, in particular due to frequent changes in pension legislation and the presumably insufficient level of financial literacy and awareness among the population.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

A compulsory social health insurance scheme, with multiple health insurance companies acting as purchasers of care, provides universal comprehensive coverage to almost all residents. The provision of health care is decentralised and based on a public-private mix. Service providers operate on the basis of contracts concluded with health insurance companies. Most hospitals and polyclinics have been decentralised to municipalities. The social insurance system is financed mainly by insurance contributions and by state contributions on behalf of certain groups. Voluntary health insurance has a limited but growing role and informal under-the-table payments are common. Certain groups of population suffer from worse health status; in particular marginalised Roma communities and the homeless.

The complex reform package of six major laws on the health-care system launched in 2004 aimed to improve efficiency of the system by promoting role of the private sector in health care provision and insurance, stipulating universal coverage, a basic health care package, and introducing symbolic out-of-pocket fees for patients. The legislative amendments adopted after 2006 suggest a certain distrust of policy makers towards market principles, for example forbidding private insurance companies to pay out profit to shareholders, forbidding patients' fees, and giving preferential treatment to state healthcare providers. It is not clear to what extent the described measures can ensure accessibility, sustainability and quality.

Slovakia had in 2006 one of the lowest life expectancies of men (70.4 years) with better prospects for women (78.4 years). According to the most recent information (2002), median lifespan in the Roma population is under 60 years. Healthy life years are 54.3 for men and 54.4 for women in 2006.

5.1.2. Accessibility

The vast majority of population is covered by health insurance (96.3% in 2006) and health care services are broadly and freely accessible to the population. Symbolic out-of-pocket payments (0.7-1.7 EUR) for drug prescriptions and outpatient and institutional care were abolished in 2006. The system features some additional charges for medicines, dental treatment, or prostheses: in 2006, the out-of-pocket payments represented 25.9% of the total health expenditure. Regional discrepancies and inequalities in access for some vulnerable groups still persist.

The new 2007 amendment on healthcare introduced healthcare districts whereby first-contact doctors in each of these districts are obliged to provide healthcare to persons residing in their district (general practitioners for adults, for children, gynaecologists, and dentists) whilst preserving freedom in choosing a healthcare provider. Another new 2007 amendment on healthcare providers established a general minimum public network of care facilities including a fixed network of emergency healthcare services.

The Ministry of Health is running the programme "Supporting the Health of Disadvantaged Communities in Slovakia", which so far has only been implemented in some marginalised Roma communities. As from 2009 it should be extended to other disadvantaged groups such as refugees or homeless.

The access to general medical services and dental care is considered to be satisfactory: self-reported unmet medical and dental care needs were 2.8% and 3.5% in 2006, respectively, compared to the EU averages of 3.1% and 5%, but with worse self-perceived access for the poor. Although not mentioned in NSR, 2007-2013 ESF programmes should support the access of disadvantaged groups to health care.

5.1.3. Quality

The awareness of patients and medical personnel of patients' rights is rather low and patients' involvement is not encouraged. The use of information technology is rather underdeveloped. The Health Insurance Companies Act from 2004 established an obligation for each company to evaluate the quality of healthcare providers and rank them according to their success rate in fulfilling criteria for quality indicators drawn up by the Ministry of Health. The Ministry also issues expert guidelines in order to introduce new, effective and uniform diagnostic and medical procedures in the treatment of selected, society-wide serious illnesses. Currently there is no evidence that this system is working effectively. The Operational programme Health may enhance the quality of health care with ERDF total allocation of 250 million EUR. Specific measure was introduced in 2007-2013 ESF Operational Programme Education aimed at education of healthcare specialists.

An order under preparation by the Ministry of Health on minimum requirements for staffing and material and equipment provision for individual types of healthcare facilities is reported to contribute to improving quality in the provision of health care and patient security. Institutional health care is provided on approx. 37 thousands beds, while insurance companies are obliged to conclude contracts for min. 29 thousands bed.

5.1.4. Sustainability

Total health expenditure (7.1% of GDP and 1130 US$ PPP per capita in 2005) has followed a relatively stable and slightly rising trend since the beginning of data provision for Slovakia (5.7% of GDP and 564 US$ PPP per capita in 1997). Both indicators are currently among the lowest in the EU. The share of public expenditure spent on health was 68.3% in 2006, down from 91.7% in 1997. DG ECFIN age-related projections show an increase in public expenditure of 1.9 percentage points of GDP between 2004-2050, which is among the highest in the EU (EU25: 1.6 pp), from 4.4% in 2004 to 6.3% of GDP in 2050. Expenditure on pharmaceuticals was the second highest in the EU as a share of GDP in 2005 (2.3% of GDP). Despite being singled out as a challenge ahead in the 2007 Country fiche, the area of financial sustainability is completely neglected in NSR. One of the key features of the current system is the very weak link between contributions and benefits, which may result in disincentives to pay health insurance contributions, weakened responsibility for people's own health condition, insufficient motivation to demand quality services, or excessive demand for 'free' care.

The NSR basically neither mentions crucial problems of Slovakia in the area of financial sustainability nor presents solutions. The debt in health care facilities according to Report on Development of Debts in Health Care rose from 186 million EUR in 2006 to 270 million in 2007, even despite a significant increase in public expenditures on health care. The reasons include strong economic development and the associated wage growth and the increase in payments by the state on behalf of economically inactive policyholders.

5.2. Long-term care

5.2.1. Description of the system

NSR understands long-term care as provision of social services and a financial contribution for care and personal assistance. Residential and non-residential care is provided mostly by municipalities and self-governing regions in pensioners' homes, lodging houses, nursing service facilities, day or rehabilitation centres, at home (chiefly through nurses), in regional integration centres and in state-owned care facilities. The system is financed by a mix of public (state budget, public health insurance funds) and private funds (with co-payments based on income).

Almost all measures described in the 2006 NSR relied on the approval of the Act on Social Services which has came into effect on 1 January 2009, so hardly any of them have been achieved. Similarly, the 2008 NSR in the area of long-term services depend entirely on provisions of the above Act, presenting a thorough analysis of challenges (population ageing, increased need for assistance to dependent persons, co-ordination of social services and health care) and proposed measures and policies to alleviate them. The long-awaited Act is seen as a milestone in the reorganisation of social services and almost a panacea. However, it has been heavily criticised by NGOs, mainly on account of restrictions as concerns freedom to choose a service provider. Basic legislative conditions for tackling challenges identified in the 2007 report were fulfilled as the Bill was passed; however, Slovakia needs to be aware that the real implementation of challenges starts only now.

5.2.2. Accessibility

The report highlights that the availability of social services is significantly influenced by policies of regional authorities, some of them being insufficiently equipped in terms of personnel, expertise, and technical equipment. The implementation of the Social Services Act should eliminate admission waiting lists within two years and reduce regional inequalities in provision of services. Its main assets include the authorisation and registration of care providers, a broader spectrum of care and provision of services, community development support, interconnection and coordination of health care and social services, income protection, financing mechanisms, qualification requirements with regard to human resources, monitoring and supervision of provision of services.

5.2.3. Quality

The NSR acknowledges the absence of quality standards and supervision, and underdevelopment in the area of human resources education. Available information suggests that services of higher quality are delivered by private care providers. Personal assistance is seen as one of the most progressive forms of social aid to severely disabled, based on the philosophy of independent living. The Social Services Act explicitly lays down recipient's right to choose the type and form of the service, enabling them to remain in a home environment, and also guarantees a residual income after paying for a social service.

5.2.4. Long-term sustainability

The NSR claims that the most fundamental problems of the current legal situation affecting financial sustainability remains the insufficient funds for covering the needs of dependent persons, the unequal position of public and non-public social services providers, and the insufficient support for the family caring for a relative. The Act should eliminate the above-mentioned shortcomings, allowing social services to be funded also from other sources (funds from associations of municipal and county authorities, health insurance company funds, income from social enterprises). However, except for the above, the NSR does not specifically address the issue of long-term financial sustainability. DG ECFIN age-related projections show an increase in public expenditure of 0.6 percentage points of GDP between 2004-2050 from 0.7% in 2004 to 1.3% in 2050.

Even if not mentioned in the NSR, 2007-2013 Structural Funds could be used in this area, in particular as regards synergies between social services and long-term care. Some support for informal carers is already established and should be further developed by the new Act (existing: financial contribution for care, pension insurance premiums paid by state for carers, new: respite care). Gender aspect is completely neglected in this field.

6. CHALLENGES AHEAD

- To increase the overall employment rate and reduce the unemployment rate, to improve access to the labour market and to increase the employability of vulnerable population groups through more targeted measures. To intensify provision of employment services at regional level to ensure a smooth transition of the potentially released qualified labour force to available job vacancies in the context of the financial crisis.

- To promote an integrative and comprehensive active inclusion policy and the social inclusion of vulnerable population groups in particular marginalised Roma communities, through support for public services and by addressing housing shortages, and to raise public awareness and step up fight against discrimination. To build a reliable institutional background for taking up this challenge.

- To strengthen the co-ordination, management, implementation, and monitoring of policy measures at national, regional, and local level with the participation of all stakeholders, and to reduce regional disparities.

- To ensure that sufficient resources for adequate pensions are available in the long run, and ensure that the pension system is predictable and that the transition costs of the partial shift into private funded schemes can be met and the long-term sustainability of public finances maintained.

- To ensure universal access to high-quality healthcare and better access to long-term care services by improving their provision and funding. Given the low population health status and reasonably good economic growth more funding could be allocated to effective and targeted health promotion, disease prevention and ensuring equitable access to care.

- To develop a stable, adequate and financially sustainable healthcare and long-term care systems based on a rational use of resources, the integration of health and social care sectors into one comprehensive system, and addressing the issue of human capital management and patients direct financial burden of care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	1,4	47,5	**2000**	56,8	62,2	51,5	29,0	21,3	**2000**	18,7	18,9	18,5	37,1
2005	6,5	55,0	**2005**	57,7	64,6	50,9	25,6	30,3	**2005**	16,3	15,5	17,2	30,1
2008*f*	7,1	69,1	**2007**	60,7	68,4	53,0	27,6	35,6	**2007**	11,1	9,9	12,7	20,3

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	68,4	76,3	12,7	16,1	n.a.	n.a.	11,0	**1995**	n.a.	n.a.	n.a.		-
2000	69,2	77,5	12,9	16,5	n.a.	n.a.	8,6	**2000**	5,5	89,4	10,6	**2005**	3,2
2006	70,4	78,4	13,3	17,3	54,3	54,4	6,1	**2006**	7.1**	68,3	25,9	**2006**	2,8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	18,5	38,1	33,0	3,5	14,0	4,6	6,8
2000	19,4	37,2	34,9	4,8	9,0	6,5	7,6
2006	15,9	45,3	31,0	3,5	7,8	3,6	8,7

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	16,6	16,2	7,2	4,4	0,7
2010	16,9	-0,8	-0,5	0,3	0,1
2030	32,3	0,3	0,5	1,3	0,2
2050	55,5	2,9	1,8	1,9	0,6

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20
Total	11	17	9	8	19	21	20	12	3,5
male	10	-	9	3	22	-	22	19	-
femal	11	-	10	11	17	-	19	11	-

Anchored at-risk of poverty	Total - fixed 2005 threshold
2005	13b
2006	9
2007	5

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	9,3	10,0	9,6	10,5
2004	12,8	10,8	10	11,6
2007	10,6	8,9	8,1	9,6

	Long Term unemployment rate % of people aged 15-64 Total	Male	Female
2000	10,3	10,3	10,2
2004	11,8	11,3	12,4
2007	8,3	7,4	9,3

	Early school-leavers % of people aged 18-24 Total	Male	Female
2000	5,6	6,7	4,6
2004	7,1	7,8	6,4
2007	7,2	8,1	6,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,86	0,75	0,87	***Aggregate replacement ratio***	0,54	0,53	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
2	1	1	DB/DC	/	-	100	/	28,75	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Finland

1. SITUATION AND KEY TRENDS

Finland's GDP grew by 4.4% in 2007 and continued to grow in 2008. However, the forecast for 2009 shows negative growth of 1.2%. The employment rate, standing at 70.3% in 2007, was well above the EU average (65.4%) and has shown a positive trend in recent times (67.2 in 2000); this, however, is expected to decrease by -1.5% in 2009 as a result of the economic downturn. The unemployment rate had also fallen below 7% (in April 2008 the cyclically adjusted unemployment rate was 5.8%), but is predicted to reach 7.8% in 2009 and 8.0% in 2010. The rise in unemployment will be counterbalanced to some extent by the decline in labour supply, since larger cohorts will retire and smaller ones enter the labour market.

Long-term unemployment has fallen but remains a major cause for exclusion and is often associated with other risk factors. The youth unemployment rate continues to decrease but is still relatively high (16.5%). The employment rate of foreigners born outside the EU-25 was 55.8% in 2007 while the employment rate of natives was 70.5% and that of those born in another EU country 74.8%. The unemployment rate of persons born outside the EU-25 was as high as 19.1% in 2007.

In 2007, 13% of Finns lived on less than 60% of the median income (in 2003 11%). The number of those at relative risk of poverty has risen even though the income of those on a low income has also increased. Certain households have a higher than average risk of poverty: elderly women (24%) and unemployed (41%). Finland has had no major problems in the area of child poverty (11%), which is well below the EU-27 average (19%).

The most important long-term challenge is the ageing of the population. Finland has implemented several measures to tackle the ageing problem. For the most part, the baby boomers still remain in the labour force, which may help making provisions for the change in population age structure.

Life expectancy at birth (75.9 years for men and 83.1 for women in 2006) shows a steady increase over time. Healthy life expectancy (men 51.7 and women 52.4 in 2005) is however decreasing. The infant mortality rate (2.7 in 2006) is one of the lowest in the EU.

Finnish gross social protection expenditures were 25.4% of GDP in 2006, which was close to the EU-27 average (25.8%). The biggest items in relation to GDP were old age and survivors benefits (9.6%), health and sickness (6.7%) and disability (3.4%). The growth of the expenditure is moderate during the present strategy planning period 2008-2010, but is expected to be rapid in the period 2020-2040.

2. OVERALL STRATEGIC APPROACH

The report does not present a clear overall strategy with quantified targets, but it describes the various policy programmes developed since 2007. The Report is more a summary of existing policies than the product of a real strategic planning process. Most elements of this strategy report are undergoing a far-reaching policy review process, which have a follow-up of their own. Such processes include social protection reform (SATA), the national development plan for social welfare and health care (KASTE) and the restructuring of municipalities and services (PARAS). Because of the nature of the preparatory work carried out in these governmental committees, the report only anticipates limited results.

The 2008-2010 Strategic Report on Social Protection and Social Inclusion of Finland (the Report) does not make many explicit references to the Lisbon strategy. It is, however, well coordinated with the Finnish Government's policy programmes, which support the Lisbon strategy.

As regards the financing of the social policy programmes, the greatest threats are related to the international environment. Maintaining and developing the universal nature of some social services may be difficult when the financial environment changes rapidly in an unfavourable direction.

Various ministries, organisations representing the poor and socially excluded, health organisations, labour market organisations, research institutes, local government representatives, and social work representatives of religious organisations and churches have participated in the strategy process. Three hearings were organised and the stakeholders were given an opportunity to make written comments on the draft report before it was finalised.

The disability perspective has been addressed in the strategy, some positive trends have been demonstrated and goals for future development are outlined. This special problem has not, however, been given much weight. The disability legislation will be reformed during 2009-2010.

As regards gender equality, or equality more generally, the perspective is well established in the report. The role of the Structural Funds is not mentioned in the Finnish report. The policy has been to use the Structural Funds to supplement the national policy programmes.

3. SOCIAL INCLUSION

3.1. Key trends

On the basis of the indicators used in the comparison between EU countries Finland can consider its current social situation to be relatively good. Social security benefits, social and health services and other public services covering the entire population have contributed to the fact that poverty and social exclusion are relatively uncommon and gender equality well achieved.

The development of the labour market has continued in recent years. The activity rate of the population in total (15-64) was as high as 75.6% in 2007 and was growing before the economical downturn. This favourable trend also covered older workers (55-64), the employment rate of which was 55%. The youth unemployment rate has, however, still been rather high (16.5%). The employment of foreign born persons has remained at a significantly lower level than that of natives. The unemployment rate of the total population has fallen during the past years, but is expected to grow due to the negative economical growth. The working poor group has stayed small, as the in-work-poverty risk was as low as 4% in 2006 (8% in EU-25).

Employment is seen as the primary measure in the creation of an inclusive society. However, only an integrated policy response could reach the most vulnerable and long-term unemployed. At the same time, reintegration into employment is more difficult in certain geographic areas, where job opportunities are scarce.

Contrasting with the good results of PISA surveys, increased demand for child welfare has raised concerns, as has the sufficiency of personnel resources e.g. in child and youth services

and mental health services. The risk of social exclusion among substance abusers and some groups of children and young people seems to have increased recently.

The level of relative poverty in Finland, standing at 13% (2007), is still among the lowest in the EU-25, although it has increased since the mid-1990s (7% in 1995). While poverty as such is not a general problem in Finland there are some groups that deserve more attention to: the long-term unemployed, children and young people threatened by social exclusion, the homeless, substance abusers, people guilty of a criminal offence and immigrants. The programme points out actions to improve the inclusion of each of these groups.

People in these groups face multiple disadvantages, which require more integrated approaches. There seems to be a gender bias concerning the above mentioned groups, as they consist mainly of men. Two groups of women are also at risk of poverty: lone parents and 65+ year-olds. The Report does not, however, mention them in the special or risky groups.

The report names alcohol consumption as a major reason for exclusion and a threat to health. The growth in consumption has increased the demand for services for alcohol abusers and the number of alcohol-related periods of hospital care. In 2006, A-clinics had approximately 44 400 clients. Detoxification and rehabilitation centres had approximately 11 200 clients. Drug experimentation and use increased in the 1990s throughout the country.

Alcohol and substances abuse has been mainly a problem involving men, but alcohol-related episodes of hospital care among women have also risen steadily year by year. The government intends to reverse the growing trend in alcohol consumption and has set the target of reducing consumption to the level of 2003.

The social problems of micro- and small entrepreneurs are not identified in the report. Small enterprises are often created in externalisation or privatisation processes and as a result of economic restructuring. The new entrepreneurs normally lose the social benefits provided by their former employers. In an economic downturn this group, which often has insufficient safety networks, is at risk of exclusion, although they have the same social rights and services as other citizens.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The 2006-2008 report did not establish explicit quantified targets. However, Finland has progressed well in terms of all the policy objectives, and it is fair to say that the current social situation in Finland is relatively good. The baseline level was already high and most of the indicators show positive development. Despite the positive general development there are big variations in the availability of services.

Guaranteeing work opportunities for as many as possible. In 2007 the employment rate edged up to 70.3% and unemployment fell to 6.9%. This positive trend, however, ended in the end of 2008 and unemployment is currently rising.

Preventing social problems and social risks. Finland has been successful in fighting poverty. The poverty risk was 29% before social transfers and only 13% after social transfers in 2007.
Safeguarding the continued existence of measures that prevent and correct social exclusion and poverty. Positive economic development has made it possible to maintain the level of social transfers and social services.

Ensuring the supply of skilled labour in services safeguarding the welfare of residents. Finland has introduced a system of care guarantee, but the system still needs to be developed further. Over a third of the population lives in an area where there are occasional problems in making immediate contact with the health centre. It has become more common for the waiting time for an appointment with a doctor in a non-emergency case to exceed two weeks. Over a third of the population (37%) lives in an area where the waiting time for an appointment with a doctor exceeds 14 days if the need is non-urgent. This situation has deteriorated over the last two years. The health guarantee does not remove the problems of poor organisation or lack of professional staff which may hamper the supply of services.

3.3. Key challenges and priorities

The challenges (policy objectives) of social inclusion are the same as in the 2006 report:

- Guaranteeing work opportunities for as many as possible;
- Preventing social problems and social risks;
- Safeguarding the continued existence of measures that prevent and correct social exclusion and poverty;
- Making the service system work better.

Key challenges in the 2008 report follow the government programme. In addition, some risk groups requiring special measures are mentioned. They include the long-term unemployed, the homeless, substance abusers, the over-indebted, people guilty of a criminal offence and immigrants threatened by social exclusion.

3.4. Policy measures

No specific policy measures are presented for the challenges above. The Report states that targets will be monitored according to the Government's welfare policy programmes. In addition a set of measures is outlined for special risk groups. Overall, the measures outlined cannot be considered ambitious. In this context, the following key areas of action could be mentioned:

Long-term unemployment. This has decreased but remains a problem for special groups. The strategy analyses the structure of these groups but does not present any real measures to tackle the problem. The legislation on social enterprises will be reviewed. A social enterprise can be a solution in big cities, but in rural areas the individual problems could better be solved by creating a special model contract for social work.

High share of youth with only basic education. The strategy proposes increasing the attractiveness and appreciation of vocational education. Vocational education should be oriented towards working life and the related intakes should be raised.

Health inequalities among social groups. The report states that one of the most important problems of Finnish public health, also when international comparisons are made, lies in socio-economic health inequalities, which have continued to widen. These inequalities will be reduced, especially through an impact on groups with the highest health risks, such as those exhibiting smoking, alcohol abuse and obesity.

Insufficient supply of welfare services (including psychiatric care) for children and youth. The report does not mention any concrete measures but refers to the Government Programme of Prime Minister Vanhanen's second cabinet. This policy programme sets general objectives and indicators, but specifies neither baselines nor measurable targets.

Consumption of alcohol and substances. The most urgent task with respect to the development of public health is to reverse the growing trend in alcohol consumption. The Government has set a target: the total consumption of alcoholic beverages is to be reduced to the level of 2003. The concrete measure to meet this target level is the reform of tax on alcoholic beverages.

Low employment rate of immigrants. Although unemployment among foreign-born persons is rather high, Finland has planned to start promoting work-based immigration. The administrative culture will be improved and structural development of the administration will be emphasised in the immigration policy. As the economic growth is turning negative, employers' interest in importing labour may wane for the period of downturn.

3.5. Governance

In Finland, the Administrative Procedure Act regulates the principles of good governance. The report was prepared in cooperation with various ministries, organisations representing the poor and socially excluded, health organisations, labour market organisations, research institutes, local government representatives, and social work representatives of religious organisations and churches.

The results of actions combating poverty and social exclusion are to be assessed in separately organised events or occasions. In the assessment of policies pursued, efforts will also be made to use the available qualitative descriptions of the development of Finnish welfare.

4. PENSIONS

The main objective of the Finnish pension system is to ensure that the population is covered against the economic risks caused by old age, disability or death of a family provider. Two pension schemes, an earnings-related pension scheme and a national pension scheme together form the total statutory pension for a pensioner. The statutory pension provision can be supplemented with a third-pillar individual pension arrangement.
The earnings-related pension scheme provides insurance-based pensions, which ensure to a reasonable degree that all wage and salary earners and self-employed persons retain their level of consumption after retirement.
The national pension scheme provides the whole population with a residence-based minimum pension which supplements the earnings-related pension.

4.1. Key trends

The pensions system was reformed in 2005. The most important objectives were to raise the effective retirement age in the long term by two to three years and to adjust the pension system to increased life expectancy. Measures to achieve these objectives have comprised, among other things, dismantling early retirement pension schemes, encouraging people to continue working longer by means of increased pension accruals, and introducing a life expectancy coefficient. The general retirement age was made flexible so that people can retire

between the ages of 63 and 68. There seems to have been good progress in achieving the objectives of the reform as the effective labour market exit age had increased by more than half a year to 62.4 in 2006 since 2005.

The financing of earnings-related pensions is a combination of a pay-as-you-go (PAYG) system and a pre-funded system based on pension contributions from both employers and employees. The PAYG system covers approximately three quarters of the earnings-related pension outlays, and the pre-funded scheme covers the rest. Despite being partially funded Finland's earnings-related pension scheme is of the defined-benefit type. During the last 10 years the pension funds' capital has tripled to 120 billion euros. Recent economic developments will halt the positive trend, but there is no reason to doubt the sustainability of the system.

4.2. Key challenges and priorities

The challenges for the sustainability of the pension system are linked to population ageing and increased life expectancy. These challenges have been identified and the necessary changes in the legislation have been made. The economic sustainability of the pensions system in Finland has been good. The economic downturn may have a deteriorating effect on the situation. Pension expenditures amounted to 11% of GDP in 2006, which is below the EU-25 average (12%). The projected costs in 2050 are estimated to be 13.7%, which is above the EU-25 average.

4.3. More people in work and working longer

Extension of active working life is made possible and encouraged by material incentives. The retirement age is flexible (62-68) and pensions accrue from the age of 18 to 52 at the rate of 1.5% of wages a year, from 53 to 62 at 1.9% and from 63 to 68 at 4.5% a year without any cap. Despite the incentives the exit age from the labour market is only around 62 years. The successful extension of working life has not only been a result of the material incentives, but also due to positive economic conditions. In the economic downturn early retirement may become a common solution both for enterprises and for older employees, in particular in cases of corporate restructuring. The threshold to enter the labour market may also become higher for the most vulnerable groups.

4.4. Privately managed pension provision

The Finnish pension system (the first pillar) is made up of two statutory pension schemes: one is the national pension scheme based on residence that provides a guaranteed minimum pension whereas the other is the employment-based, earnings-related pension scheme.

Voluntary pension schemes (the second and third pillars) play a minor role in Finland due to the lack of pension ceilings and the extensive coverage of the systems. In 2007 about 18% of households had individual supplementary pension insurance.

The popularity of individual pension insurance has increased in recent years, and this trend is expected to continue. There are several reasons for this. Almost all of the collective supplementary pension arrangements have been closed, and new employees can no longer join them. The individual pension arrangement now replaces the collective arrangements. A very common personal motive for acquiring a voluntary pension scheme is early retirement. Another reason, especially as regards women who often have a shorter working career, can be the insufficient replacement ratio. Individual pension saving has also been favoured in personal income taxation.

4.5. Minimum income provision for older people

In 2006 the average total pension of pensioners who received a pension in their own right (earnings-related and national pensions, including survivors' pensions) was €1 194 a month (gross). This was about 48% of the average income of wage and salary earners and of the self-employed in 2006. Pensioners' average pension in their own right (does not include survivors' pensions) was €1 113 a month in 2006, about 45% of the median income in the said year. In 2006 the average pension in their own right (earnings-related and national pensions) of those who had retired in that year on an old-age pension was €1 558, about 63% of the average income for people in employment. The level of old-age pensioners' total pension compared to the income of economically active people has remained fairly stable, at about 50%, since the beginning of the 1990s.

The minimum level of the income of pensioners is composed of the full amount of the national pension and the statutory supplements payable to them. In 2008, the full national pension of a single pensioner is €558.46 a month and that of a married or cohabiting pensioner €495.35 a month.

Elderly people have a higher poverty risk than the national average (13%) and the risk is considerably higher among elderly women (26%). Elderly women who receive only the minimum pension are identified as a particularly vulnerable group. Under the Finnish pension system, pension entitlements are not divided between spouses in case of divorce. A potential risk group could be foreign-born persons with a short working life in Finland and hardly any pension rights from their country of origin.

4.6. Information and transparency

As the earnings-related pension system in Finland is based on work and pay, the issues regarding earnings-related pensions are prepared together with the key labour market organisations. Employees are generally well aware of their pension rights. Pension companies and institutions send annually a pension data record to all private-sector employees aged 18 to 67 years who are resident in Finland.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The 399 municipalities are required to arrange health services for their residents. Based on the provisions of general law local authorities organise the services themselves, together with other municipalities, by purchasing services from private service providers or from abroad, or by distributing service vouchers to users for purchasing services from a private provider. A

wide range of services include primary health care – PHC (in health centres), specialist and hospital care (in outpatient clinics or inpatient wards). Public hospitals are run by municipal federations, i.e. hospital districts. There are 20 hospital districts in Finland.

Two major reforms will have a strong influence on the health services. The municipal and service structure reform (PARAS) creates a minimum population base of approximately 20 000 inhabitants for the organisation of services and to allow for activities in some hospital districts.

The national development plan for social and health care services (KASTE) launched in 2008 aims to identify needs and implement reforms in cooperation with interest groups and actors in the field, especially municipalities. The objective of the programme is to reduce social exclusion, boost the involvement of municipal inhabitants and improve their well-being and health, reduce inequalities in well-being and health between population groups, raise the quality, effectiveness and availability of services and narrow down regional inequalities.

The average life expectancy at birth was 79.6 years in 2006. In 20 years there has been an increase of almost 5 years. In terms of gender there is a big difference: the life expectancy of men is 75.9 years while that of women is 83.1 years.

5.1.2. Accessibility

According to a study carried out in April 2008, over a third of the population lives in an area where there are occasional problems in making immediate contact with the health centre and it is common for the waiting time for an appointment with a doctor in a non-emergency case to exceed two weeks.

The availability of healthcare services in the municipal system has been improved through amended legislation, which came into force on 1 March 2005, with time limits for access to non-emergency treatment and the choice of another hospital when the wait is exceeded. This system is assessed by healthcare authorities. Each hospital district's joint municipal board is responsible for the organisation of specialised medical care within its area based on uniform medical grounds. The reform of access to non-urgent treatment has significantly reduced the number of patients waiting for such treatment.

The whole population is covered by the municipal health services and the sickness insurance system. This does not, however, mean a free health service. Most municipal health services involve a fee for the client. These fees have two main purposes: to fund operations and direct demand. The share of operating expenses borne by households varies with the services involved so that in 2006 it was on average 11.4% for social welfare services, 7.6% for primary health care, 20.4% for oral health care, 4.3% for specialised care, and 17.1% for inpatient care for the elderly.

5.1.3. Quality

Good professional skills ensure a high-standard service for clients. The report does not give any results of quality measurements and it does not refer to any explicit quality targets. There are, however, national evidence-based Current Care Guidelines which have been prepared for the treatment of various diseases (the total number of these Guidelines was 90 in the autumn of 2008). Quality recommendations have been prepared e.g. for health promotion, mental health care services, substance abuse services, services for older people, and pupil and student health care. The development of quality standards takes place in the context of the

development of patient safety, which has been one of the focal points of health care. The utilisation of assessments and feedback from clients and patients has increased in the assessment of the quality of services.

Although the report does not show any new quality measurement results, there is one convincing indicator, child mortality, which has been low and continues to decrease. The prenatal mortality rate is very low (3.0), while the EU average is 6.0.

5.1.4. Sustainability

In Finland, expenditure on healthcare services was 8.2% of GDP in 2006, below the EU average level (9.0%). The low level of salaries of Finnish healthcare workers explains this. According to the new statistics, healthcare expenditure has grown in real terms since 1993 by approximately 3.3% each year. Expenditure on medicines has grown by approximately 8.0% each year during that period. Dental care expenditure has increased by 5.4% each year due to the expansion of dental care coverage. Since December 2002, the entire population has been entitled to publicly-funded dental care. Occupational health expenditure has also grown considerably, by 5.2% a year. Other expenses have grown at a significantly slower pace.

Although in general healthcare workers appear sufficient there are large regional differences and the shortage of doctors has remained almost unchanged during the 2000s. The lack of doctors particularly concerns remote areas and is greater in PHC than in specialised care. However, the lack of dentists in health centres has been growing. The shortfall in nursing staff numbers (nurses, auxiliary nurses, and nursing assistants) is considerably smaller. The evolution of the need for healthcare staff is regularly monitored.

It is estimated that 43% of municipal social welfare and healthcare staff working in 2003 will retire by 2020. Efforts have been made to increase the number of study places for doctors and dentists, in basic professional education in the field of social welfare and health, and in polytechnic education.

Pharmaceuticals constitute an essential part of modern health care, and their significance is increasing. More than a billion euros went to medicine reimbursements in 2007. Reviews of medicine prices and generic substitution with competing medicines have slightly slowed down the pace of expenditure growth.

According to the Government Programme, the medicine reimbursement system will be overhauled to further limit current annual growth in medicine expenditure of 10% to a maximum of 5% in 2008-2011. This includes taking into account the cost-effectiveness of new medicines and promoting safe pharmacotherapy.

5.2. Long-term care

5.2.1. Description of the system

Long-term care provision is like healthcare provision. A municipality may provide services alone or in cooperation with other municipalities, purchase them from private or public providers or distribute service vouchers to users. Long-term care is provided in the inpatient wards of health centres and non-medical long-term care in institutions for older persons. Municipal social welfare and health services also include rehabilitation and maintenance of functional capacity for the aged and services for the disabled, including a personal service plan to establish the required service and support measures in consultation with the disabled person and his or her carer or family members.

The field of informal care has been put on the political agenda. The Informal Care Act entered into force as of the beginning of 2006 and is a major milestone in reforming the system. It defines informal care as encompassing services necessary to the client, together with compensation for the informal care, leave and support services for the carer included in the care and service plan. As of the beginning of 2007, the Act was amended to increase the caregiver's number of statutory days off from two to three days per month. The minimum amount of support for informal care is €317.22 per month. The ongoing municipal and service structure reform (PARAS) has significant impacts on the service system.

5.2.2. Accessibility

The coverage of services has developed in Finland as follows: at the end of 2006, 90.1% of over-75s were living at home. This calculation excludes all those in long-term hospital care, old people's residential homes and housing with 24-hour assistance. In 2005, 11.5% of over-75s received regular home care and 3.7% received informal care support, 3.9% were living in sheltered housing with 24-hour assistance, and 6.5% were in long-term institutional care.
Traditional long-term institutional care has been replaced especially by intensified sheltered housing. This change reflects older people's own wishes to live in a homely environment, such as sheltered housing units with 24-hour assistance. There are, however, significant regional differences.

5.2.3. Quality

Qualitative objectives have also been set for developing services in the National Framework for High-Quality Services for Older People. High-quality services are:

– Client-oriented and allow clients and their families to participate in service planning, decision-making and assessment;

– Based on a comprehensive assessment of service needs, the living environment and client resources, assessing the individual's physical, cognitive, mental, social, linguistic and cultural needs and resources, as well as environmental factors;

– Goal-oriented and regularly assessed against a single written plan for care, rehabilitation and/or services;

– Based on a work method that promotes functional capacity and rehabilitation;

– Implemented in cooperation with the client, the various service providers, and relatives and friends;

– Given in a safe and timely manner;

– Using existing research results and information on good practices; and

– Effective, i.e. attain the individual and social targets set for the services.

The National Framework is not only qualitative, it also contains quantitative targets.

5.2.4. Long-term sustainability

Although Finland will see more rapid ageing of its population than most other countries it is well prepared for the change in the age structure. The country has also succeeded in containing costs, as evidenced by the small share of healthcare expenditure in relation to GDP. In 2005, the share of GDP devoted to healthcare spending was 8.3%, which is below the average level for OECD countries (9.0% in 2005).

In the funding of social welfare and healthcare services, user fees will be set at levels such that services are available for everyone and people are guided towards appropriate use of the services.

6. CHALLENGES AHEAD

- To implement more effective policies for tackling the root causes and consequences of excessive consumption of alcoholic beverages in terms of social exclusion and to improve social services provided to adolescents.

- To closely monitor the adequacy of future pensions with special reference to women, micro-entrepreneurs, immigrants and people with a short working history, while also facilitating efforts to extend working lives for these groups and the rest of the population.

- To continue with ongoing reforms in the healthcare system (PARAS reform) with a view to improving the overall efficiency of the system (including through better organisation of resources in health institutions), while improving accessibility in terms of reducing both waiting times and regional differences.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita **	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	15-64 Male	15-64 Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	15+ Male	15+ Female	15-24
2000	5,0	117,3	**2000**	67,2	70,1	64,2	41,4	41,6	**2000**	9,8	9,1	10,6	21,4
2005	2,8	114,3	**2005**	68,4	70,3	66,5	40,5	52,7	**2005**	8,4	8,2	8,6	20,1
2008f	1,5	114,1	**2007**	70,3	72,1	68,5	44,6	55,0	**2007**	6,9	6,5	7,2	16,5

* Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast

2. Demography and health

Eurostat	Life expectancy at birth Male	Life expectancy at birth Female	Life expectancy at 65 Male	Life expectancy at 65 Female	Healthy life expectancy at birth Male	Healthy life expectancy at birth Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	72,8	80,4	14,6	18,7	n.a.	n.a.	3,9	**1995**	7,7	74,1	20,5		-
2000	74,2	81,2	15,5	19,5	56,3	56.8s	3,8	**2000**	7,0	73,4	21,0	**2005**	3,0
2006	75,9	83,1	16,9	21,2	52.9b	52.7b	2,7	**2006**	8,2	76,0	18,7	**2006**	2,5

s: Eurostat estimate; p: provisional; b: break in series

*THE: Total Health Expenditures

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits / **Age-related projection of expenditure (AWG)**

Eurostat	Total expenditure* (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2006) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	31,5	32,8	20,9	14,4	13,4	3,6	15,0	**2004**	24,8	25,4	10,7	5,6	1,7
2000	25,1	35,8	23,8	10,5	12,5	3,5	13,9	**2010**	25,7	0,2	0,5	0,2	0,2
2006	26,2	37,8	26,2	8,5	11,6	3,2	12,7	**2030**	43,9	4,7	3,3	1,0	1,3
								2050	46,6	5,2	3,1	1,4	1,8

* including administrative costs

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	13	11	11	22	14	12	17	10	3,6	**2005**	12
male	12	n.a.	12	18	15	n.a.	18	10	-	**2006**	11
female	14	n.a.	11	24	14	n.a.	16	10	-	**2007**	11

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female		Long Term unemployment rate: % of people aged 15-64 Total	Male	Female		Early school-leavers: % of people aged 18-24 Total	Male	Female
2001	-	-	-	-	**2000**	2,8	2,8	2,7	**2000**	8.9b	6.5b	11.3b
2004	5,7	11	11,2	10,9	**2004**	2,1	2,3	2	**2004**	8,7	6,9	10,6
2007	4,4	9,1	9,6	8,6	**2007**	1,6	1,7	1,4	**2007**	7,9	6,3	9,7

*: excluding students; i: change in methodology; b: break in series

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,74	0,79	0,72	**Aggregate replacement ratio**	0,46	0,46	0,48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: Statutory pensions	Occupational & voluntary: Estimate of current (2002)	Assumption
-11	-13	-12	DB	/	-	100	/	21,6	/	-

* (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)

Sweden

1. SITUATION AND KEY TRENDS

In 2007 there was a deceleration in the Swedish economic growth rate, with GDP growth at 2.7% in 2007 compared to 4.1% in 2006. The global financial turmoil has depressed the economic outlook and the forecast shows a fall by 1.4% in 2009, followed by a slight growth in 2010.[176] The employment rate is one of the highest in the EU, with an overall rate of 74.2%, well over the EU target of 70%. This is mainly due to a high female employment rate of 71.8% and a large number of older workers in employment (70%). The youth unemployment rate is however still very high at 19.1%, way above the EU average (15.53%). Foreign-born are overrepresented among the unemployed youth. The overall employment gap between persons born inside and outside the country is one of the highest in the EU (at 13.1 percentage points in 2007). This remains a challenge, as Sweden is currently experiencing its highest level of immigration ever. According to national statistics, nearly 100 000 people settled in Sweden in 2007, most of whom are people who have been granted a residence permit after having applied for asylum, or for family reasons.

The overall at-risk-of-poverty rate is still low (11% in 2007 compared to 16% in the EU-25), and compared to other EU countries Sweden has one of the most equal income distributions. Nevertheless, both relative and absolute poverty vary in different population groups. Single adult households with children have a considerably higher poverty rate (24%). According to national statistics, the poverty rate is almost three times higher among foreign-born compared to native-born persons. Child poverty is also highest among those whose parents are born outside Sweden: among these 38.8% are poor according to national statistics.

Sweden is projected to face less challenging demographic trends than most EU Member States. The fertility rate is relatively high compared to other Member States (1.88 in 2007, according to national data). The old-age dependency ratio is estimated to increase from 27.8% in 2010 to 46.7% in 2060 (the EU average will over this period increase from 25.9% to 53.5%). Both life expectancy at birth (78.8 for men and 83.1 for women) and healthy life expectancy (67.1 for men and 67 for women) show a steady increase over time. Gross expenditure on social protection in relation to GDP is the highest in the EU (32.0% in 2005), but is expected to decline until 2020, followed by a slight increase for the period 2020-2040. In 2006 the biggest expenditure items in relation to GDP were pensions (12.1%), health care (7.8%) and disability (4.5%).

2. OVERALL STRATEGIC APPROACH

The overarching aim of Swedish social policy is to provide social protection for the whole population, with supplementary support to specific groups only when necessary. The Swedish National Strategy Report (NSR) identifies a range of social conditions where improvements are needed. The overall policy objective for the period 2008-2010 is strongly focused on reducing exclusion through labour market integration. A higher employment rate is seen as essential for securing a future generous welfare policy as well as important for personal and social development and for participation in society. In the area of health care, more efficient use of resources is identified as a main challenge. Both gender and disability policies in Sweden are mainstreamed in all policy areas.

[176] According to the European Commission Interim Forecast, January 2009.

Sweden's priorities for European Social Fund (ESF) funding 2007-2013 are well in line with the overarching objectives in the NSR. These include improving the adaptability and employability of workers, and increasing the labour supply by addressing particularly youth, people with a migrant background and those on long-term sickness leave. Furthermore, the European Regional Development Fund (ERDF) will partly be used to support entrepreneurship and thus lead to the creation of new jobs.

3. SOCIAL INCLUSION

3.1. Key trends

The overall at-risk-of-poverty rate has increased from 9% in 2005 to 11% in 2007. The reason for the increase in the relative poverty rate is, according to the NSR, growing income inequalities (although the S80/S20 income quintile share ratio is still among the lowest in the EU in 2007, at 3.4). Groups with higher poverty rates are single-parent households (24%) and elderly women (14%). As stated, national statistics show that foreign-born and children with a migrant background also have a considerably higher poverty rate than the rest of the population. The in-work poverty rate is just below the EU average, at 7% for the total population (8% for men and 6% for women) and, in general, people outside the labour market have a higher risk of poverty (26% for unemployed and 31% for other inactive). The poverty-reducing effect of social transfers is however evident, as these reduce poverty by more than 50%. The poverty threshold in Sweden is also among the highest in the EU.

The employment rate has risen from 72.5% in 2005 to 74.2% in 2007, with some improvement both among youth and among people with a migrant background. The gap between persons born outside and persons born in the country has however decreased only slightly (from 13.8 in 2005 to 13.1 in 2007). There has also been a slight decrease in youth unemployment, from 21.3% in 2006 to 19.1% in 2007, but it still remains very high. Overall, unemployment is expected to rise significantly from 6.2% of the labour force in 2008 to about 8.5% in 2010.[177] Sick leave rates are continuing to fall and the number of people in receipt of sickness benefit has fallen by around 50% since the peak in 2002. The number of people receiving long-term sickness or activity compensation[178] is declining slowly, however. According to national data, 542 494 persons received sickness or activity compensation in August 2008, a 1.9% decrease since August 2007.

According to international comparisons, the educational system generally performs well in terms of quality and of preventing social exclusion. The main problem is the lower attainment of children with a migrant background. Another issue of concern is the rise in the rate of early school leavers, reaching 8.6% in 2007 (10.2% for male and 7% for female) but still remaining below the EU average, however. Again, children with migrant backgrounds are overrepresented among this category.

[177] European Commission Interim Forecast, January 2009.
[178] Sickness and activity compensation is the equivalent of disability pension.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The previous action plan for social inclusion, presented by the then newly appointed government in April 2007, identified four priority areas for social inclusion: employment and education, integration (i.e. social inclusion of people with a migrant background), homelessness and exclusion from the housing market, and vulnerable groups within the population.

Recent *labour market reforms* have focused on strengthening work incentives, and favouring the entry of disadvantaged groups into the labour market through subsidised employment, job and development guarantees and more efficient rehabilitation. As stated, sick leave rates are continuing to fall but the number of people receiving long-term sickness and activity compensation has remained constant for the last couple of years. As also stated, the employment rate has increased slightly among the young and foreign-born, but among people with disabilities there has been an increase in unemployment. As for *education*, recent and announced reforms address issues of basic skills, quality of teaching, greater emphasis on vocational education and transition from school to work.

The policy aim to *improve the social inclusion of people with a migrant background* has been closely connected to the general labour market reforms and measures in the area of education. Several initiatives are in progress to ensure that new arrivals are offered work-oriented programmes early on and that their knowledge and experience are put to better use through assessment of diplomas obtained abroad and supplementary training for university graduates. Foreign-born accounted for almost half of the increase in employment during the first half of 2008. The employment gap between foreign-born and the native-born population still remains high, and for women the gap has in fact remained constant. A special national strategy for the education of newly arrived children and youth has been devised, and special measures to improve educational conditions in vulnerable areas have been taken. Nonetheless, there has been an increase in the rate of students with a migrant background leaving compulsory school without meeting basic requirements.

In the area of *homelessness* statistics are being developed which will monitor the trend more satisfactorily from 2009 on. The target mentioned in the 2006-2008 report that no children should be evicted has not been achieved. Initiatives taken to *strengthen groups in particularly vulnerable situations* include measures to improve the quality of social care for children and adolescents. No progress in reducing violence against women is reported, but several measures have been taken and the knowledge of how to address the problem is improving (the fact that crimes reported to the police have increased is most likely a result of this). The number of people in misuse care has remained constant and the number of care episodes in non-institutional psychiatric care has increased, particularly among women.

3.3. Key challenges and priorities

The Swedish NSR presents four key policy objectives 2008-2010 to combat poverty and social exclusion. The priority objectives build to some extent on the previous period (2006-2008) and are focused on:

- Increasing the possibility of social inclusion for the elderly;
- Reducing exclusion among young people;
- Reducing absence from work due to ill-health; and

– Strengthening groups in particularly vulnerable situations.

Reducing the gap on the labour market between those born inside and outside Sweden is specifically mentioned as 'an important starting-point for continued efforts' in the new NSR, but has been dropped as a priority. The former priority on homelessness has been included in the objective of strengthening vulnerable groups. Overall, the priorities are well in line with the challenges identified in the Joint Report 2007.

The NSR identifies the direction in which it wants to push development and indicators for follow-up are specified for each objective. No measurable targets are, however, mentioned.

3.4. Policy measures

The demographic development has made *social inclusion for the elderly* a priority. The focus is on keeping the elderly active through continued labour market participation and through the promotion of an active and social lifestyle. Tax reductions and employment subsidies for older workers will improve incentives to stay longer in the labour market. Priority will also be given to improving physical accessibility in society and long-term care. Economic conditions for primarily the least well-off pensioners will also be improved, which hopefully will reduce the high at-risk-of-poverty rate among elderly women.

To *reduce exclusion among young people*, the reform initiatives continue to focus both on education and the labour market, as well as improved matching between the two. A special national strategy for the education of newly arrived children and young people has been devised and extra funds are being invested to enable Swedish teaching to be developed for those born outside Sweden, with the aim of speeding up the possibility of work and education. Increased mental ill-health among teenage girls and young women is an issue of particular concern and a development centre for the mental health of children has been established to improve preventive measures, early detection and early support.

In order to *reduce absence from work due to ill-health*, active rehabilitation measures and improved support are mentioned, with a focus on early action and reinforced links to the right to sickness benefit. Improved prevention care and rehabilitation at company level will be further supported. Furthermore, a pilot activity with alternative actors (mainly social enterprises) in rehabilitation has been introduced.

The continued priority given to s*trengthening groups in particularly vulnerable situations* includes continuous promotion of the quality of social services, strengthening support for women who are subjected to violence and their children, fighting honour-related violence, strengthening care of people with misuse and addiction problems and their families, as well as continuing the previous priority of combating homelessness and exclusion from the housing market.

Gender aspects and mainstreaming of social inclusion of people with a migrant background are generally well reflected in the policy measures and there is a balance between prevention and alleviation. A weakness in the NSR is that it does not include any discussion on how the strong work-line policy for social inclusion will be affected by weakened labour demand in an economic downturn. People who remain outside the labour market are increasingly exposed to poverty. Furthermore, groups with a weak labour market attachment are usually the first ones to lose their job when demand is falling. A risk with the extremely high focus on activation is accordingly that it may increase exclusion among those who for various reasons cannot find an entrance into the labour market.

3.5. Governance

Different state authorities, NGOs and social partners have had the possibility to participate in the process of preparing the Swedish strategy for social inclusion. Some NGOs, however, have argued that no opportunity for real dialogue was provided and have asked for an earlier dialogue in the future. The strategy report is, however, more a summary of existing policies than the result of a real strategic planning process, and the importance of a continuous dialogue with stakeholders is underlined in the report. NGOs, the Swedish Association of Local Authorities and Regions and the National Board of Health and Welfare take part in a commission for service user influence on social development issues in the Ministry of Health and Social Affairs, and the public inquiry system is recognised as an important tool in policy making.

General indicators for monitoring progress towards the achievement of each priority policy objective have been identified in the report. Monitoring and evaluation arrangements are made through mechanisms already in place.

4. PENSIONS

4.1. Key trends

The Swedish statutory pension system has since 1999 been in the process of gradually changing over to a new system. The former system was a defined-benefit system based on the fifteen best income years of thirty worked. The new system is a defined-contribution system where all income earned, up to a certain ceiling, influences the pension. The contribution constitutes 18.5% of the wage earned, up to a ceiling. 16 percentage points finance pensions on a pay-as-you-go basis through the mechanism of notional accounts (income pension) and 2.5 percentage points are invested in one or more funds selected by the individual (so-called premium pension). The statutory pension system is supplemented by sector-wide occupational pension schemes.

The retirement age is not specifically stipulated. The lowest possible age to receive an income pension and premium pension is 61. From 65 a guarantee pension may be obtained by those with a low-income pension, and 67 is the lowest age for mandatory retirement. Many of those aged over 60 are still working and the effective labour market exit age is at 63.9 among the highest in the EU.

The Swedish pension system generally ensures an adequate standard of living. A gender gap can still be seen — the relative median income of the elderly was 84% for men and 73% for women in 2007. This is however a reflection of past career profiles and gender differences in the age structure of the elderly. Considering the high employment rate among women the gap will diminish in time. On the other hand, the current pay gap between women and men and the higher share of women in part-time jobs will to some extent maintain differences in retirement income. The aggregated replacement ratio was 61% in 2007 (63% for men and 54% for women). Calculations for current and projected theoretical replacement rates show that net pensions in relation to net earnings at the point of retirement in Sweden will drop by 13 percentage points between 2006 and 2046 for an average earner retiring at age 65 reflecting the affects in increasing longevity. Public pension expenditure, including funded statutory pensions, is projected to increase from 10.6% to 11.2% of GDP between 2004 and 2050, which in comparison to most other Member States is very low.

4.2. Key challenges and priorities

The Swedish public pension system is adequate and financially stable. In order to keep the replacement rate constant, however, longer working lives and increased participation rates among older workers are required. The described change in the income-related pension system is intended to encourage higher labour force participation and longer working lives, as the size of the annual pension will be decided by lifetime earnings and the chosen age of retirement. Pensions increase the later a person chooses to retire, due to further-earned pension rights during the additional working years and decreasing remaining life expectancy. The retirement age has increased slightly in recent years. However, projections show that even if people work longer to compensate for the effect of an ever longer life the period of time in retirement continues to increase for all cohorts. According to current projections, a worker retiring at 65 after 40 years with average earnings would see the replacement rate decrease by 13 percentage points from 2006 to 2046, partly due to increases in longevity. Even if a person retiring in 2046 were to compensate for this longevity effect by working longer, he or she would still be in retirement longer than a person who retires at 65 in 2006. Public expenditure on pensions is projected to increase very slowly until 2050 (by only 0.6 percentage points).

The outcome of the pension reform is continuously monitored. In previous years the balance between assets and liabilities has shown a marginal surplus only. In the calculation of assets the current value of the large reserve funds is included, causing the balance to be sensitive to volatility on the financial market. A deficit in the system causes the indexation of pensions and earned pension entitlements to be lowered by automatic adjustment.

4.3. More people in work and working longer

The employment rate of older workers (67% for women and 73% for men) is the highest in the EU. As stated, the principle of lifetime earnings — fundamental to the national pension system — provides good incentives to work. Spreading information about the clear correlation in the statutory pension schemes between contributions and the size of the future pension is thus part of the strategy in the NSR to get people to stay longer in the labour market. Judging from the different pension schemes affecting retirement incentives it is important to study how different schemes affect the incentives to work longer for different income groups. For low-income groups the level of the guarantee pension creates lower incentives to work longer, but the NSR argues that price-indexation of the pension provides an incentive to earn more income-related pension. In income groups where incomes exceed the ceiling in the statutory schemes, it is important to study the incentives in occupational schemes as these schemes take on a more important role in retirement.

As stated, a current challenge for Sweden is the late age of establishment in the labour market, defined as when 75% of an age cohort is employed in the labour market. This age is 27 according to the NSR, compared to just over 20 in 1990 and the issue needs to be addressed in order to secure economic growth and adequate pensions in the future.

4.4. Privately managed pension provision

Around 90% of wage earners are covered by some form of occupational pension scheme. The schemes are based on premium reserves with a large proportion of their assets consisting of shares, partly depending on the choices made by the individual participant. Generally speaking these schemes are not mentioned much in the NSR and yet they provide a large share of retirement income for many people, especially those with incomes above the ceiling

in the statutory system. Accordingly, it would be interesting to know more about how these schemes affect work incentives and income gaps and address gender issues.
According to national statistics, 38% of 20-64 year olds are also covered by individual private pensions. Women, more often than men, have private pensions and high-income earners are more likely to take out private pensions than people with lower incomes. The importance of these private pensions has been rising steadily over the last 10 years.

4.5. Minimum income provision for older people

In 2007 the poverty rate among the elderly in Sweden was the same as for people below the age of 65. However, while the risk is much higher for women (10% for people under 65 and 14% for 65+) the risk is actually lower for elderly men (11% compared to 7%). As with the total population, social transfers reduce poverty among the elderly to a great extent (from 23% before social transfers to 11% after).

The old-age guarantee pension, means-tested only against other income-related statutory pensions, provides a minimum pension level for persons from the age of 65 years. The guarantee pension provides a high level of protection compared to many other EU Member States. The guarantee pension is price-indexed, which indicates that the relative level of this pension will fall over time. The means-tested housing allowances also supplement the incomes of numerous pensioners. For those who have not been resident in Sweden long enough to be eligible for a full guarantee pension there is special maintenance support for the elderly. This support is means-tested, price-indexed and tax-free and intended to guarantee a reasonable standard of living for people aged 65 or over.

4.6. Information and transparency

All those insured under the national pension system receive annual information on the evolution of their own pension. The annual information provides accumulated pension entitlements as well as projections of the pension an individual would receive if he or she chose to retire at some alternative pension ages. This information does not, however, include information on collectively bargained or private pensions. An internet portal that also provides information on occupational pensions is available, but few people use it.

According to a survey by the Swedish Social Insurance Agency from December 2007, 40% say that they know the national pension system quite well. Accordingly, despite past efforts to inform people about the Swedish pension system, knowledge of the system among the insured remains inadequate, and is increasing only very slowly. Improving information about the national pension is an ongoing task for the government.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Health care in Sweden is coordinated at municipal, county and national level. The county councils and municipalities levy taxes to finance health services and their autonomy means that services can be organised and prioritised differently in different parts of the country. Health care is almost entirely tax-financed and healthcare services are mainly supplied by public providers but private care providers are being promoted by the government to some

extent and private care is likely to become more important in future. The government's objective for Swedish healthcare policy is for the population to be offered needs-orientated, accessible and efficient care of high quality. The policy has thus come to focus on initiatives that improve accessibility, quality, freedom of choice, and diversity of care providers.

5.1.2. Accessibility

Accessibility to health care is generally good in Sweden and all residents are covered by public or primary private insurance. Adult asylum-seekers are, however, only entitled to subsidised emergency care, and undocumented people have to pay the full cost of all treatment, including emergency procedures. However, no one is denied emergency health care because of difficulty with payment. In practice, some regions and county councils have nonetheless decided to provide health care for asylum-seekers and undocumented migrants on the same basis as for resident persons, which mean that there are regional disparities in accessibility for these groups.

The self-reported unmet need for medical care (due to waiting time, costs or distance) is increasing. At 2.9% in 2006, it is still slightly under the EU average. For dental care the corresponding percentage is much higher, 7.7% in 2006 (EU average 5%). Under the National Care Guarantee the county councils are required to offer care within certain time limits. Despite this and other initiatives aimed at improving accessibility, long waiting times remain a problem. More resources have been made available to psychiatric health in recent years, but waiting times are still lengthy here as well. A strengthened care guarantee is under implementation, which would mean that waiting times for visits and treatments would not exceed 30 days for child and adolescent psychiatry (rather than 90 days, as stated in the general care guarantee). As part of a larger inquiry appointed in 2007, the possibility of transforming the National Care Guarantee into a statutory regulation is currently being investigated. The government has also initiated a special government grant based on performance, which means that compensation is only distributed if the county council has performed well against the National Care Guarantee (the grant is €1 million per year, starting in 2010 based on evaluation of the accessibility statistics from 2009).

Outpatient care, hospital care and prescribed medicines are usually provided with only patient co-payment fees to be paid. Maximum, total co-payments per year per patient apply in most areas (so called high-cost schemes), but county councils can apply different co-payment rules and amounts.

5.1.3. Quality

The National Board of Health and Welfare and the counties' administrative boards are responsible for supervision, follow-up and evaluation of county council and municipal healthcare services. Several measures have been taken over the past couple of years, aimed at ensuring quality in health care. These include the government's Strategy for Good Care, aiming to improve the use of information and communication technology within health care as well as improving the freedom of choice for the individual. The strategy points out the importance of interplay between measures for open comparisons, advanced benefit systems, the effective supply of information and the diversity of care providers through such means as employee takeovers. Patient safety is another priority issue mentioned in the NSR. A review of patient safety from a legislative point of view is currently being undertaken.

Improving quality in psychiatry is considered a crucial issue. Investments have been made especially in child and adolescent psychiatry. Efforts have also been made to raise expertise in psychiatric health care and in social services for people with mental disabilities.

A challenge with the decentralised health care system is that there are considerable differences between different regions, with regard both to health indicators and to patient-received quality. The NSR does not, however, provide information on the actual situation regarding regional variations in performance.

5.1.4. Sustainability

Total healthcare expenditure has remained fairly constant in the last two decades (9.2% of GDP and 3 202 PPP$ per capita in 2006). This is slightly above the EU average, but compared to most countries which are similar to Sweden in many other respects, healthcare costs are relatively low. Public healthcare expenditure as a percentage of total healthcare expenditure has fallen steadily from 92% in 1980 to 81.7% in 2005. According to projections, public healthcare expenditure is projected to increase by 1% of GDP by 2050 due to population ageing.

Many healthcare professionals are close to retirement age and as the educational system is not producing enough new ones, the Swedish healthcare system is facing a lack of qualified personnel. Many professionals are now recruited from other countries, for example Poland and Germany. In psychiatry the situation is particularly problematic as a good knowledge of the Swedish language is essential for being able to work in that speciality. An expansion of the number of students in medicine and care at Swedish universities would accordingly also be important.

5.2. Long-term care

5.2.1. Description of the system

Municipal long-term care is seen as an important guarantor of social protection and inclusion for the elderly population and people with disabilities. The 290 municipalities have a statutory duty to meet the social service and housing needs of persons with disabilities and the elderly, but their autonomy means that services are organised and prioritised differently in different municipalities. The individual's need for subsidised support is assessed in relation to income. The national policy for the elderly and the national disability policy stipulate that both groups should be able to live independent lives and should be enabled to live in their own home as long as possible. Long-term care has been restructured over the last 15 years, with a reduction in institutional living and care and an increase in those living and receiving services provided at home.

5.2.2. Accessibility

Access to long-term care depends on the municipality a person is living in, and varies in different parts of the country. The above-mentioned restructuring and downsizing of institutional care has in some cases led to a noticeable lack of places in institutions/special housing, resulting in long waiting times. New provisions have been introduced to tackle this, e.g. municipalities that do not implement a decision on special accommodation within a reasonable time will have to pay a charge to the central government.

The proportion of elderly people who receive health and medical care from the private sector has increased in the current decade. Various client-choice systems have been introduced in some municipalities, giving the elderly the option to choose providers themselves, either private or local-authority.

5.2.3. Quality

The NSR underlines that a number of measures have been adopted and that more resources have been allocated to counties and municipalities to develop quality in long-term care. These initiatives have the effect of driving the development of better national statistics and quality indicators that provide the necessary basis for open comparisons of quality in health and social care of the elderly. No description of quality in long-term care is included in the NSR but, as has been stated, there are wide local differences between municipalities and there may also be wide differences in quality, costs and outcomes within a municipality.

5.2.4. Long-term sustainability

The long-term sustainability of care of the elderly is dependent on sound public finances and high labour force participation to finance projected care needs. Public long-term care expenditure is projected to increase by 1.7% of GDP by 2050 due to population ageing (reaching 5.5% of GDP in 2050).

The Ministry of Health and Social Affairs is currently working with the Ministry of Finance on a project which is intended to shed light on the long-term demand for and costs of welfare services, including health and social services for the elderly.

6. CHALLENGES AHEAD

- To continue to address the high youth unemployment rate as well as the employment gap between the foreign and native-born population and to continue to support the transfer of the high stock of people in sickness and disability pension schemes to the labour market. This includes pursuing efforts to reform the education system, including improved vocational training, in order to reduce drop-outs and social exclusion among young people, in particular those with a migrant background.

- To address the higher levels of risk of poverty among lone parents, elderly women and people with a migrant background, especially children.

- To continue efforts to improve the general knowledge of the pension system, especially clarifying the different sources of a person's pension.

- To address the regional differences in access and quality performance of the healthcare services provided.

- To ensure access to long-term care, especially in special housing, provided by the municipalities within an acceptable time, and to ensure that persons can move freely from one municipality to another and receive the necessary support and care.

- To further pursue improvements in psychiatric care, notably the capacity to immediately take care of persons with mental problems that are seeking care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	4,4	126,7	2000	73,0	75,1	70,9	42,2	65,0	2000	5,6	5,9	5,3	10,5
2005	3,3	120,3	2005	72.5b	74.4b	70.4b	38,7	69.4b	2005	7.4b	7.5b	7.3b	21.1b
2008f	0,5	118,1	2007	74,2	76,5	71,8	42,2	70,0	2007	6,1	5,8	6,4	19,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth Male	Female	Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	76,2	81,4	16,0	19,6	n.a	n.a	4,1	1995	8,0	86,6	n.a.		-
2000	77,4	82,0	16,7	20,0	63,1	61,9	3,4	2000	8,2	84,9	13,8	2005	2,6
2006	78,8	83,1	17,7	20,9	67.1b	67.0b	2,5	2006	9,2	81,7	16.2**	2006	2,9

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	33,6	37,7	21,8	10,9	11,4	6,3	11,9
2000	30,1	39,4	27,0	7,1	9,0	4,4	13,0
2006	30,7	40,2	26,0	5,5	9,8	3,6	14,9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in 2004 and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	26,7	29,6	10,6	6,7	3,8
2010	27,8	-1,4	-0,5	0,1	-0,1
2030	37,4	1,3	0,4	0,8	1,1
2050	41,9	2,2	0,6	1,0	1,7

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20
Total	11	12	10	11	20	17	24	11	3,4
male	11	-	11	7	22	-	26	11	-
femal	11	-	10	14	18	-	22	12	-

Anchored at-risk of poverty	Total - fixed 2005 threshold
2005	9
2006	11
2007	9

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	:	:	:	:
2004	:	:	:	:
2007	:	:	:	:

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	1,4	1,7	1
2004	1,2	1,4	1
2007	0,9	0,9	0,8

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	7,7	9,2	6,2
2004	8,6	9,3	7,9
2007	8.6b	10.2b	7.0b

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,78	1	0,73	**Aggregate replacement ratio**	0,61	0,63	0,54

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate: Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions: Estimate of current (2002)	Assumption
-13	-13	-11	NDC/DC	-2	DB	100	90	17,2	13,7	13,7

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

United Kingdom

1. SITUATION AND KEY TRENDS

The UK enjoyed solid economic performance during recent years, and GDP grew by 3% in 2007. The crisis in the financial and housing markets has depressed the economic outlook and the UK economy is expected to slow to 0.7% in 2008 and to contract in 2009.

The employment rate is high for all groups and the UK exceeds all quantitative Lisbon targets on employment. However, the high rate of people living in jobless households (10.7% of adults) continues to be a cause for concern despite strong economic growth and the government's activation measures. The problem is especially acute for children, as 16.7% live in a household where nobody works and which is the highest in the EU (the EU-average is 9.4%). The female employment rate is high (65.5%) partly being due to a flexible labour market and opportunities for part-time work thus facilitating reconciliation between work and family life. Eurostat data suggests that only 7.8% of part-time work is involuntary (the second lowest in the EU) but the high proportion of women working part-time (42%) also affects gender pay gap, under-utilisation of women's skills and child poverty**.** Further improvements, such as increasing the availability of full-time childcare and improving the quality of part-time jobs would be beneficial. The number of people who are economically inactive because of poor health continues to be a concern.

Income inequality in the UK is high, both compared to other EU countries and by historical standards as the substantial increase which took place in the second half of the 1980s has not been reversed. This has significant impacts upon people's life chances because in the UK there is a much stronger correlation between educational achievement and socio-economic background than in most other countries. The relative poverty rates also exceed the EU averages for all groups.

The structure and share of social protection expenditure of GDP (26.4% in 2006) is around the EU average. Social transfers (excluding pensions) reduce poverty by 11 percentage points or by 37% (from 30% to 19%), which is around the EU average. The UK faces similar demographic trends to other EU Member States, though to a somewhat lesser extent. The projected old age dependency ratio (38 in 2050) is significantly below the EU average of 50.4. Between 2004 and 2050 age-related public spending as a percentage of GDP is expected to increase by 4 percentage points.

The UK has a long history of immigration and 12.6% (in 2007) of the working age population was born outside the UK. Following the EU enlargement of 2004, the UK experienced a high rate of mobility from the eight new Member States which put pressure on public services in some local communities. The employment rate gaps between people born inside and outside the country are slightly above the EU average; however, this has to be seen in the light of the high employment rate — 62.8% for people born outside the EU-25 and 75.4% for people born in another EU-25 country — which is above the EU average. For several groups of ethnic minorities, the employment rate varies greatly with gender. Certain ethnic minorities continue to exhibit higher poverty rates and one third of ethnic minority children live in poverty.

2. OVERALL STRATEGIC APPROACH

The main priorities identified by the National Strategy Report (NSR) remain the same as in 2006-2008 and include facilitating access to the labour market, eradicating child poverty, tackling discrimination and ensuring access to services. Gendered analysis in the NSR could be strengthened regarding employment policies (particularly in relation to employment of older women, women from ethnic minorities and part-time work), child poverty, health and long term care and pension adequacy of current women pensioners.

The UK has a strong tradition of evidence-based policy. There is a clear focus on quantifiable targets and performance measures are transparent and closely monitored. The targets and policies are usually shared and coordinated between several Departments, reflecting the multi-dimensional nature of social inclusion. Good governance is promoted by the involvement of stakeholders in the development of policies. There is an effective interaction between the strategy on social inclusion and the Lisbon strategy. The UK approach to social inclusion is focused on employment as the best route out of poverty and on increasing employment opportunities for the disadvantaged. Improving the skills of the population is seen as a contribution to increased employability and social cohesion, and as the response to the challenges of globalisation. Measures that make work pay have addressed poverty and created incentives to enter employment. The European Social Fund supports the priorities of the NSR by contributing to policies aimed at increasing labour market participation, tackling discrimination and enhancing the skills level of the low skilled. It also contributes to reducing child poverty by improving parents' access to the labour market.

3. SOCIAL INCLUSION

3.1. Key trends

The relative risk of poverty after social transfers (19%) continues to be above the EU average (16%) in 2007. However, in absolute terms the incomes of the poor in the UK greatly exceed the incomes of the poor in most other countries, as the poverty threshold (one person household), at €12 572 per year, is the fourth highest in the EU. According to Eurostat data, old people are at the highest risk of poverty (30% for old people and 23% for children in 2007); however national data show a higher poverty rate for children[179]. The discrepancy is due to different methodologies. Disabled people, certain ethnic minorities, jobless single parents and people living in deprived areas continue to exhibit higher poverty rates.

Income inequalities are above the EU average, with the Gini coefficient standing at 33 (EU-25 average is 30) and s80/s20 income share ratio of 5.5 (EU-27 is 4.8). The increase in Gini coefficient after 2005 followed a fall over the period 2001-2005 and as a result, income inequality remained pretty much unchanged over the last decade. In-work poverty (6% for full-time and 12% for part-time workers) is around the EU average.

Despite high employment rates, the proportion of adults (10.7%) and children (16.7%) living in jobless households is among the highest in the EU in 2007. The rate has remained around 11% for adults over the last 7 years. The rate of young people not in education, employment or training has stagnated over the last decade and is particularly high among the low skilled. Unemployment traps are minimised, but inactivity and low wage traps are in most cases higher than in most other EU countries.

[179] According to national data the poverty rate for children in 2006/07 is 21% before housing costs and 29% after housing cots. Poverty rate for older people is 21% and 18% respectively. National data also indicates that pensioners are less likely to be in poverty- measured after housing costs - than the population as a whole.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

There has been good progress over the last ten years across most areas identified as priorities by the previous NSR, although a number of indicators showed a deterioration over the last period (pensioner poverty, employment rates of several disadvantaged groups, gender pay gap).

According to national data, over the period 1998-2006 the risk of children living in poverty fell from 26% to 22%. The number of children in poverty fell from 3.4 million to 2.9 million (relative poverty) and from 3.4 million to 1.7 million (absolute poverty).

Regarding access to the labour market, several disadvantaged groups (single parents, people with disabilities, older people and ethnic minorities), except for the least skilled, have experienced improvements in their labour market position over the last 10 years. The current economic difficulties may hinder further progress in this area. It is difficult to assess overall progress on the priority of ensuring access to quality services as there are many areas and initiatives and an integrated approach is not explicitly mentioned. There has been a significant increase in investment in education (from 4.6% of GDP in 1999 to 5.5% in 2005). The increased investment in health care has contributed to improved accessibility and quality. Regarding transport, although there have been developments aimed at improving access for disadvantaged groups, further improvements are needed to enhance general access to transport. In England, the number of households living in fuel poverty increased to 3.5 million compared to 3.4 million in 1998. There has been progress in reducing re-offending (by 7.4% compared to 2000), bringing down the number of adults without a bank account (from 2 million to 1.3 million in two years) and increasing the proportion of vulnerable households living in decent homes (from 43% in 1996 to 68% currently).

Progress had been made in some areas regarding equalities. Over the last ten years, the gender pay gap has been reduced, although the latest data show that it has widened over the past year. Overall school attainment for disadvantaged groups has improved. Socio-economic background appears to be the strongest determinant of educational outcome and the attainment gaps between disadvantaged pupils and their peers are large but narrowing. The attainment gaps of most ethnic minorities have narrowed.

3.3. Key challenges and priorities

The key priorities identified by the 2006-2008 National Strategy Report are the same as in the previous reporting period. The selected priorities are appropriate and broadly consistent with the challenges identified by the 2007 Joint Report. Despite the challenges identified in the 2007 Joint Report, the inequalities in terms of income and wealth are largely neglected; a different approach is taken by Scotland, which is committed to increasing the total income and proportion of income earned by the poorest three income deciles by 2017. Income inequality remains a persistent problem and is closely related to inequalities in health, education and life chances.

3.4. Policy measures

The UK set ambitious targets to reduce child poverty by a quarter by 2004 (target narrowly missed), to halve it by 2010 and to eradicate it by 2020. As the child poverty rate has been significantly decreased, it becomes more challenging to reduce it even further and the existing policies might not be sufficient to meet the targets. Child poverty in the UK is tackled though

measures to move more parents on low income into work, social transfers, a wide range of local initiatives and measures addressing the wider causes of poverty. In 2008, the government announced new measures to increase social transfers to families with children. A further investment of £125 million over the next three years is aimed to help prepare for the next decade, supported by pilot schemes to develop new and innovative ideas for tackling child poverty.

The government's overall employment rate aspiration of 80% in the long term is very ambitious, especially taken into account the pace of employment growth in recent years. Active labour market policies are undergoing a process of transformation towards more personalised support, increased contracting out of employment services and integration of employment and skills provision. The welfare reform introduces increased conditionality combined with increased support aimed at moving people off benefits and into work. The national minimum wage and working tax credits help provide incentives to enter employment. Regarding people with disabilities, the 'Pathways to Work' programme was rolled out in Great Britain and made compulsory for certain claimants of incapacity benefits considered to be capable of work. The budget for the programme which assists disabled people into work and within the workplace will double (for special equipment, adaptations to work premises, help with transportation). Starting from October 2008, single parents are expected to search for work once their youngest child reaches 12; the age limit is planned to be decreased further. The reform is expected to address the low employment rates of single parents, as part of a package to eradicate child poverty by 2020 and accompanied by pre-work and in-work support measures.

There is a wide range of measures to improve educational attainment, such as school benchmarking, merit pay for teachers, use of targets and plans to provide one-to-one tuition to low-achieving children. Section 5.1.2 provides information on measures regarding access to healthcare. Access to transport is facilitated by the introduction of low-floor vehicles, tailored solutions for specific groups and a wide range of local projects. The main measures to tackle fuel poverty are a package of heating and insulation measures, financial help for older people with heating costs and the requirement for energy companies to achieve 40% of their energy savings by helping vulnerable customers increase their energy efficiency. The government has allocated resources and developed strategies and action plans to promote digital and financial inclusion and improve the well-being and independence of older people.

Concerning action on discrimination, the main policy development is the establishment of an Equality and Human Rights Commission in Great Britain (a separate Commission exists for Northern Ireland) responsible for promoting equality and tackling discrimination in relation to race, gender, disability, sexual orientation, age, religion and belief. Further measures to tackle discrimination were announced in an Equalities Bill. To monitor developments in this area, the government has set quantifiable targets, including a reduction of the gender pay gap and narrowing gaps between disadvantaged groups and the general population in respect of different aspects of active inclusion.

3.5. Governance

Most of the key aspects of social inclusion are devolved to the four countries. The community and voluntary sector are actively engaged in social inclusion processes. In preparing the NSR the government is working together with stakeholder groups consisting of representatives from key government departments, devolved administrations, local government, the voluntary sector and people experiencing poverty. The 12 month project *Bridging the Policy Gap* aimed at increasing awareness of European action in the field of social inclusion and social

protection. The first UK conference of people experiencing poverty was held in 2007 and is considered a successful contribution to the enriching experience of policy making. There is some scope for improving effective follow-up strategies of the social inclusion process.

4. PENSIONS

4.1. Key trends

In contrast to many other European countries, the UK state pension system is concerned with preventing poverty and providing a foundation for saving, rather than providing retirement income similar to that in working life. The UK state pension consists of a flat-rate Basic State Pension (BSP) and an additional pension called State Second Pension (S2P) which is earnings-related but following reform will become increasingly a flat-rate addition to the Basic State Pension. This state foundation is supplemented by private pension provision consisting mainly of occupational and personal pensions.

The BSP is based on the number of qualifying years built up through National Insurance Contributions, and its value is currently indexed to prices.[180] Recent reforms will make the BSP more generous and easier to qualify for. Currently, 11 million people in the UK receive the BSP (nearly the entire population above state pension age), but only 85% of men and 35% of women qualify for the full amount. For everyone reaching state pension age (SPA) on or after April 2010, only 30 qualifying years will be needed for a full BSP, down from the 44 years for men and 39 years for women currently required. This is expected to raise entitlement to full BSP to over 90% among both men and women by 2025. Another change will be the removal of the de-minimis rule, under which one does not currently qualify for any BSP if one has fewer than 25% of the required qualifying years. More generous crediting arrangements for periods spent caring for children or the severely disabled will also improve entitlement to BSP and S2P. From 2012 (or later depending on affordability), the BSP will be up-rated in line with earnings.

The SPA for women will be gradually equalised with that of men rising from 60 to 65 between 2010 and 2020. Between 2024 and 2046 it will increase from 65 to 68 years for both men and women. Deferring retirement by working and claiming state pension or delaying claiming a state pension is encouraged. For private provision, the earliest possible age to take a pension will rise from 50 years to 55 from 2010.

Recent reforms also include measures aimed at encouraging private pension provision. Legislation was approved in 2008, stipulating that from 2012 all eligible workers, who are not already in a good quality workplace scheme, will be automatically enrolled into either their employers' pension scheme or a new savings vehicle, Personal Accounts. For the first time, all employers will be required to contribute a minimum of 3% (on a band of earnings) to an eligible employee's workplace pension scheme for those who do not actively opt out. Employees will contribute 4%, while government will provide around 1% in the form of tax relief. The self-employed will not be automatically enrolled but will be able to opt in. Further measures to increase private pensions include the reduction of legislative burdens on occupational pension schemes and the simplification of the pension taxation regime. Much of the overall success of the reform will depend on the level of participation in workplace-related schemes, which in turn may be affected by the current deterioration of financial market conditions.

[180] Though in practice since 1997 there has been an increase of more than 7% in real terms in its value, due to above-inflation up-rating of the Basic State Pension.

4.2. Key challenges and priorities

The UK, like other European countries, is facing increased longevity which poses long-term challenges for the sustainability of its pension system. In 2006, total pension expenditure in the UK was 10.7% of GDP (EU average: 11.9%). The dependency ratio in the UK is forecast to increase comparatively more slowly than in other Member States. The public pension expenditure as a % of GDP is expected to increase by 2 percentage points and reach 8.6% in 2050. In 2007, the aggregate replacement rate in the UK is 0.41, which is below the EU average of 0.49[181]. Latest Indicators Subgroup projections on net theoretical replacement rates suggest that pensions in relation to earnings at the point of retirement in the UK will drop by 4 percentage points between 2006 and 2046 for an average earner retiring at age 65. Most of this drop takes place in the statutory defined benefit scheme, partly reflecting the increase in the retirement age in the UK to ensure the sustainability of the pension system. The UK has also introduced a number of other measures, including increasing the earliest possible age at which a private pension can be drawn, promoting longer working lives by increasing the deferral rate of the state pension (from 7.4% to 10.4% in 2005) and allowing people to receive their state pension while continuing to work.

The key challenge identified in the last Joint Report is to continue to address the adequacy of pensions. The reform measures outlined in the previous section (increased eligibility for a state pension, pension uprating according to earnings, including periods spent caring in pension entitlements, encouraging private pensions) should increase access to and improve the pension adequacy of future pensioners. Concerning the pension adequacy of today's pensioners, the income of elderly persons has increased significantly over the last decade[182], keeping pace with the strong growth in earnings. Ensuring this trend persists, and continuing to tackle inequality and poverty among pensioners, is the main challenge faced by policymakers.

4.3. More people in work and working longer

In the UK, the employment rates for older workers (66.3% for men and 48.9% for women in 2007) are among the highest in Europe. The average age of exit from the labour market was 62.6 years in 2006 (EU-27 – 61.2 years.) Alongside the initiatives already described (rise in pension age, incentives to defer the state pension, increase in age when the occupational pension can be drawn) the government also emphasises supportive measures to help people to stay in the labour market. The most important tools are the active labour market policy New Deal 50 Plus aimed at older people, legislation to outlaw age discrimination in employment and vocational training and the Age Positive initiative, which promotes the benefits of employing older people. The UK has a comparatively high number of people on incapacity benefits and for a long time they have served as an early exit from the labour market. The government has embarked on welfare reforms with the aim of reducing the number of people on sickness benefits and moving them into work. The main measures include introducing a new medical test to better determine benefit eligibility and increased income conditionality, combined with increased support for those deemed to be able to work.

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[181] It should, however, be kept in mind that the median income from employment for older workers (55-64 years old) in the UK is 40% higher than the EU average (in euros, 2007)

[182] Eurostat data indicate that the median income of the 65+ in the UK has risen significantly during the last decade), from being 85% of EU-15 average in 1997 to 109% in 2007, although the largest increases took place in late 90s.

4.4. Privately managed pension provision

For those retiring today, defined benefit (DB) schemes are predominant, but there is a continuing shift from DB schemes to defined contribution (DC) schemes, where the investment risk is with the pension scheme member. The contribution rates are also significantly higher for open DB schemes than for open DC schemes and typically employers also pay a larger proportion of the total contributions in DB schemes than in DC. Participation in private pension schemes is encouraged by tax incentives. However, the regressive nature of these tax reliefs contributes to increasing inequality. There are concerns that coverage of private pension savings is low (only 56% of working age employees are contributing to a private pension) and has been declining. Participation in private pension schemes varies greatly by earning level and gender. To promote private savings, the government has implemented or will implement several measures described in previous sections (most crucially Personal Accounts but also simplification of legislation and the taxation regime and tax relief). There are also provisions to deal with risks: a Pensions Regulator (regulates work-based pension schemes) and a Pension Protection Fund (pays compensation if the employer becomes insolvent and the pension scheme is under-funded). However, the recent financial crisis poses significant challenges to increased participation in private pensions and adequacy levels.

4.5. Minimum income provision for older people

According to Eurostat data, the risk of poverty for people above 65 is higher (27% for men and 32% for women) than the EU25 average (16% for men and 22% for women). According to national data, pensioner poverty has decreased over the last decade, although during the last year it rose by 2 percentage points. Possible explanations for the last increase are that median earnings grew in excess of inflation and age-related payments were made in 2005/2006 but not repeated the following year.

All those aged 60 or over and living in Great Britain are entitled to claim the Guarantee Credit, which ensures that the weekly income for single persons does not fall below £124.05 and £189.35 for couples. Moreover those aged 65 or over may also be entitled to the Savings Credit, which rewards those who have made some savings towards their retirement. These two elements together make up the Pension Credit. To ensure a better take-up of the Pension Credit, data matching is used to identify those entitled and face-to-face visits are offered to the most vulnerable pensioners. In addition to direct support for pensioners with low incomes, income-related benefits are also provided for additional and varying spending commitments, such as rent and council tax. During cold months, there is also financial support for older people to cover heating costs.

4.6. Information and transparency

The complexity of the UK pension system continues to be problematic. To improve information and transparency, a range of programmes have been launched to focus on improving financial capability, particularly to help those most at risk of taking poor financial decisions. People also have access to personalised pension forecasts and a pension tracing service which helps find lost pension schemes. Generic pension information is available via websites and leaflets. The Pensions Advisory Service provides free information, advice and guidance on the whole spectrum of pensions. The Pensions Education Fund was established to provide impartial and accurate information to employees and self-employed who are at a risk of under-saving.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Healthcare in the UK is delivered through the mainly publicly funded National Health Service (NHS), which provides comprehensive and universal coverage. Primary and secondary care is provided by employees of the NHS or contracted providers. Health care services are free at the point of delivery but there are a limited number of co-payments. Responsibility for health care is devolved to the four constituent countries of the UK. Scotland, Wales and Northern Ireland receive a block grant from HM Treasury and determine its allocation to health and social care and other devolved functions. All four countries in the UK give high priority to improving quality and access, prevention, moving more services out of hospitals into local communities, ensuring more personalised care and tackling health inequalities. During recent years, all four countries have published a number policy documents outlining their vision of health care as well as priorities, challenges and policy responses.

Life expectancy at birth (77.1 for males and 81.1 for females in 2005) is broadly around the EU average. It has increased by about three years for men and two years for women over the last decade. The number of healthy life years is 63.2 for men and 65 for women.

5.1.2. Accessibility

In the UK there is universal access to healthcare for the resident population. Concerning access to health care, the UK is among the most equitable in the EU, as the self-reported unmet need for health care is below the EU average and is fairly evenly distributed across different income groups. Patients who seek private healthcare are still entitled to NHS treatment; however, they cannot benefit from both services for the same episode of treatment. Around 11% of the UK population is covered by private insurance. As a consequence of devolution, there are differences in access to health care between the four countries as there are different regional priorities concerning resource allocation and service development. For example, waiting times in England are significantly shorter than in the rest of the UK. In England there are co-payments for prescription drugs with exemptions for certain groups; in Scotland and Wales drugs are free of charge. Independently of co-payments there are variations in drug accessibility both between and within the countries (availability of cancer drugs being the most noticeable example). The National Institute for Health and Clinical Excellence (NICE) decides which treatments and medicines should be available to NHS patients and the appraisals are based on weighing up the costs against the benefits. The regions can offer access to drugs on a local basis independently of approval from NICE, resulting in variations in the availability of drugs. Concerning waiting times, all countries have set quantifiable targets and significant progress has been made (especially in England). In the UK, there have been significant absolute improvements in the health of people in disadvantaged groups and areas. Despite these improvements, in England inequalities in health persist and, in some cases have widened. The current strategy on health inequalities focuses on the wider determinants of health, the lives people lead and what the NHS can do. An ongoing evaluation of enacted programmes has been made available with a commitment by the government to continue supporting actions in order to meet the targets, and more action on the factors that drive inequalities. In Scotland, a Ministerial Task Force was established in 2007 to identify priorities and practical actions to tackle health inequalities. In Wales, the government has provided funding for projects to promote awareness and understanding of health inequalities and stimulate action. In Northern Ireland, resources are allocated taking into account the duty to ensure equal access to various groups and demographic factors, and

additional resources are targeted to sparsely populated areas. All residents should be able to access treatment within one hour in case of an accident or emergency

5.1.3. Quality

Quality healthcare is a priority for all the constituent countries of the UK, where there are healthcare standards in place along with mechanisms to monitor quality. Health technology assessment programmes have been developed to evaluate the effectiveness and broader impact of healthcare treatments and tests. In England, during the last decade the main challenge was capacity; now the main challenge is to improve the quality of healthcare. There is emphasis on improved delivery and governance and expanding patient choice. Quality is also monitored by using patient surveys. Further plans to improve quality include developing comparable quality indicators and introducing a legal duty for healthcare providers to publish regular reports to the public on the quality of their services. A new system of tariffs will ensure that money follows the patient and that prices reflect the cost of best practice rather than the average cost. In Scotland, policy developments aim to improve the safety of hospital care, support health care staff to drive improvements and share best practices and use patient surveys to improve health care services. In Wales, monitoring patient safety is one of the key issues and the culture of reporting and learning from patient safety incidents is actively promoted. In Northern Ireland there are initiatives to improve clinical and social care governance, promote an informed safety culture and develop new standards.

5.1.4. Sustainability

While still below the EU average (9% of GDP) in relative terms, health expenditure rose from 6.8% of GDP in 1997 to 8.4% of GDP in 2006 and is projected to increase further. The increase in spending is a deliberate policy action with the aim of providing better healthcare services. However, a comprehensive evaluation of increased investment, its effectiveness and overall impact on different parts of the health system would be appropriate. Policies to address sustainability include prevention, promotion of healthy lifestyles and public health and moving more services out of hospitals. Though the UK currently has one of the lowest numbers of practicing clinicians per 1000 population, this number is steadily increasing and is predicted to increase further. The UK also has one of the highest numbers of nurses and midwives. England is the only country within the UK that has adopted a Payment by Results system, whereby a large proportion of hospitals' income is dependent on the volume of activity that they undertake. The price (national tariff) is based on average cost data collected and submitted by NHS providers. Prices are adjusted to take account of unavoidable regional cost differences. To create incentives for efficiency, Scotland has implemented a national tariff which is the estimated average cost of different procedures. A programme was launched to attack waste, duplication and bureaucracy in the public sector. As part of the programme, the health sector has identified £613 million in savings over the three year period. In Wales, the government allocates resources to local health boards to pay for the costs of hospital treatments provided by NHS Trusts or other independent providers. Northern Ireland is planning to introduce a tariff in shadow form based on the average cost, with an aim of encouraging providers to become more efficient. To make the health sector more streamlined and efficient, 18 former Trusts have been merged into six.

5.2. Long-term care

5.2.1. Description of the system

The responsibility for long-term care is devolved to the four countries of the UK. In England and Wales, long-term services are means-tested. In Scotland, long-term care is free for those in need. Northern Ireland is the only country where healthcare and long-term care services are integrated; the country is currently discussing the possibility of introducing free long-term care.

5.2.2. Accessibility

All four countries have introduced or are planning to introduce measures to support unpaid informal carers. Local authorities determine eligibility and access to care. However, the assessment allows considerable discretion over the decisions. In England, Wales and Northern Ireland, local authorities contribute towards some of the cost of care and it varies between countries and care locations. Co-payments and additional user charges that are not covered for persons above the means-tested threshold can act as barriers to accessibility. England has implemented a pilot scheme under which people can choose to take money from the local council and arrange their own care. In Scotland, there is evidence that free long-term care enjoys broad support, although there are suspicions that need assessment and eligibility rules have been applied inconsistently across the country.

5.2.3. Quality

All four countries have mechanisms in place to monitor the quality of long-term care. In England, responsibility for quality assurance has moved from the local authorities to the central government. The regulatory body inspects the performance of long-term care against National Minimum Standards. The regulatory body can place legal conditions on providers failing to meet requirements to carry out improvements. There are some concerns that the perspectives of users are not well integrated into the standards of the inspection process.

5.2.4. Long-term sustainability

In all the constituent parts of the UK the level of funding for long-term care is increasing. In Scotland, where long-term care is free, it is predicted that the costs will rise substantially over the next 20 years. In England and Northern Ireland there are consultations on the long-term sustainability of long-term care in light of demographic change. In Great Britain, there is a general problem of care coordination between the healthcare services and personal social services, which has implications for the sustainability of the system and future needs assessment. The countries are seeking ways to ensure integrated health and social care services.

6. CHALLENGES AHEAD

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

- To tackle levels of economic inactivity by improved engagement with vulnerable groups, whilst adequately supporting the transition to quality and sustainable work and reducing the number of jobless households.

- To pursue the reform process and continue to address pensions adequacy; to implement improved access to quality private pension schemes and to monitor the situation, especially in light of the current financial crisis.

- To build on the progress made and to continue to improve accessibility and quality of healthcare services.

- To look at ways of improving integration of health and long-term care services and addressing discretion in the assessment of needs and eligibility rules.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population) 15-64 Total	Male	Female	15-24	55-64	Eurostat	Unemployment rate (% of labour force) 15+ Total	Male	Female	15-24
2000	3,9	119,0	**2000**	71,0	77,7	64,5	55,8	50,4	**2000**	5,6	6,1	4,9	12,0
2005	2,1	121,8	**2005**	71,7	77,7	65,8	54,4	56,8	**2005**	4,8	5,2	4,3	12,8
2008*f*	0,7	115,5	**2007**	71,5	77,5	65,5	52,9	57,4	**2007**	5,3	5,6	4,9	14,3

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth Male	Female	Life expectancy at 65 Male	Female	Healthy life expectancy at birth (2005 instead of 2006) Male	Female	Infant mortality rate	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
1995	74,0	79,2	14,6	18,2	60,6	61,2	6,2	**1995**	6,9	83,9	10,9		-
2000	75,5	80,2	15,7	18,9	61,3	61,2	5,6	**2000**	7,2	80,9	13,3	**2005**	2,3
2006	77,1	81,1	17,0	19,5	63.2b,p	65.0b,p	4,5	**2006**	8,4	87.3d	11.9**	**2006**	1,9

s: Eurostat estimate; p: provisional; b: break in series; d: change in methodology — **THE: Tot. Health Expenditure; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	27,7	43,1	24,0	5,6	8,9	7,5	10,9
2000	26,4	48,8	25,5	3,0	6,9	6,4	9,4
2006	26,4	44,7	31,8	2,4	6,1	6,3	8,7

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	24,3	19,6	6,6	7,0	1,0
2010	24,7	-0,2	0,0	0,2	0,0
2030	33,2	2,2	1,3	1,1	0,3
2050	38,0	4,0	2,0	1,9	0,8

4. Social inclusion and pensions adequacy (Eurostat)

SILC 2007	At-risk-of-poverty rate Total	Children 0-17	18-64	65+	Poverty risk gap Total	Children 0-17	18-64	65+	Income inequalities S80/S20	Anchored at-risk of poverty	Total - fixed 2005 threshold
Total	19	23	15	30	23	22	25	20	5,5	**2005**	19b
male	18	-	14	27	23	-	26	18	-	**2006**	18
femal	20	-	16	32	23	-	24	21	-	**2007**	16

	People living in jobless households: Children Total	% of people aged 18-59* Total	Male	Female
2001	17,0	11,2	9,1	13,3
2004	16,3	10,8	8,8	12,8
2007	16,7	10,7	8,8	12,7

	Long Term unemployment rate (% of people aged 15-64) Total	Male	Female
2000	1,4	1,9	0,9
2004	1,0	1,2	0,6
2007	1,3	1,6	0,9

	Early school-leavers (% of people aged 18-24) Total	Male	Female
2000	18,4	18,9	17,9
2004	13,6	14,1	13,1
2007	17.0b	18.2b	15.8b

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,82	0,91	0,80	***Aggregate replacement ratio***	0,41	0,42	0,44

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046): Net Total	Gross replacement rate Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Assumptions: Coverage rate (%) Statutory pensions	Occupational and voluntary pensions	Contribution rates: pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-4	-2	-3	DB	1	DC	100	53(M)/56(F)	19,85	9	8

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Annex: Indicators

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[183]. Source: SILC.

+ **Illustrative threshold value:** Value of the at-risk-of-poverty threshold (60% median national equivalised income) in PPS for an illustrative household type (e.g. single person household). Source: SILC.

1b. Relative median poverty risk gap: Difference between the median equivalised income of persons aged 0+ below the at-risk-of poverty threshold and the threshold itself, expressed as a percentage of the at-risk-of-poverty threshold. Source: SILC.

2. S80/S20: Ratio of total income received by the 20% of the country's population with the highest income (top quintile) to that received by the 20% of the country's population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income. Source: SILC.

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

4. Early school-leavers: Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training is 0, 1 or 2 according to the 1997 International Standard Classification of Education — ISCED 97) and have not received education or training in the four weeks preceding the survey. Source: LFS.

5. People living in jobless households: Proportion of people living in jobless households, expressed as a share of all people in the same age group[184]. This indicator should be analysed in the light of context indicator No 8: jobless households by main household types. Source: LFS.

6. Projected total public social expenditure: Age-related projections of total public social expenditure (e.g. pensions, healthcare, long-term care, education and unemployment transfers), current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-20-30-40-50).

Specific assumptions agreed in the AWG/EPC. See 'The 2005 EPC projections of age-related expenditures (2004-2050) for EU-25: underlying assumptions and projection methodologies' Source: EPC/AWG.

7a. Median relative income of elderly people: Median equivalised income of people aged 65+ as a ratio of income of people aged 0-64. Source: EU-SILC.

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[183] **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.

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

7b. Aggregate replacement ratio: Median individual pensions of 65-74 year-olds relative to median individual earnings of 50-59 year-olds, excluding other social benefits. Source: EU-SILC.

8. Self-reported unmet need for medical care: Total self-reported unmet need for medical care for the following three reasons: financial barriers + waiting times + too far to travel.

+ **Care utilisation:** To be analysed together with care utilisation defined as the number of visits to a doctor (GP or specialist) during the last 12 months. Source: EU-SILC.

9. At-risk-of-poverty rate anchored at a fixed moment in time (2005): Share of persons aged 0+ with an equivalised disposable income below the at-risk-of-poverty threshold calculated in the year 2005 (1st EU-SILC income reference year for all 25 EU countries), adjusted for inflation over the years. Source: SILC.

10. Employment rate of older workers: Persons in employment in the 55–59 and 60–64 age groups as a proportion of the total population in the same age group. Source: LFS.

11. In-work poverty risk: Individuals who are classified as employed[185] (distinguishing between 'wage and salary employment plus self-employment' and 'wage and salary employment' only) and who are at risk of poverty.

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

12. Activity rate: Share of employed and unemployed people in the total population of working age, 15-64. Source: LFS.

13. Regional disparities — coefficient of variation of employment rates: Standard deviation[186] of regional employment rates divided by the weighted national average (15-64 age group). (NUTS II). Source: LFS.

14. Total health expenditure per capita: Total health expenditure per capita in PPP. Source: EUROSTAT based on system of health accounts (SHA) data.

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185 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.

186 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).

2. Data sources

Indicators of income and living conditions: EU-SILC

For the first time this year, EU-SILC data are available for 25 EU countries. The newly implemented reference source of statistics on income and social exclusion is the Framework Regulation (No 1177/2003) for the European Survey on Income and Living Conditions (EU-SILC). The technical aspects of this instrument are developed by Commission implementing regulations, which are published in the Official Journal. The data for Bulgaria and Romania are still based on the national household budget surveys under the transitional arrangements agreed for the European Statistical System[187].

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

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

It should also be noted that the definition currently used for income excludes non-monetary income components, which include the value of goods produced for own consumption[188] and non-cash employee income. This component will be available for all countries from the SILC (2007) exercise onwards, and will therefore be included in the indicators to be published in January 2009.

The reference year for the data is the year to which the income information refers (i.e. the 'income year'), which in most cases differs from the survey year in which the data were collected. Accordingly, 2006 data refer to the income situation of the population in 2005, even if the information was collected in 2006. EU aggregates are computed as population-weighted averages of available national values.

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

[188] 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.

Note on trends

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

Limitations

The limited sample size for certain data sources used for the collection of income data and the specific difficulties of collecting accurate information on disposable income directly from households or through administrative records raise certain concerns as regards data quality. This is particularly the case for information on income at the two ends of the income distribution.
Furthermore, household surveys do not cover persons living in collective households, homeless persons or other difficult-to-reach groups.

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

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

Confidence intervals

Indicators are estimated values based on a sample drawn from the target population and thus are affected by sampling error. Statistical theory provides us with tools for calculating confidence intervals in which the population value lies with a high probability. The confidence intervals are centred around the estimated values reported and their length is a measure of the precision of these estimates. The precision depends on the design of the survey and can thus vary between countries. However, the EU-SILC Regulation provides for national samples to be designed so as to achieve a confidence interval of +/-1% around the estimated value of the total at-risk-of-poverty rate. Eurostat is computing these intervals for a number of indicators and exact values will be reported in EU quality reports. First computations show that the confidence intervals around the total at-risk-of-poverty rate are of the order of +/-0.8%. For the S80/S20 income quintile share ratio, the confidence intervals are of the order of +/-0.2. For the relative median at-risk-of-poverty gap, they are of the order of +/-1.7. For the Gini coefficient, they are of the order of +/-0.9. These indications of precision must be taken into account when interpreting the data.

LFS: the European Union Labour Force Survey

The European Union Labour Force Survey (LFS) is the EU's harmonised survey on labour market developments. The survey has been carried out since 1983 in the EU Members States, with some states providing quarterly results from a continuous labour force survey, and others conducting a

single annual survey in the spring. From 2005, all EU Member States have conducted a quarterly survey. If not mentioned otherwise, the results based on the LFS refer to surveys conducted in the spring ('second quarter' in all countries except for France and Austria, which is 'first quarter') of each year. It also provides data for Bulgaria, Croatia and Romania.

The Annual Averages of Labour Force Data series is a harmonised, consistent series of annual averages of quarterly results on employment statistics based on the LFS, completed through estimates when quarterly data are not available. It covers all the EU-15 (for the period from 1991 to present) and all new Member States and Candidate Countries (since 1996 or later, depending on data availability) except the Former Yugoslav Republic of Macedonia. The Annual Averages of Labour Force Data consist of two series: 1) population, employment and unemployment, and 2) employment by economic activity and employment status. The first series is based mainly on the EU LFS. Data covers the population living in private households only (collective households are excluded) and refers to the place of residence (household residence concept). They are broken down by gender and aggregate age group (15–24, 25–54, 55–64 and 15–64). Unemployment data is also broken down by job search duration (less than 6 months, 6–11, 12–23, 24 months or more). The second series is based on the ESA 1995 national accounts employment data. Data covers all people employed in resident producer units (domestic concept), including people living in collective households. They are broken down by sex, working-time status (full-time/part-time) and contract status (permanent/temporary) using LFS distributions. All key employment indicators presented in this document are based on the Annual Averages of Labour Force Data series. They represent yearly averages unless stated otherwise. Where the Annual Averages of Labour Force Data series does not provide the relevant breakdowns, the original LFS data has been used for this report.

Age-related expenditure projections

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

The projections are made on the basis of a common population projection and agreed common underlying economic assumptions that have been endorsed by the EPC. The projections are made on the basis of 'no policy change', i.e. only reflecting enacted legislation but not possible future policy changes (although account is taken of provisions in enacted legislation that enter into force over time). The pension projections are made on the basis of legislation enacted by mid-2005. They are also made on the basis of the current behaviour of economic agents, without assuming any future changes in behaviour over time: for example, this is reflected in the assumptions for participation rates, which are based on the most recently observed trends by age and gender. While the underlying assumptions have been made by applying a common methodology uniformly to all Member States, for several countries adjustments have been made to avoid an overly mechanical approach that leads to economically unsound outcomes and to take due account of significant country-specific circumstances. The pension projections were made using the models of national authorities, and thus reflect the current institutional features of national pension systems. In contrast, the projections for healthcare, long-term care, education and unemployment transfers were made using common models developed by the European Commission in close cooperation with the EPC and its Working Group on Ageing Populations. The projection results show the combined impact of expected changes in the size and demographic structure of the population, projected macroeconomic developments and assumed neutral evolution in the health status of the population in each Member State of the European Union.

Pension expenditure

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

Replacement rates

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

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

Healthcare expenditure — WHO Health for All database (www.who.int\nha)

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

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

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