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Joint Report on Social Protection and Social Inclusion

SUPPORTING DOCUMENT

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1. SCOPE AND OUTLINE OF THE REPORT

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

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

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

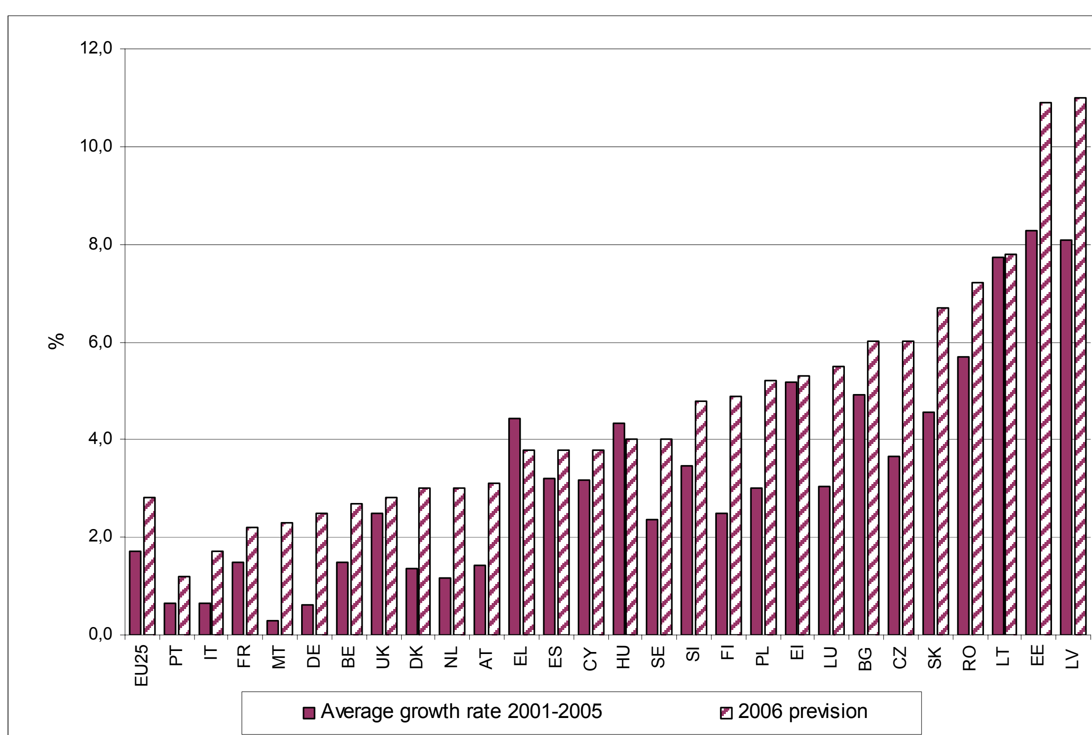
Part Two has three sections. Section 1 assesses Member States' Strategies for Social Inclusion. It explores how Member States set out to address inequalities in access to the resources, rights and services needed for full participation in society, to achieve active social inclusion while fighting poverty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

2. PART ONE: QUANTITATIVE ANALYSIS

2.1. The Economic and Demographic Context and Developments

Between 2001 and 2005, average economic growth in the EU25 was 1.7% per year, but this hides the good performance of countries like Ireland, Greece and Spain (over 3% per year on average) and the new Member States (around 4.6%). The gap between the richest and the poorest countries in Europe continued to narrow during the period. While the average GDP per capita of the five richest countries in Europe remained at 125% of the EU25 average[1], the average GDP per capita of the five poorest moved up from 42% of the EU25 average in 2000 to 51.4% in 2005. For 2006, a projected 2.3% EU25 average growth rate reflects signs of recovery observed in most Member States.

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

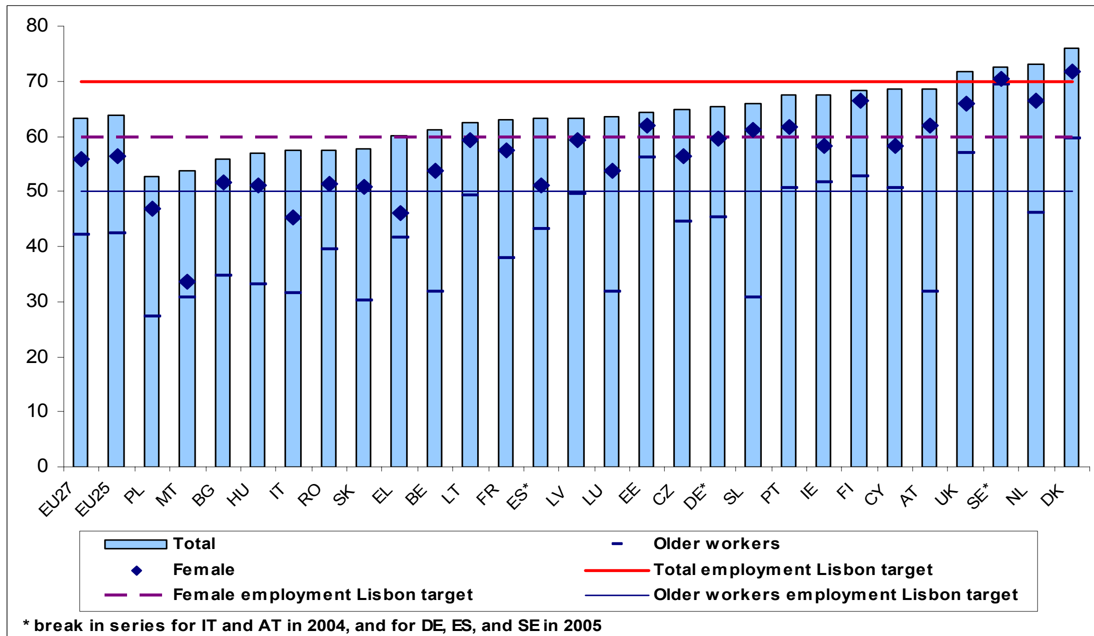


Source: Eurostat – National Accounts

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

[1] In PPS and excluding Luxembourg

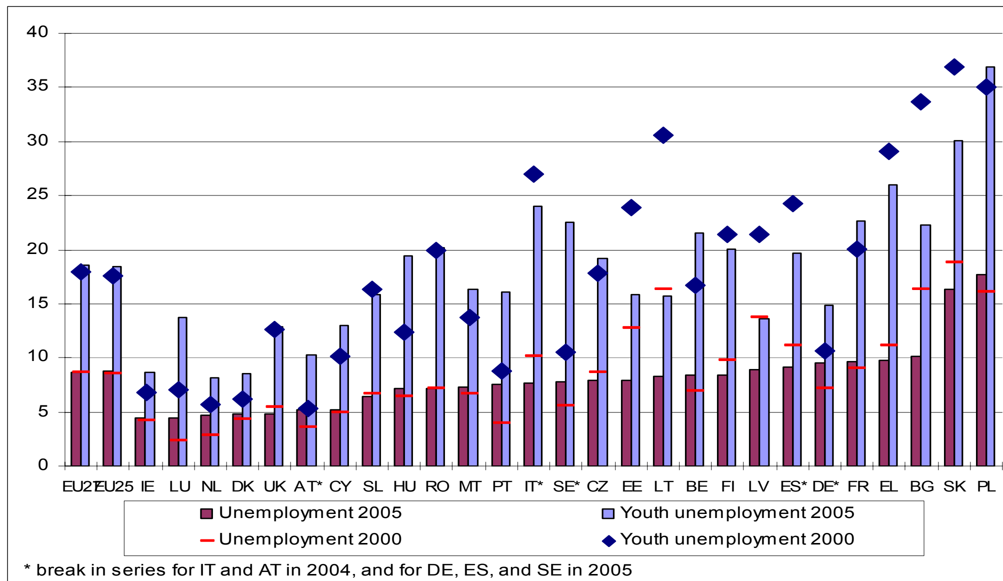
Figure 2: employment rates in the EU; total, women and older workers; 2005.



Source: Eurostat - Labour Force Survey

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

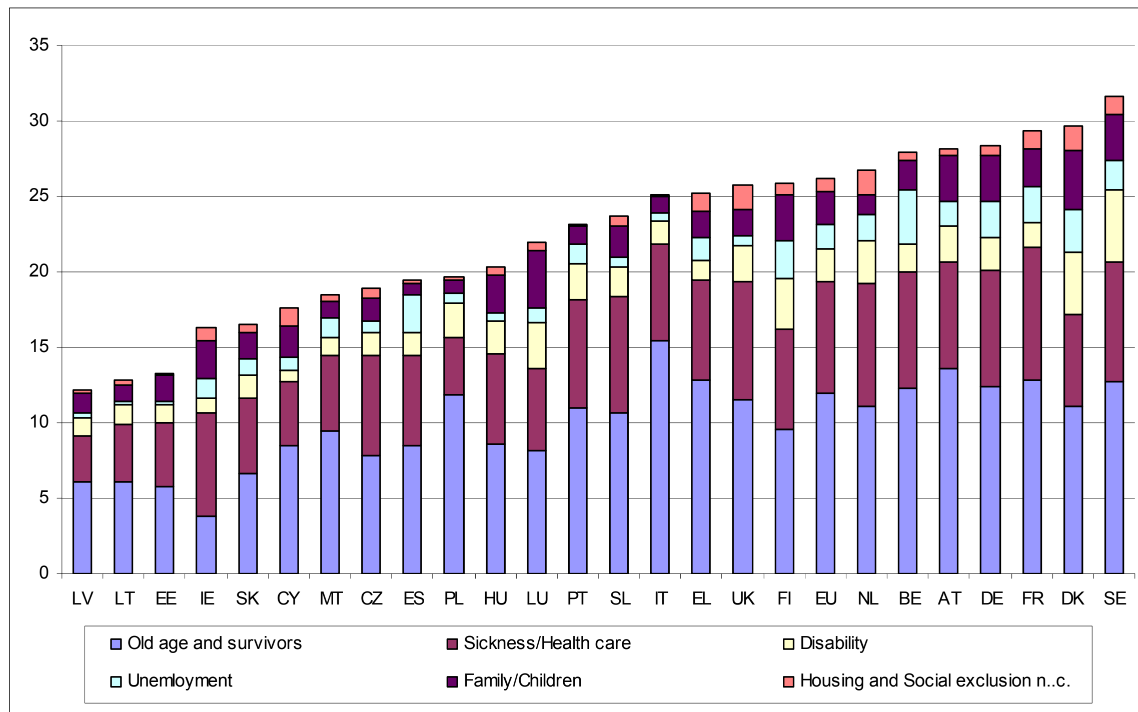
Figure 3: Unemployment and youth unemployment; 2000 and 2005.



Source: Eurostat - Labour Force Survey

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

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



Source: Eurostat - ESSPROS

In the coming decades, the size and age-structure of Europe's population will undergo dramatic changes due to low fertility rates, increases in life expectancy and the retirement of the baby-boom generation. Member States have started to address the demographic challenge in a context of tight fiscal constraints. The situation in public finances in the EU has deteriorated in a number of countries since 2000. Debt ratios in 2006 remained above the 60% of GDP threshold in Belgium, Germany, Greece, France, Italy, Austria, Portugal, Cyprus and Malta. Reforms have had a significant impact in BE and EL (where however the debt ratio remains close to 90% or more), and in AT and CY where the debt ratio is expected to fall below the 60% thresholds in the coming two years.[2]

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

Nevertheless, ageing is a consequence of the positive fact that life expectancy has continued to increase. For the EU-25, from 1995 to 2005 life expectancy at birth has increased from 72.8 to 75.8 years of age for males and from 79.7 to 81.9 for females. Between 1993 and 2003,

[2] See statistical annex for full data.

significant increases in life expectancy at the age of 45 (from 30.5 to 32.5 for males and from 36.3 to 37.8 for females) and at 65 (14.7 to 16.3 for males and from 18.9 to 19.9 for females) indicate that gains in life expectancy are more and more happening in older age. The challenge is now for social protection systems to ensure that people are living and working longer in good health, not only to improve the well-being of citizens but also to help maintain a healthy work-force and to limit increases in expenditure on health and long-term care in old age.

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

The first objective of the streamlined Open Method of Co-ordination in the field of social protection and social inclusion is the promotion of social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies.

There are a number of aspects to social outcomes, including income and living standards, access to good quality health services, educational and work opportunities. This chapter aims to give a snapshot of the social situation in the European Union from this multidimensional perspective, based on the set of indicators agreed at EU level to monitor progress in this area. It will also highlight the role of social protection and employment policies in fighting against poverty and social exclusion.

2.2.1. Poverty and social exclusion: the income dimension

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

Income poverty still affects 16% of the EU population…

In 2004, the average **at-risk-of-poverty rate** in the EU was 16%[3] while national figures ranged from 9% in Sweden and 10% in the Czech Republic to 21% in Lithuania and Poland and 20% in Ireland, Greece, Spain and Portugal. In most countries, the at-risk-of-poverty rate (for the population aged 16 or more) was higher for **women,** the difference reaching 4 percentage points in Bulgaria and Italy, while at EU level the gender gap was 2 percentage points. Only in Hungary and Poland was the at-risk-of-poverty rate marginally greater for men. However, when looking at the gender dimension, it is important to interpret figures with

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

caution since they assume equal distribution of resources within the household, which might not necessarily be the case.

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

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

The risk of poverty for **people** aged 65 and more is particularly high in Ireland (33%) and Cyprus (51%), while it is also significantly high in comparison to the population as a whole in a number of Member States[4]. However, recent measures introduced in some Member States, including minimum income guarantee schemes and increases in the minimum income guarantee, are likely to have decreased the poverty risk in recent years. Older women, without exception, are at greater risk of poverty than older men, who are on the whole no more exposed to the risk of poverty than their younger counterparts. The oldest cohorts (aged 75 and over) tend to be more at risk of poverty than those over 65 and women represent a majority of these older people. Higher poverty risk amongst the oldest people is linked to several factors. Low incomes or interrupted careers, which particularly affect women, coupled with the indexation rules in some countries, generally result in a progressive worsening of retirement incomes as older cohorts grow older.

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

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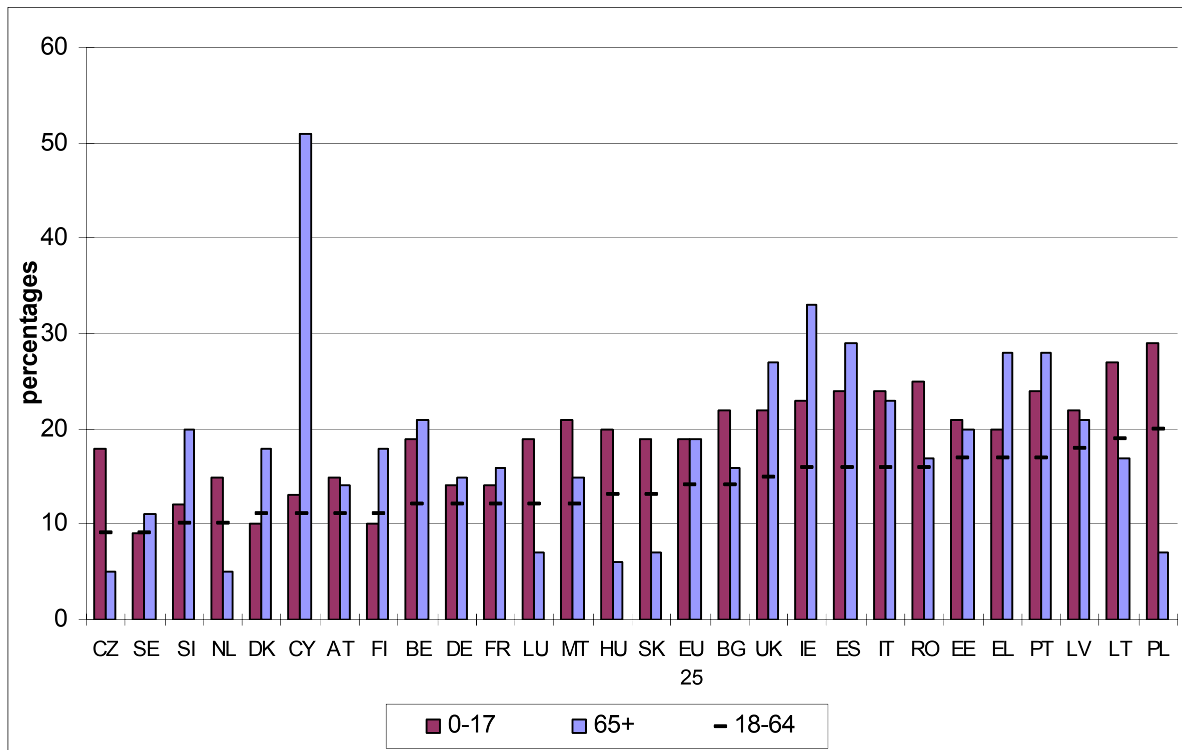
[4] To evaluate the relative position of older people, only monetary income (notably deriving from pensions) is taken into account. The wealth of pensioners, in particular house ownership (and associated imputed rents) and private savings, which have a strong effect on the income distribution of pensioners,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

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



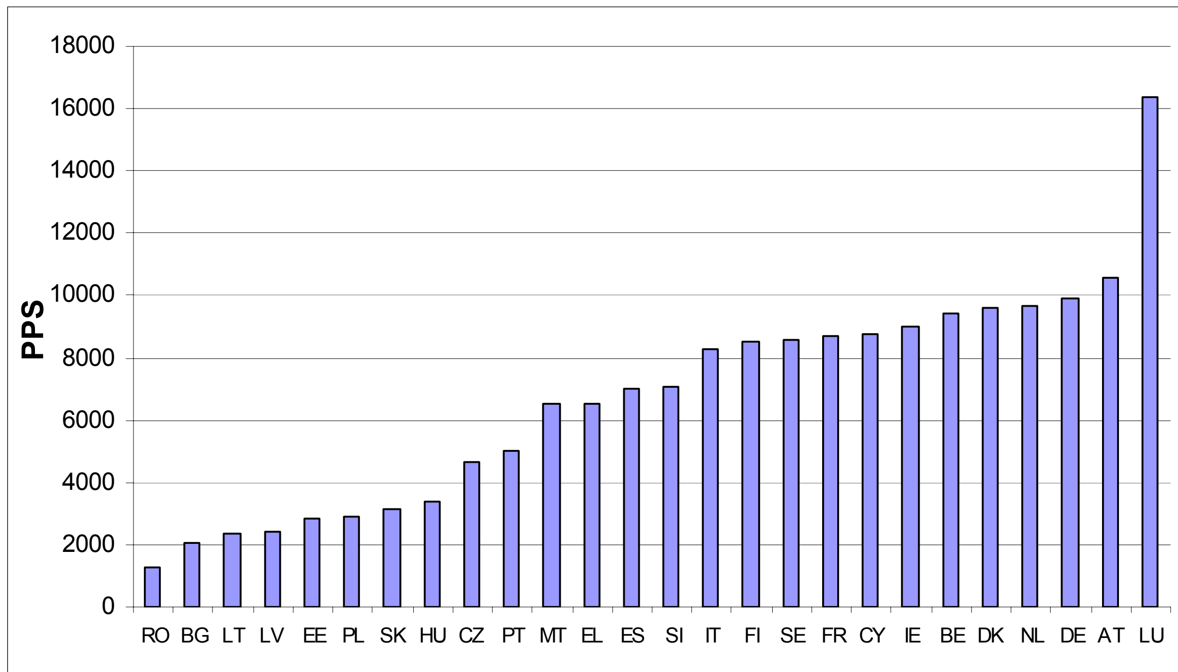
Notes: provisional data for HU and the UK; age brackets 0-15, 16-64 and 65+ for BG, RO and SI.

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

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

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

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



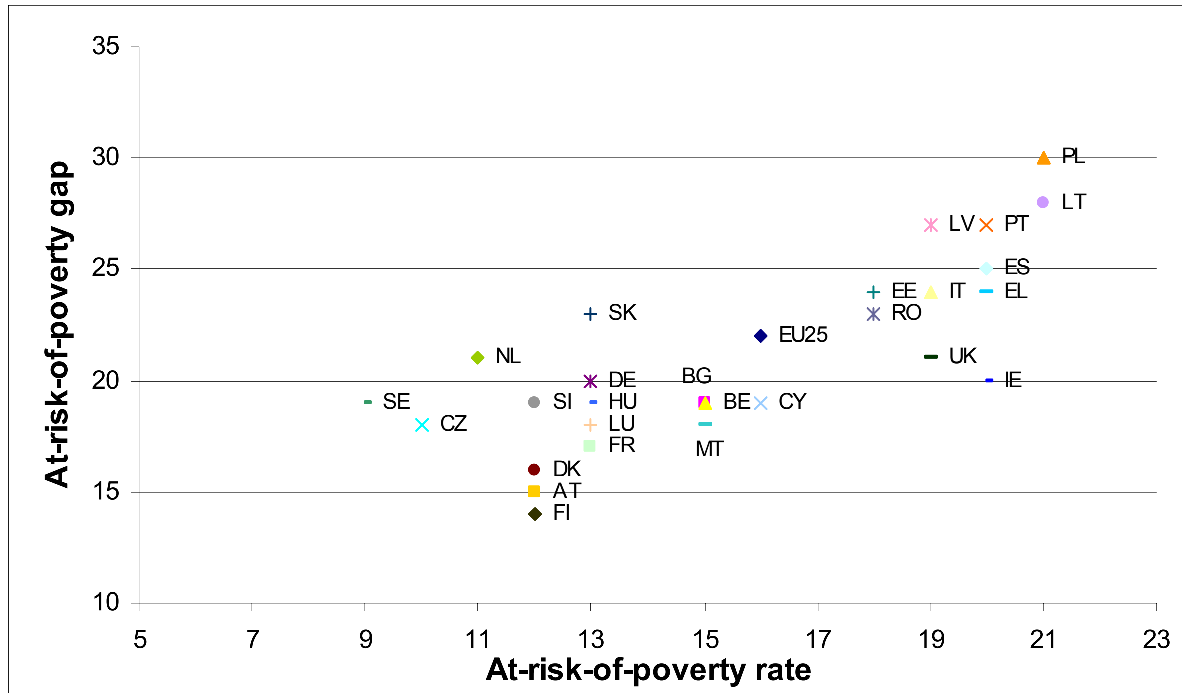
Notes: provisional data for HU.

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

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

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

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



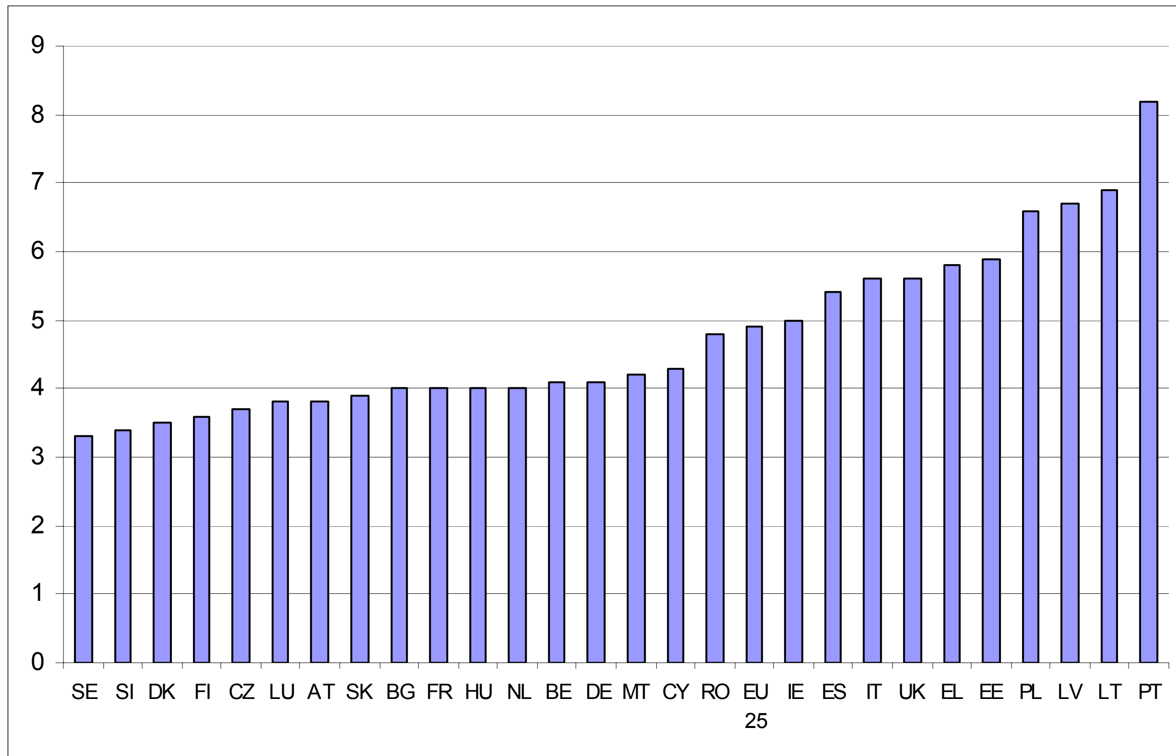
Notes: provisional data for HU and the UK.

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

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

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

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



Notes: provisional data for HU and the UK.

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

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

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

A comparison between the standard at-risk-of-poverty rate and the hypothetical situation where social transfers are absent, other things being equal, shows that such transfers have an important redistributive effect that helps to reduce the number of people who are at risk of poverty. In the absence of all social transfers[5], the average poverty risk for EU Member States would be considerably higher than it is in reality, by the order of 10 percentage points (average pre-transfer risk rate of 26% compared with the post-transfer rate of 16%). Figure 9 shows the percentage drop (in absolute terms) of the at-risk-of-poverty rate allowed by social transfers[6].

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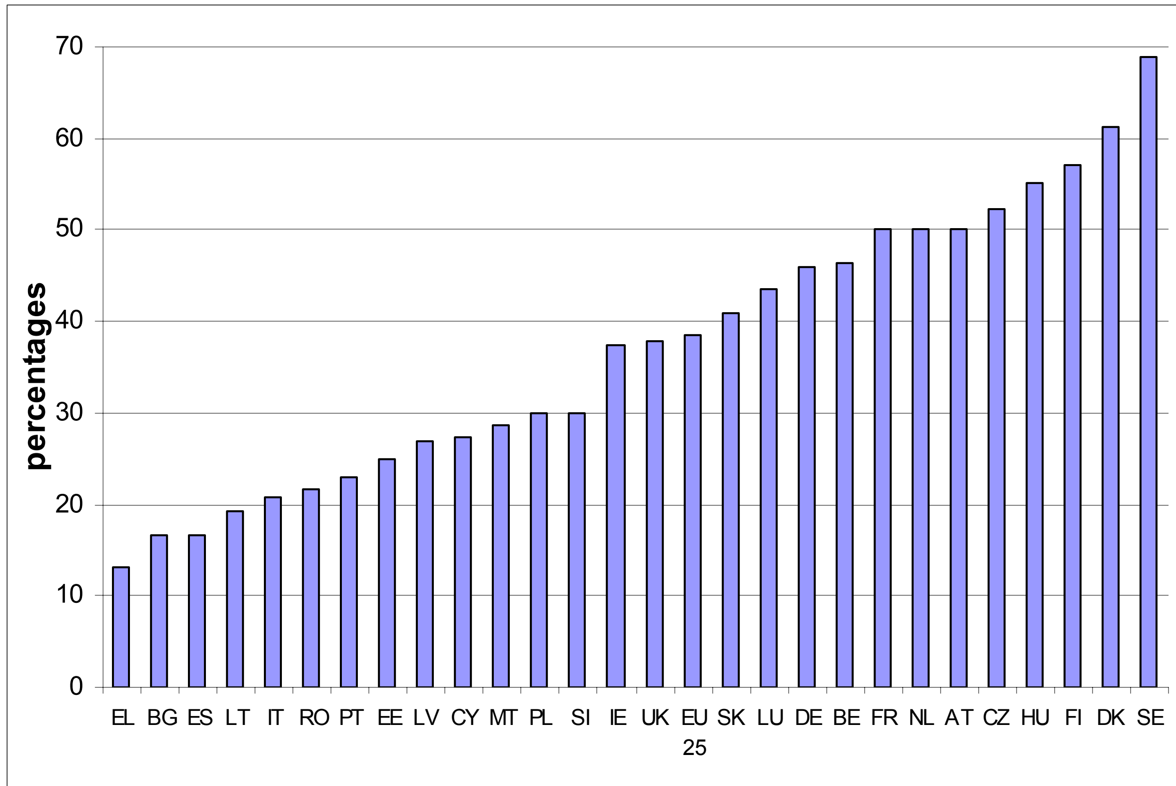
[5] For the purpose of this analysis, pensions are considered primary income since their role is not only to redistribute resources across income groups but also, and primarily, over the life-cycle of individuals and/or across generations.

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

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

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

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



Notes: provisional data for HU.

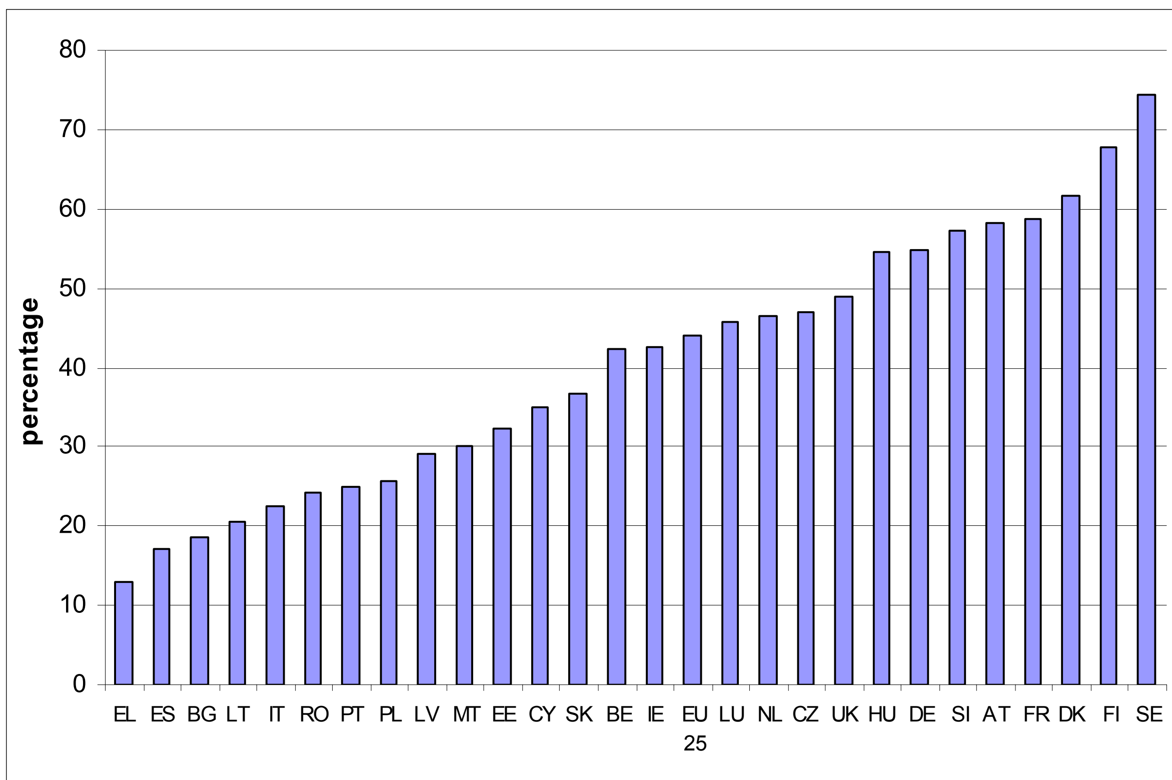
Source: EU-SILC, Eurostat; national sources for BG, RO and the UK. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004) and the UK (survey and income year: 2003).

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

disregarding any possible behavioural changes that the situation of absence of social transfers would involve.

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

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



Notes: provisional data for HU and the UK; age bracket 0-15 BG, RO, SI and the UK.

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

BOX 1: Social assistance and risk of poverty

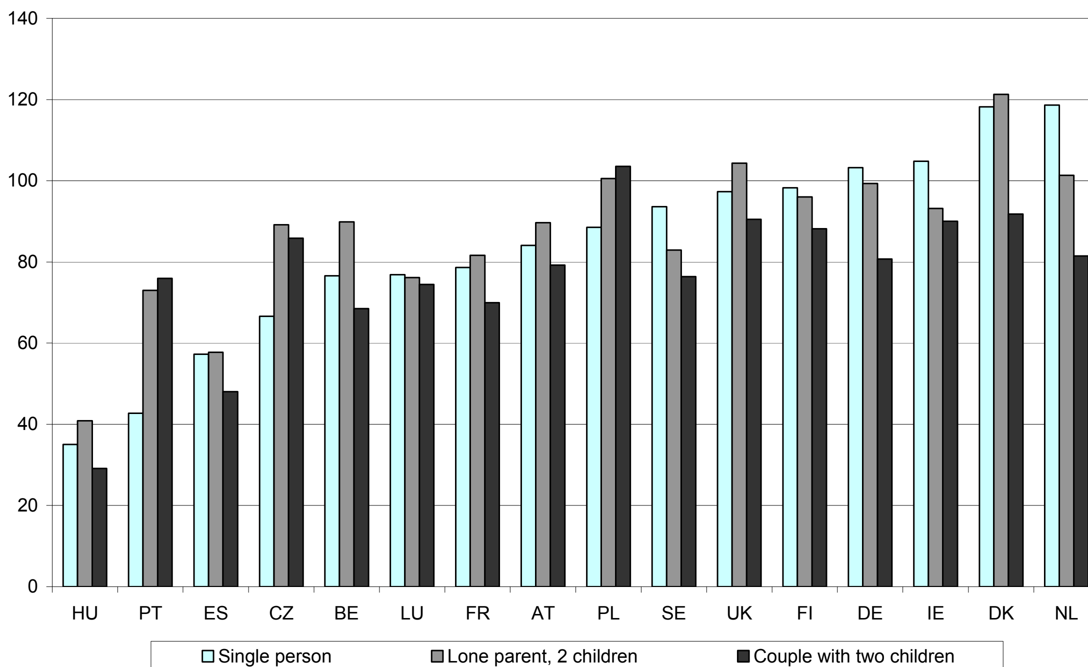
Countries differ substantially in terms of the minimum safety nets they provide to workless households[7], even when comparing them relative to the at-risk-of-poverty threshold that depends on living standards in each country. Only a few countries provide workless households with a minimum income and related (i.e. housing) benefits that are sufficient to lift them close to or above the 60% of median income threshold, and this only with respect to some family types. So, for example, lone parents can receive benefit income at or above the poverty threshold level only in Poland, the United Kingdom, Germany, Denmark and the Netherlands; whereas in all countries but Poland, couples with two children relying on social assistance benefits would have disposable income levels below 60% of the median. In

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

Hungary and Spain, all three family types are likely to receive less than 40% of median income with out-of-work benefits. Some Member States argue that the main purpose of social assistance is to meet basic needs rather than compensate for income differences between low income households and the rest of the population. Furthermore, these basic needs can be met by cash transfers, benefits in kind or a mixture of both.

Figure 11: Net income of social assistance recipients – 2003

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



Only countries where non-categorical social assistance benefits are in place are considered.

Source: Joint EC-OECD project using OECD tax-benefit models, and Eurostat

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

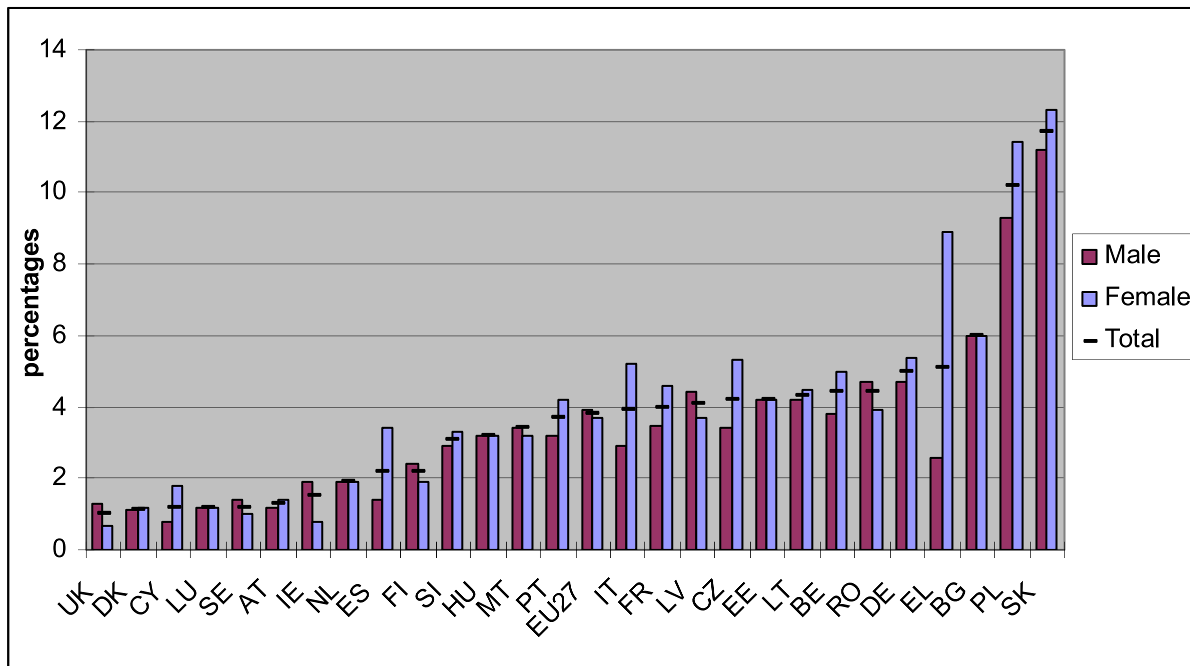
Social protection can provide relief from poverty but does not in itself help individuals and families durably elude poverty. If they are to be effective in combating poverty and social exclusion, social transfers must be accompanied by adequate health care, education, housing, social services and measures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

Joblessness is not only one of the main causes of poor living standards but is also in itself a central dimension of social exclusion, since a job is a key determinant of people's ability to fully participate in society, build a social network and realise their potential. Among all the different types of joblessness, long-term unemployment is clearly associated with social distress. The term covers people who have been searching for a job, but who have been

unable to find one for more than 12 months[8]. Long-term unemployment represents an important loss of income for the individuals concerned, who also tend to lose their skills and the self-esteem necessary to regain a foothold in the labour market.

In 2005, **long-term unemployment** affected 3.8% of the active population in the EU-27 (3.9% in the EU-25), on average more men (3.9%) than women (3.7%). The differences between Member States are considerable. Long-term unemployment rates are equal or below 1.5% in Ireland, Austria, Sweden, Luxembourg, Cyprus, Denmark and the United Kingdom, where only 1% of the active population is affected, but is equal or more than 5% in Germany, Greece and Bulgaria and 10% in Poland and Slovakia. The gender gap is particularly large in Poland, Italy and Greece where the long-term unemployment rates for women are respectively 2.1, 2.3 and 6.3 percentage points higher than for men. In only seven Member States - the United Kingdom, Sweden, Ireland, Finland, Malta, Latvia and Romania - are long-term unemployment rates higher for men than for women. Long-term unemployment has remained broadly unchanged in the five-year period between 2000 and 2005 for the EU-25 and decreased by 0.3 percentage points in the EU-27. The long-term unemployment rate decreased by more than 2 percentage points in Bulgaria, Spain, Italy, Latvia and Lithuania, while it increased by 1.4 percentage points in Slovakia and 2.8 in Poland.

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



Notes: provisional data for SE.

Source: Eurostat, Labour Force Survey, annual averages, based on 1990 census.

The term "at risk of poverty" refers to those individuals whose *household* income is below a certain threshold, since economic well-being depends on the sum of all the resources contributed by all members of the household. Therefore, joblessness is even more problematic

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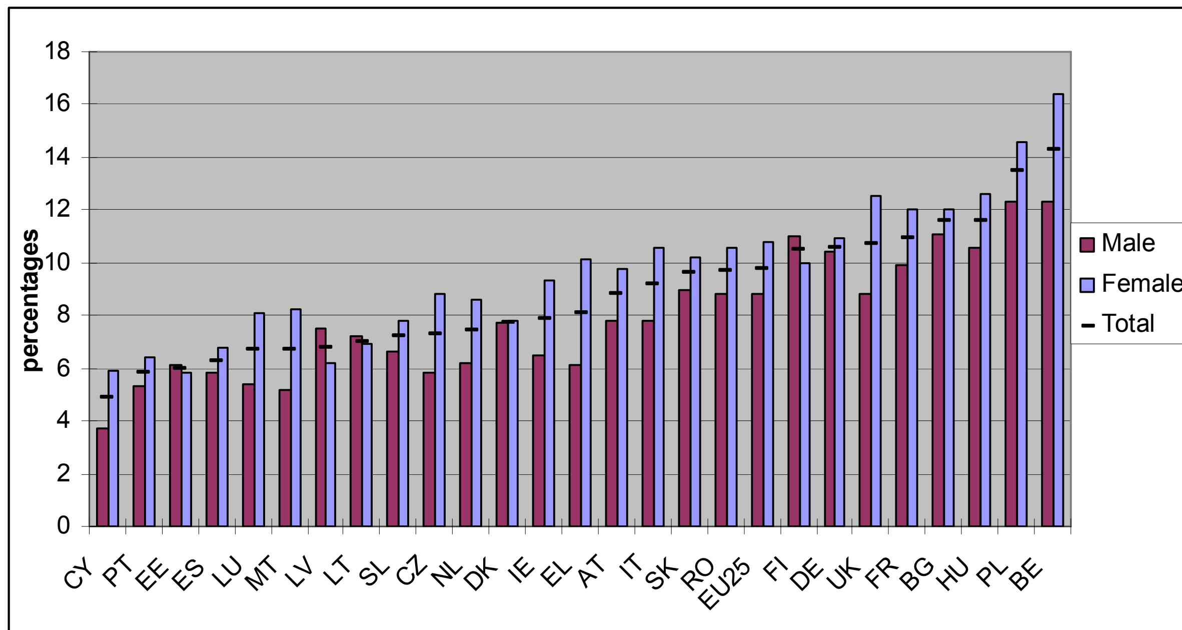
[8] Long-term unemployment is defined as the total long-term (over 12 months) unemployed population (ILO definition) as a proportion of the total active population aged 15 years or more.

when it concerns not only one individual, but all the members of the household. Furthermore, the potentially adverse impact of living in a **jobless household** goes beyond the lack of work income, as it extends to the lack of contact with the labour market.

In the EU25, the percentage of people aged 18-59 and living in households where no one works was 9.8% in 2006. This proportion ranged from below 6% in Cyprus and Portugal, to 13.5% in Poland and 14.3% in Belgium. It is interesting to note that even Member States with relatively high employment rates, such as Finland, Germany and the United Kingdom, also have above-average rates of people living in jobless households, pointing to a greater polarisation between "job-poor" and "job-rich" households in these countries[9].

In the EU, the proportion of women living in jobless households at 10.8% is two percentage points higher than for men, and this gap is equal to 3 percentage points or more in the Czech Republic, Malta, the United Kingdom, Greece and Belgium, where it reaches 4.1 percentage points.

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



Notes: In CY, the reference population (denominator) excludes students abroad.. Data for SE not available. Provisional data for DK, LU and FI.

Source: Eurostat, Labour Force Survey - Quarter 2 results

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

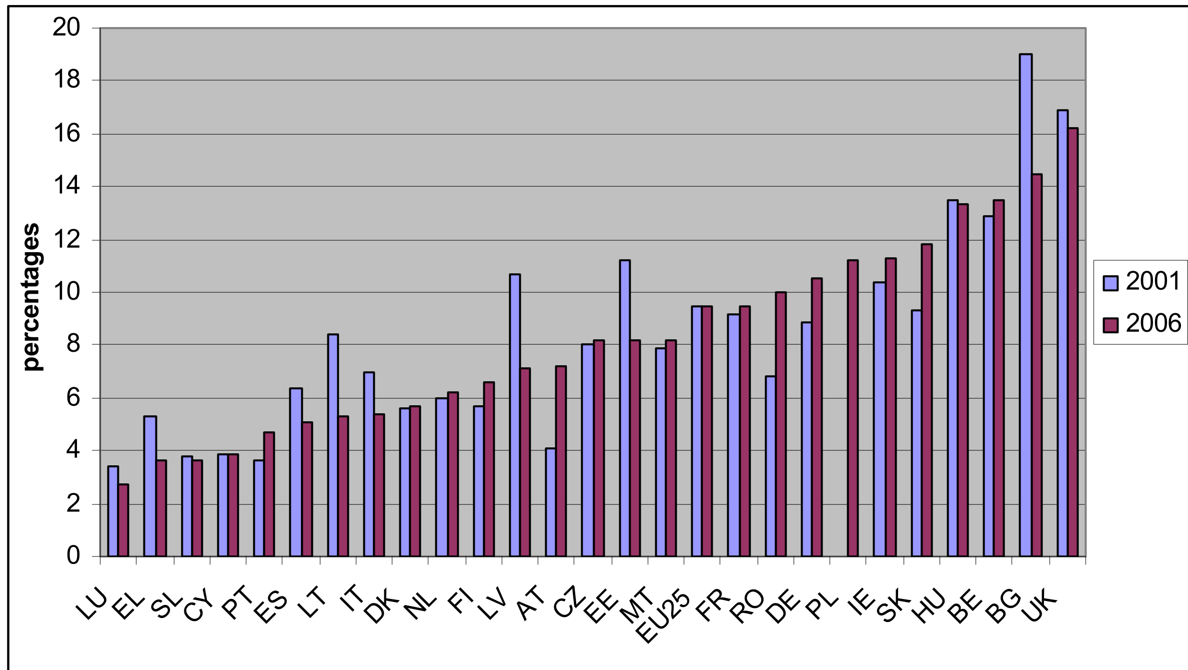
Particular concerns are raised when children grow up in a jobless household, as the absence of a working adult could be a factor affecting the educational and future labour market

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

achievement of children. In 2006, the proportion of **children living in jobless households** was slightly lower than that of prime-age adults (9.5%), but variations across Member States are more marked, ranging from 2.7% in Luxembourg to 16.2% in the UK.

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

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



Notes: data for the EU estimated. In DK, LU, EE, LV, LT, CY, MT and SI, the degree of variation of results over time is partly influenced by a low sample size. In CY, the reference population (denominator) excludes students abroad.

Source: Eurostat, Labour Force Survey - Quarter 2 results; in the first column, 2002 data for DK and LT, 2003 data for FI; data for SE and for PL prior to 2006 not available.

BOX 2: Social protection and employment: making work pay

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

The unemployment trap

- Unemployment benefit systems are intended to provide income security during unemployment and to allow a better and more efficient match between workers and jobs as

they allow individuals to spend more time on job searching. At the same time, unemployment benefits can reduce the financial incentives to return to work and thus lower job search intensity. The term **unemployment trap** refers to the situation where net in-work earnings are low relative to out-of-work income of the unemployed and their families.

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

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

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

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

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

Table 1 also shows percentage point changes in METRs faced by unemployed persons between 2001 and 2004: for most countries the figures are negative, which shows that policy efforts to review tax and benefit systems to enhance financial incentives to work are bearing fruit. In most cases, reductions in METRs have been achieved through mechanisms that allow in-work earnings to be topped up, rather than by reducing out-of-work incomes, notably by allowing beneficiaries to retain part of their benefits upon taking up work. In general, reforms of benefit systems aimed at getting beneficiaries into work tend to attach conditions with regard to active job search or participation in active labour market programmes, affecting benefit coverage rather than levels. However, in some countries, benefits have been increased by less than nominal wages, resulting in lower replacement rates and lower METRs. In the Slovak Republic, the "stronger incentives to work stem in large part from the relatively low level of social assistance that is now offered, together with the fact that social assistance is reduced less abruptly if the recipient begins to earn labour income" following the welfare reform that came into force on 1 January 2004.[10]

The inactivity trap

METRs faced by inactive individuals considering taking up a job and who are not or no longer entitled to unemployment benefits are generally lower than those affecting unemployment-to-work transitions. This is to be expected given that out-of-work income support benefits on which these people can rely are lower than unemployment benefits. Still, in many cases, the entry into a low-paid job would result in an increase in net income of no more than 30-40% of the increase in gross terms. Greece, Italy and, to a lesser extent, Spain, Hungary and Portugal, are notable exceptions: in these countries, the absence or low level of minimum income schemes[11] explains the very low level of METRs. In Ireland, METRs are also low, due to in-work benefits to raise incentives to work for lone parents, whereas the combination of low out-of-work benefits and income supplements for workers explains the low inactivity METRs in the Slovak Republic.

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

The case of the two-earner couple with children can be seen to illustrate the case of potential second earners, normally women, who have to choose between staying at home and looking after their children or working and using child care services. While the availability of quality child care services is essential to ensuring the participation of parents, especially mothers, in the labour market, child care

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

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

costs can be a major expenditure item for working parents. Low-wage second earners in about half the countries for which estimates are available see more than 70% of their additional earnings consumed by child care fees, taxes and reduced benefits. For lone parents, the payoff from employment can be even lower. The best example is Ireland, where a METR of 54% for lone parents (with two children, but with no childcare costs) shoots up to 131% when childcare costs are included.

2.2.4. Educational barriers to social inclusion: early school leaving

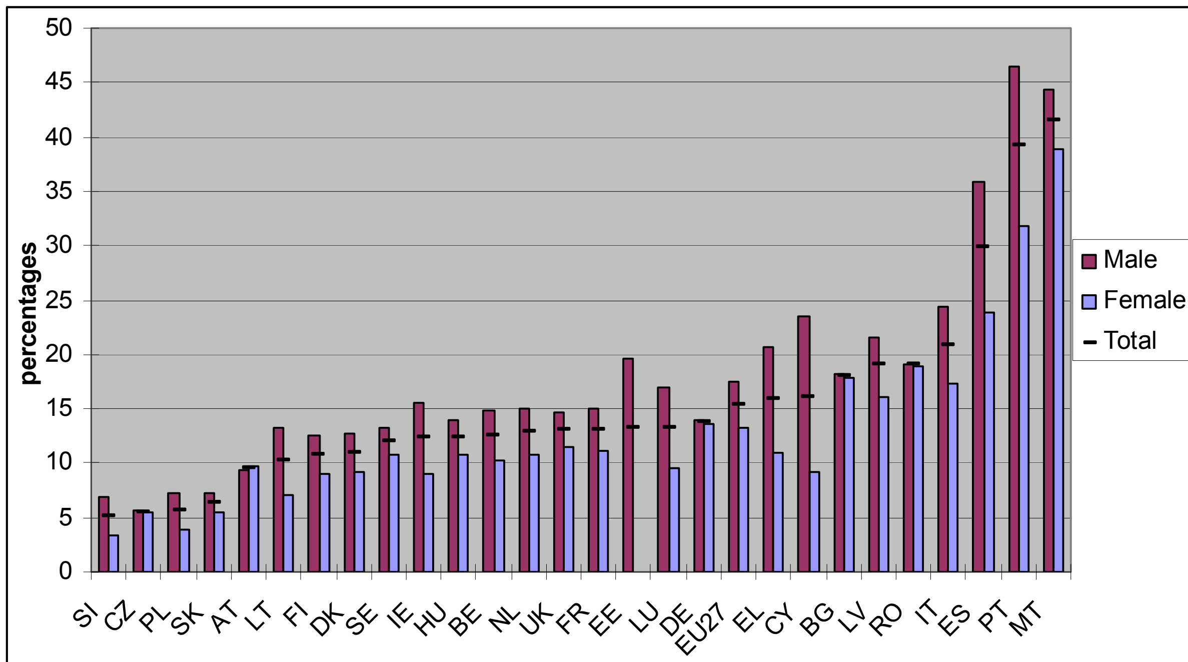
The lack of basic competencies and qualifications is a major barrier to inclusion in society. This is even more the case in an increasingly knowledge-based society and economy and a skilled workforce is a key factor in supporting the Lisbon agenda for jobs and growth. This is why improving the adaptability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

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

This percentage reaches almost 30% in Spain, 39% in Portugal and almost 42% in Malta. On the other hand, countries with the lowest proportion of early school leavers include Poland, the Czech Republic and Slovenia, where the figures are below 6%. In all Member States, the percentage of early school leavers is higher for young men, except in Romania, Bulgaria, Germany, and the Czech Republic where they are broadly similar[12].

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

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



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

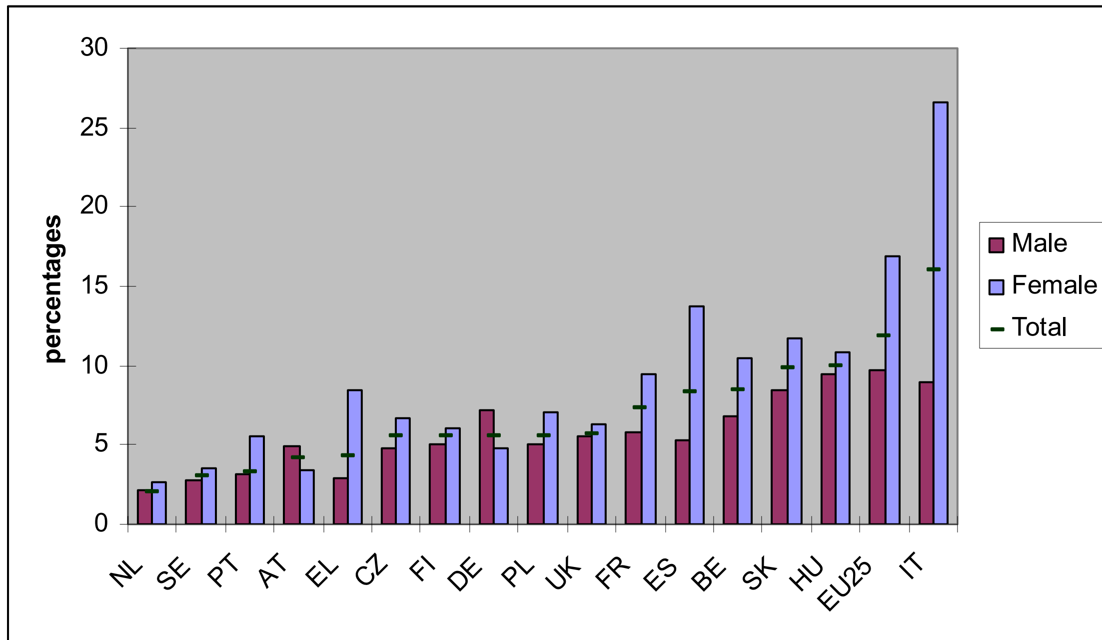
2.2.5. Regional cohesion

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

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

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

Figure 16: Dispersion of regional employment rates – 2005.



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

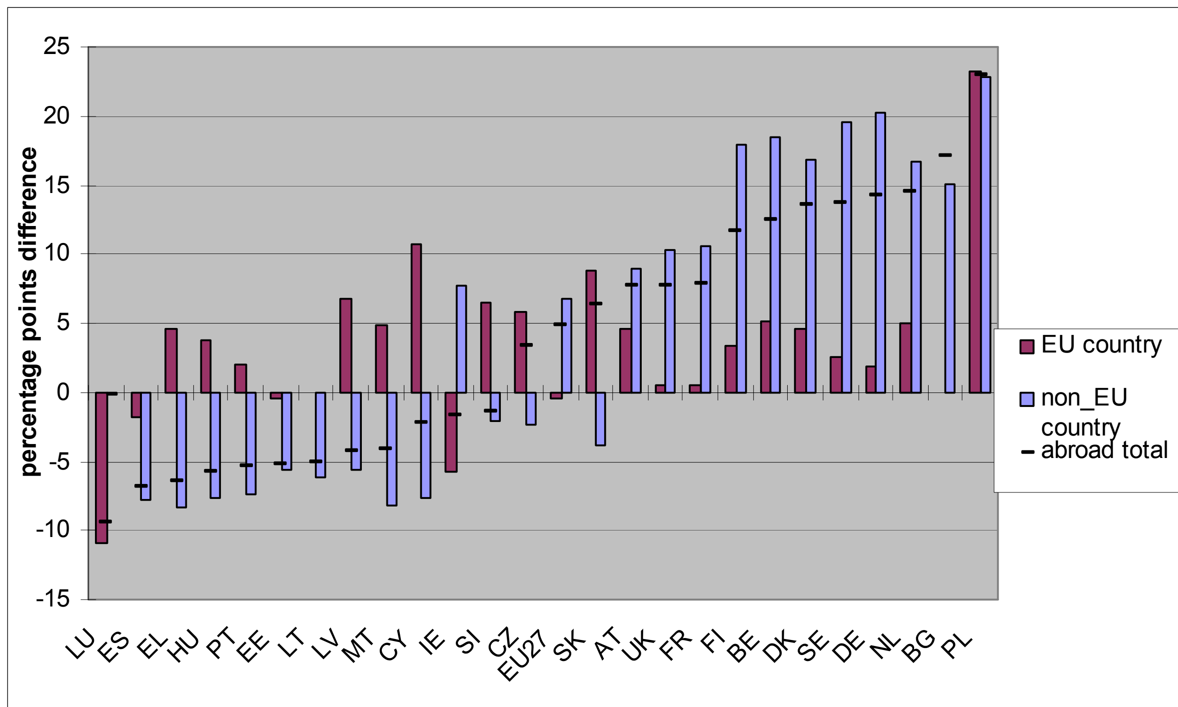
Source: Eurostat - Labour Force Survey, Annual averages.

2.2.6. *The labour market situation of immigrants*

Concerning the employment situation of foreign born residents, the employment gap is positive in almost all old Member States, except Luxembourg, Greece, Spain, Portugal and Ireland, and in Slovakia, Bulgaria and Poland. If the foreign born population is divided as to whether they were born in another EU country or outside the EU, in the former case the employment gap with those born in the country is almost zero for the EU as a whole, but it reaches almost 7 percentage points in the latter. The employment gap depends on a number of factors, including the composition and size[13] of the migrant population in terms of age structure, skill level and household composition. Member States also differ in relation to developments in migration flows over time and in legal requirements for entry into the country – in particular whether a job is a pre-condition.

Figure 17: Employment gap of foreign born residents, in percentage points

(Employment rate of born in country – employment rate of born abroad in the EU or outside the EU), 2005.



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

Source: Eurostat, LFS annual averages.

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

2.2.7. *The labour market situation of older people*

The Stockholm European Council has set a target of 50% by 2010 for employment rates of people aged 55-64 and, despite recent improvements, the EU has a significant way to go to reach this goal, as currently the employment rate is around 42.5% in 2005. A second target related to older workers was set by the Barcelona European Council in spring 2002. It focuses on the average labour market withdrawal age which is to rise by five years by 2010. The average labour market exit age is currently (2005) estimated at 60.9 years[14]. In the long run, the adequacy and sustainability of pension systems will probably require an improvement in labour market participation of older workers even beyond these targets.

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

BOX 3 – Strengthened incentives to work longer

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

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

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

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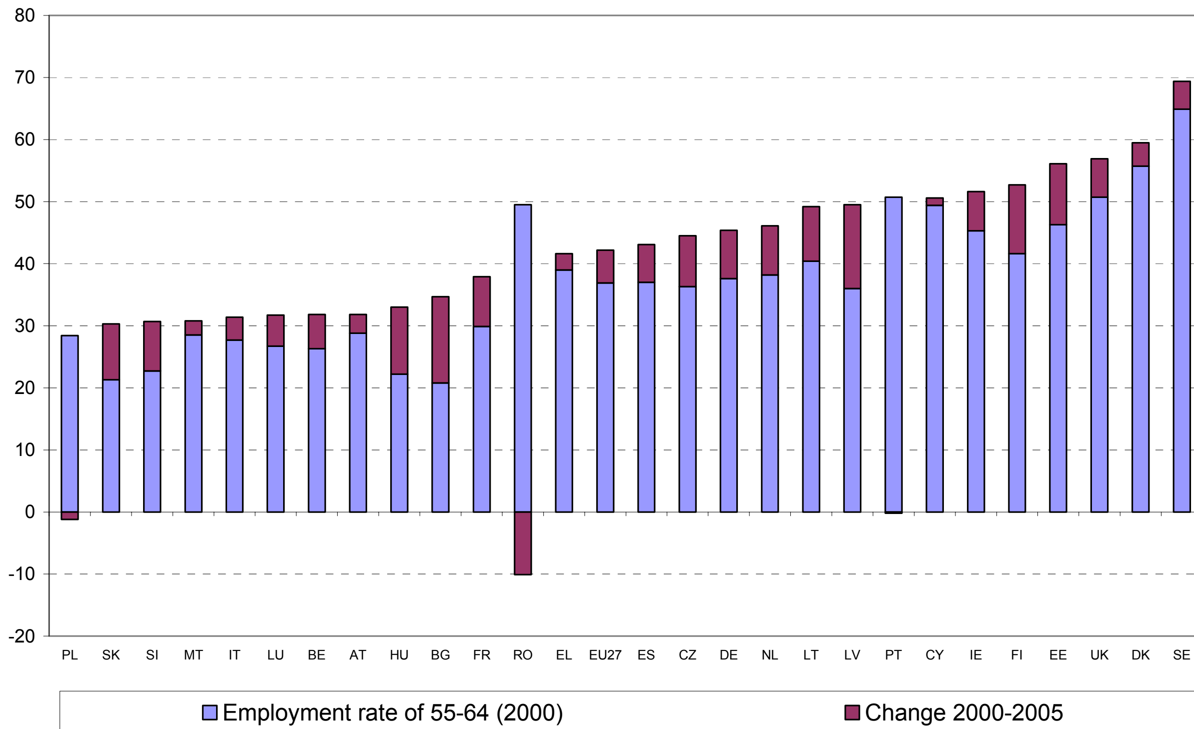
[14] The estimation is based on labour market exit probabilities between age 50 and 70. Note that the methodology can result in spurious variations from one year to the next which can make it more difficult to monitor progress over time.

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

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



Source: Labour Force Survey, annual averages.

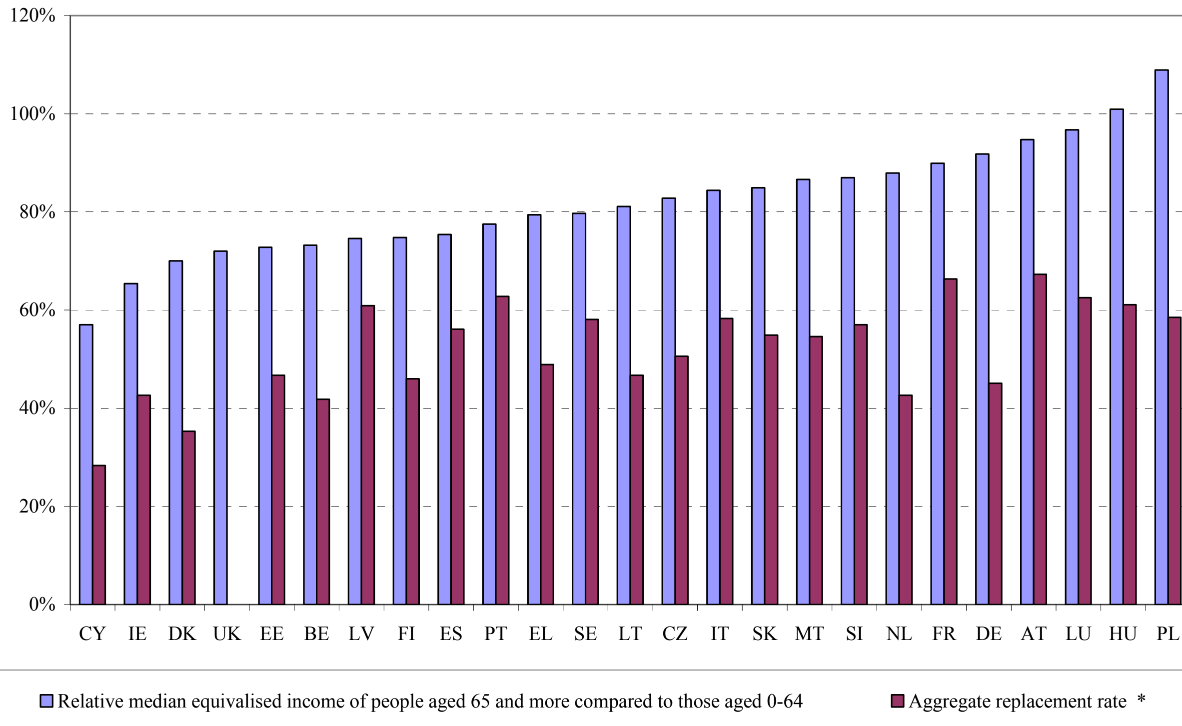
In spite of these recent improvements, in a number of Member States, the employment rate of older workers lies below or around 30% (Belgium, Italy, Luxemburg, Malta, Austria, Poland, Slovenia and Slovakia), or between 30% and 45% (Bulgaria, Hungary, the Czech Republic, Greece, Spain, France and Romania),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

2.2.8. The role of pension systems in maintaining living standards

Pension systems not only aim to ensure that older people do not have to live in poverty (see section 2.1), but more generally facilitate the maintenance to a reasonable degree of the living standard achieved during their working lives. Public pensions are essential in this respect and they will generally continue to be the main source of pensions for retired people in the future.

Older people report living standards that are relatively close to that of the general population, mostly ranging between 75% and 90% of that of the 0-64 population (see figure 19). In some Member States, the level is significantly below 75% (Ireland and Cyprus), reflecting relatively low pension entitlements as well as fast economic growth which mainly benefits people of active age, while in a number of Member States, the relative income of older people is close to 75% (Belgium, Denmark, Estonia, Spain, Portugal, Finland, Sweden and United Kingdom). By contrast, a number of Member States report levels higher than 90% (France, Germany, Luxembourg, Austria, Hungary and Poland).

Figure 19 – Indicators on current adequacy of pensions



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

Source: Eurostat, data (income year 2004).

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

Future adequacy and sustainability of pensions

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

Between 2004 and 2050, public spending on all age-related provision (pensions, health care and long-term care, education and unemployment benefits) is projected to rise in most

Member States, on the basis of current policies, although the degree varies greatly between countries (some Member States have introduced reforms since 2004 that will also affect future spending). The budgetary impact of ageing in most Member States starts becoming apparent as of 2010. However, the largest increases in spending are projected to take place between 2020 and 2040. For the euro area and the EU-15 as a whole, public spending is projected to increase by about 4 percentage points between 2004 and 2050 (including the funded tier of statutory pensions and occupational pension, the increase is about 4.5 percentage points). For the EU-10, the increase in overall age-related spending is projected to rise by about 2.9 percentage points (when including the funded tier of statutory pensions and occupational pension).

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

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

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

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

Reforms of statutory schemes will for most Member States lead to a decrease of replacement rates at given retirement ages (at 65 in the case considered). This also reflects the need to adapt pension systems to the trend towards an increase in life expectancy at 60 or 65, for all types of pension provision (be they financed on a pay-as-you-go mechanism or through funded defined-contribution or defined-benefit schemes). Indeed, against a backdrop of rising longevity, unchanged levels of replacement rates at a given age inevitably mean greater pressure on pension expenditures for all types of pension provision.

Trends in theoretical replacement rates for the base case suggest that, for most Member States, overall replacement rates are set to decline over the coming decades.[15] Net theoretical replacement rates are projected to decline in 12 Member States.[16] Given that second pillar pensions generally do not provide full coverage of the population, it is significant that the decline in gross replacement rates of first pillar statutory schemes is even more marked: gross theoretical replacement rates for first pillar are projected to decline in 14 Member States (the situation does not change significantly in 8 other Member States).[17]

BOX 4: Promoting adequate and sustainable pensions

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

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

The base case describes the situation for a typical case including different types of schemes chosen depending on the national framework, while in practice situations are by nature diverse. The evolution of the overall (net) replacement rate indeed reflects different contributions, that of statutory schemes (pay-as-you-go and possibly including a funded tier) and, in some Member States, that of private pension schemes. In those Member States, the latter contribution will benefit only those who are actually covered by such schemes, so a significant share of pensioners will depend solely on the contribution provided by statutory schemes (for more information see the 2006 Report on replacement rates[18]).

The tendency towards a decline in prospective replacement rates at a given age is a result of various adjustments. In earnings-related pensions, the contribution period taken into account in calculating

[15] See 2006 ISG Report on replacement rates.

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

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

[18] http://ec.europa.eu/employment_social/social_protection/docs/isg_repl_rates_en.pdf

pensions, and the pace of revaluation of past wages (no revaluation, revaluation against prices, against wages, or a mix), the pace of indexation of current pensions, and the statutory retirement age are generally the target of adjustments during reforms. Pension levels can also be lowered by adjusting the formula used to calculate benefits, notably by introducing mechanisms to take into account future demographic trends.

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

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

2.2.9. The health dimension

It was previously mentioned that an ageing population could pose a financial burden on health and long-term care systems. In this context, it is important to know how long people can expect to live in good health or without disability, i.e. whether ageing is accompanied by extended ill-health/disability or, rather, by its compression i.e. people are living longer but are spending less time in ill-health/ disability. The two alternatives have different implications in terms of future care costs.[19] We therefore need to look at healthy life years (also called healthy life expectancy or disability-free life expectancy): [20] the number of remaining years that a person of a certain age is still likely to live without disability. The measure distinguishes between years of life free of any limitation of activity and years experienced with at least one limitation. The emphasis is not exclusively on the length of life, as is the case for life expectancy, but also on the quality of life. The indicator was developed to reflect the fact that not all years of a person's life are typically lived in perfect health. Chronic disease, frailty, and disability tend to become more prevalent at older ages, so that a population with a higher life expectancy may not be healthier. However, if healthy life years increase more rapidly than life expectancy then, not only are people living longer, they are also living a greater portion of their lives free of disability. Analysing this indicator together with life expectancy can help countries understand whether more effort is needed to promote health and prevent ill-health.

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[19] See ECFIN and EPC-AWG projections.

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

The figures[21] suggest that for the EU-15 the general increase in life expectancy has also meant a general increase in healthy life years. For the EU15 the number of healthy life years for males and females has increased respectively from 63.2 in 1999 to 64.5 years in 2003 and from 63.9 in 1999 to 66 years in 2003. Healthy life years at birth in the EU-15 are, on average, 12 years shorter than overall life expectancy for men and 17 years shorter for women. Healthy life expectancy is higher for women than for men in all countries with the exception of Denmark, the Netherlands, Finland the United Kingdom. While men have seen an increase in their healthy life years in all countries, some countries (Greece, Ireland, The Netherlands, Finland and the United Kingdom) show a small reduction or only a very small improvement in female healthy life expectancy over the decade. In 2003, for all Member States with available data, men in the EU-15 can expect to live 84.9% of their life without disability. Women can expect to live 81.3% of their lives free of disability. Hence, though women live longer and more (absolute number of) years free of disability they also spend a higher proportion of their lives in disability (potentially at an older age). Looking at healthy life years at 65, a trend cannot be identified and the following remarks must be treated with caution. Overall, healthy life expectancy at 65 is greater for women than it is for men except in Germany and Portugal. The increase in healthy life expectancy at 65 is clearer for men than for women in all countries (from 9.4 in 2001 to 9.5 in 2003) except in Denmark, Greece and Sweden where a small reduction is noted. The healthy life expectancy of women at 65 shows no overall increase though Spain, France, Italy and Austria show an increase.

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

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

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

The health status of the EU population has improved considerably in recent decades. Life expectancy at birth increased by more than 30 years in the 20th century and infant mortality fell remarkably and is among the lowest in the world (Social Situation Report 2003; WHO European Health Report 2005). Healthy years of life have also increased and avoidable mortality has declined. Two broad

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

developments are typically associated with a secular increase in life expectancy: improvements in overall living conditions and medical advances and more widely available medical care (i.e. a rising share of resources devoted to health and a more equitable distribution).

Measuring the effect of health care on health has received considerable attention in the past.[22] McKeown (1979), in a first influential study, suggests that better nutrition, hygiene and the use of immunisation and therapeutic interventions (emphasising the importance of preventive and primary care) explain the decline in death rates. A study in the Netherlands estimated that the contribution of health care to the mortality decline between 1850 and 1970 ranged from 4.7% to 18 %.[23] A pool of studies[24] shows that health care expenditure is associated with growth in life expectancy and disability-adjusted life expectancy and a decline in infant, child and maternal mortality. Other studies[25] confirm that healthcare interventions (i.e. treatment and preventive activities) have had a substantial effect on the decline in 'avoidable' mortality especially over the past 30 years. Moreover, the quality of a country's primary care system is negatively associated with all-cause mortality and premature mortality and cause-specific premature mortality in 18 wealthy OECD countries over three decades (WHO Health Evidence Network, 2006; Macinko et al. 2003). In Europe the SHARE study (2005) demonstrates that a 1% increase in health care expenditure is associated with a 4.2% increase in the proportion of very healthy respondents in SHARE countries. Nixon and Ulmann (2006) find that increases in health care expenditure are strongly associated with declines in infant mortality and increases in life expectancy in the EU, as in the studies they review.

Despite economic growth and increases in health care expenditure and population coverage, ***substantial inequalities*** in life expectancy, healthy life expectancy, mortality, avoidable mortality and specific mortality causes, self-perceived health and disability, and mental health ***continue to exist across population groups*** in all European countries and may have widened during the last decades of the 20th century.[26] People with less education, lower occupational class and lower income tend to die younger and have a higher prevalence of disease[27]. Differences in access to care and care utilisation (e.g. Van Doorslaer and Masseria, 2004) may explain part of the observed inequalities. Higher socio-economic groups may have taken up more effective health care interventions and may have higher survival rates because of better access, quality and compliance to treatments. Indeed, as highlighted in the 2007 Joint Report on Social Protection and Social Inclusion there are important barriers to access such as service availability and distribution, waiting times, financial costs of care, information.

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

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

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

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

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

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

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

schemes that ensure an adequate income, policies that reduce social inequalities, poverty and social exclusion, a generally supportive social environment providing education opportunities and opportunities to participate in paid and unpaid volunteer work throughout life and adequate health promotion.

2.3. The Lisbon Strategy and its Impact on Social Cohesion

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

2.3.1. Employment and its impact on the poverty risk

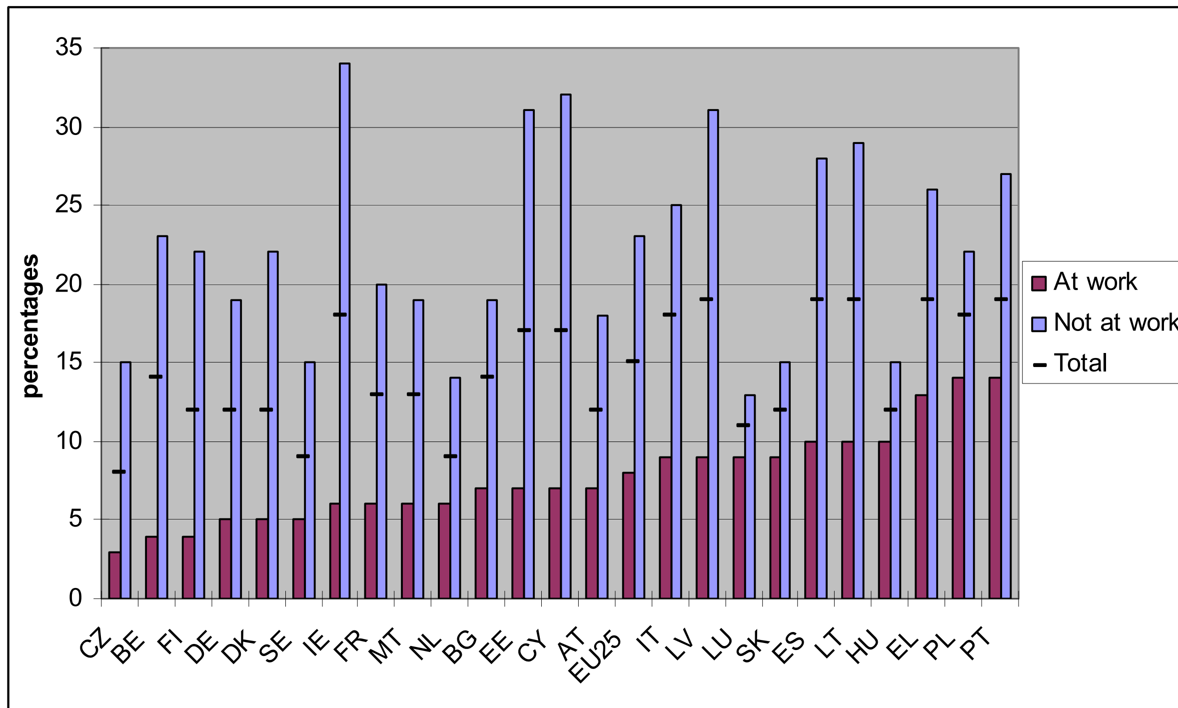
A job is the best safeguard against poverty and social exclusion…

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

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

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

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



Notes: provisional data for HU. Data for RO, SI and UK not available.

Source: Eurostat, EU-SILC (survey year 2005, income year 2004). National data source for BG (survey and income year 2004

In-work poverty is linked to low pay, low skills, precarious and often part-time employment.[28] Quality employment is essential to lift individuals out of poverty and "in order to promote [it] it is necessary to develop employability, in particular through policies to promote the acquisition of skills and life-long learning".[29] It is also necessary to put in place sound macroeconomic policies to facilitate employment creation and a stable economic climate conducive to higher investment in human capital on the part of employers.

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

But poverty risks are associated not only with the employment situation of individuals but also with the household type in which they live and with the economic status of those with whom they share the household. The incidence of poverty risk is broadly similar for households with or without children when all working age members of the household are in full-time work. However, the combination of care responsibilities *and* exclusion from the labour market for all household members[30] produces the highest risk of poverty, where as

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

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

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

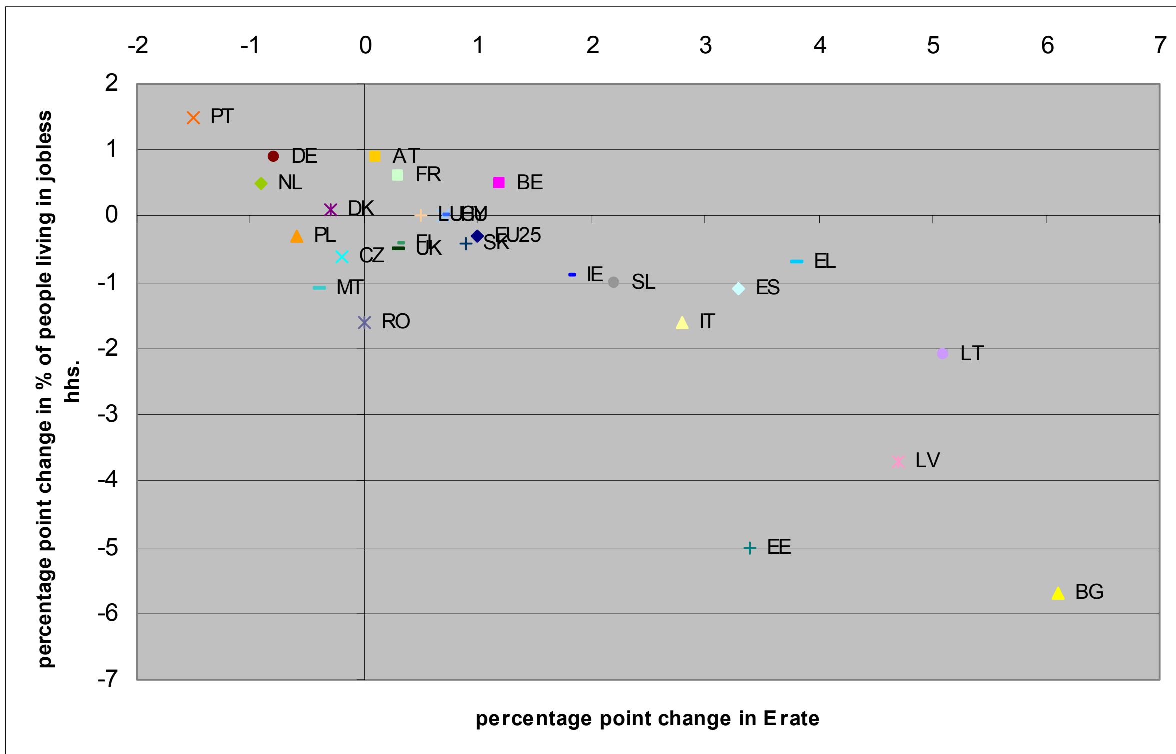
many as 64% of those living in jobless households[31] with dependent children are at risk of poverty in the EU-25. This percentage rises to just over 70% in Belgium and France, to 78% in Belgium and the Czech Republic and 81% in Estonia and over 80% in the Baltic States. Low levels of labour market attachment can also be insufficient to safeguard individuals from poverty, especially in the case of households with dependent children. Households with a work intensity of less than 0.5 *and* dependent children have a particularly high incidence of poverty risk in Luxembourg (54%), Estonia (56%) and Lithuania (64%).

2.3.2. Employment growth and jobless households

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

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

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



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

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

A significant factor in meeting the pension challenge and more generally meeting the challenge of an ageing society is to ensure that people work longer and that average effective retirement ages continue to increase. Extending working lives can strongly contribute to both the adequacy and the financial sustainability of pension systems. An extra 2 years of active life would translate into a corresponding increase in the theoretical replacement rate ranging from 5 to 10 percentage points depending on the Member States.[32] More in-depth analysis is nevertheless needed, in particular of the extent to which these increases in replacement rates associated with extending active life will change in the future.

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

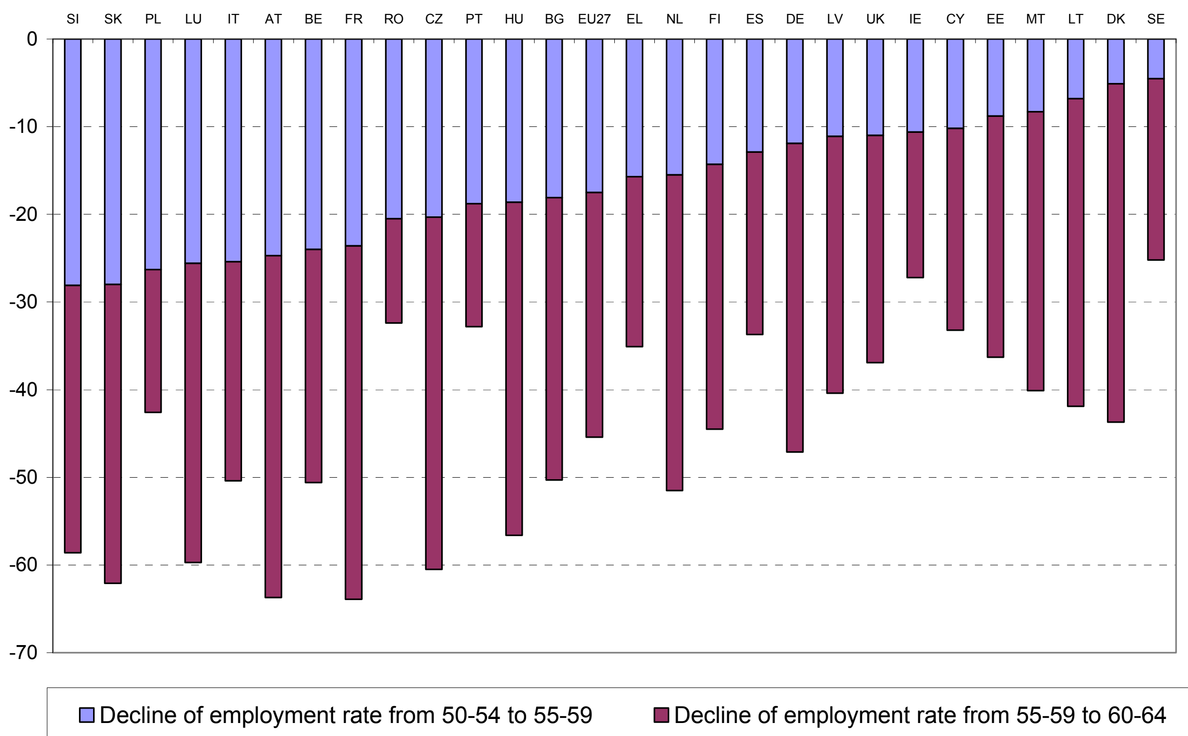
Importantly, early retirement is no longer seen as a way to make room for young people or reduce unemployment. Continued vocational training offers a tremendous opportunity for older workers to acquire new skills and to update qualifications throughout their professional

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

lives. Furthermore, it is essential for Member States to provide suitable access for older workers to appropriate employment. Progress in this area is set out in detail in the 2007 Annual Progress Report on Growth and Jobs. The report provides evidence that comprehensive ageing strategies can achieve good results, though few Member States address ageing as an integral part of the lifecycle approach to work.

The potential increase in employment rates among older people is significant. The pace of the decline in employment rates at age 55 and 60 varies greatly among Member States (see figure 22 below).[33] While, on average, the employment rate of those aged 55-59 is 17 p.p. lower than that of those aged 50-54, the decrease varies from about 5 p.p. (Denmark and Sweden) to 25 p.p. or more (Belgium, Italy, Luxemburg, Slovenia, Austria, Poland and the Slovak Republic). A particular objective for all Member States is to reduce the extent of inactivity before retirement; for many Member States the main focus will be on the 55-59 age group, for whom the employment rate is already falling considerably (see figure 22), whilesome will also target earlier ages.

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



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

If all Member States recorded a decline in the employment rate between the 50-54 and 55-59 age groups comparable with the levels of those Member States with the best records (about 5

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

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

2.3.4. The impact of economic outcomes on health

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

It can also be shown that economic outcomes also matter for health, as highlighted by extensive academic literature in the area, the 2005 European Commission report *The Contribution of health to the economy in the European Union* and the 2001 WHO report by the Commission on Macroeconomics and Health. Sustained economic growth is typically associated with better living conditions (e.g. housing, sanitation, hygiene, nutrition) and fewer living and occupational hazards. The positive impact of economic growth on health is particularly strong if growth is channelled into raising the incomes of the poor and increasing public expenditure, notably health care expenditure, social security and education. Thus, though GDP growth impacts positively on health, much depends on how the additional wealth is distributed and utilised.

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

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

3. PART TWO: THEMATIC ANALYSIS

3.1. Strategies for Social Inclusion

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

This more focused and strategic approach, and the strengthened emphasis on policy implementation, will contribute to making further progress on the achievement of the three Common Objectives[34] relating to social inclusion which were adopted by the European Council in March 2006:

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

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

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

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

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

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

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

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

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

Tackling child poverty

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

Member States approach the issue in different ways, but often with a mix of policies addressing the manifold dimensions of the problem[35] – increasing the family's income, improving access to services, including decent housing, or protecting the rights of children and their families. While the overall approach is universal, complementary measures targeting the most disadvantaged children and families are often part of the strategy. Two aspects stand out: ensuring equal opportunities with respect to education, including early intervention, and promoting parents' participation in the labour market.

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

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

[35] See 3 examples in the box below.

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

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

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

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

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

Striving to make education systems conducive to social inclusion

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

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

of acute economic and social disadvantage (IE, CY for immigrant children, IT, CZ, LT, PL, RO for Roma, UK).

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

Breaking the link between social origins and educational outcomes is crucial in order to prevent deprived children from becoming disadvantaged young people. The key is to tackle *early school leaving*, which increases the risk of exclusion from the labour market, of job insecurity and of low quality employment. On average, 15% of students leave school early, but in some countries more than a third of young people are affected. Member States have set a benchmark for reducing early school leaving in the framework of the Education and Training 2010 work programme, and almost all reports focus on the issue. Significant additional efforts are needed in order to reach this benchmark – no more than 10% early school leavers by 2010.[36]

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

In **FR** the programme for educational success (*Réussite educative*) is targeted at children experiencing hardship and/or living in deprived areas. The aim is to reinforce the capacity of the educational system and institutional partners to follow up personally 200,000 children over time from age 2 to 16. These actions will mobilise multi-disciplinary teams (teachers, social workers, psychologists, health workers, etc.). A strong monitoring system is in place and results are expected from 2007 on.

RO's *Gata, Dispus si Capabil* project involves the NGO *Associatia Ovidiu Rom* working in partnership with local government in three neighbourhoods to increase school attendance and performance among Roma children, and to help Roma mothers find jobs. Since 2001, 400 children have been helped to enrol in school, stay on longer at school or improve their school results, and 100 women have obtained and kept jobs.

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

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

Ensuring access to lifelong learning

The importance of adult participation in lifelong learning is recognised in many reports. The focus is mainly on the acquisition of basic skills. A number of measures are planned to reconcile family responsibilities and participation in LLL activities (e.g. in DE: special aid programmes and adequate infrastructure). In IE, the Back to Education Allowance will facilitate access to education for disadvantaged groups and disadvantaged communities. In PT, an ambitious training and certification measure is also planned for adults with poor qualifications. EL is implementing legislation aimed at increasing participation in adult education, and is focusing on second-chance schools. MT is setting up lifelong learning community centres that encourage literacy and skills development.

Some recognition is given to the fact that, as Europe continues to move towards a "knowledge-based society", accessibility and usability of ICT products and services, coupled with the necessary digital skills are paramount to people's social and economic participation.

The significant contribution that guidance and counselling can make to social inclusion is often highlighted. Several reports state that the national guidance system should be reinforced. IT, in particular, refers to setting up a comprehensive, lifelong guidance system.

Ensuring access to services and upgrading their quality

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

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

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

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

Improving access to housing and fighting homelessness

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

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

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

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

specific integration initiatives in disadvantaged housing areas (e.g. special crime prevention activities, homework help, voluntary work and business start-ups).

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

AT's *Länder* programmes to "prevent eviction" aim at durably reducing and preventing homelessness with a special focus on lone parents. The project aims at ensuring proper cooperation between all stakeholders (landlords, communities, social services providers and courts) that can help prevent the multiple factors that lead to the risk of eviction. The specific objectives are, for instance, to prevent forced eviction, and provide integrated access to welfare structures (enhancing access to social services), as well as affordable housing for the most vulnerable. In the Vienna region, where they have long been implemented, the projects have produced positive and sustained outcomes.

Reducing health inequalities and ensuring equal access to health care

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

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

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

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

Access to financial services and tackling over-indebtedness

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

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

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

With regard to *debt settlement*, NL is putting in place a comprehensive debt amnesty system and measures to strengthen the amicable settlement process.[37] DK is launching a pilot project on remission of public-sector debt for people who have been social assistance claimants for four years or more, provided that the person finds and keeps a job or subsidised employment, or starts a course of education or rehabilitation process.

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

Furthering territorial cohesion

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

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

DE's *Handlungsprogram "Soziale Stadt NRW"* (Social City Action Programme in Nordrhein-Westfalen) is an interdisciplinary programme of action targeted at eradicating complex disadvantages in neighbourhoods. This programme has been running under the Urban Planning Ministry since 1993. The programme is currently supporting multi-objective projects in 37 neighbourhoods, combining town planning measures with social, housing and economic and labour market policies. The local population participate in the renewal of their own neighbourhoods. Evaluation, conducted largely by the local authorities, has been standardised since 2003.

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

3.1.2. Promoting active inclusion and fighting poverty

Employability and integration of people furthest from the labour market

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

Member States are increasingly adopting "active inclusion"[38] as the preferred route to promoting social and labour market integration. An element of this is the clearly discernible trend towards making access to benefits conditional on job searching and availability for the labour market. A balanced active inclusion approach requires this to be accompanied by opportunities to build human capital, including the acquisition of IT skills, and address any existing educational disadvantage, and by adequate counselling and guidance offered to the individual. Crucially, income support should be guaranteed at an adequate level, otherwise conditionality risks pushing the most disadvantaged even further to the margins.

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

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

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

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

Policies to support labour market integration operate from both sides of the labour market, i.e. the supply side and demand side. With respect to *supply*, the strategic reports recognise the need to equip individuals with the skills and knowledge required by today's labour market, to

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

provide them with the right incentives to participate actively in society and to support them in their job search. This approach covers a set of policies in the following three areas:

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

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

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

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

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

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

segmentation (for example in ES and IT, where further targeted incentives are meant to promote women's employment in the south).

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

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

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

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

The contribution of the social economy

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

more fully in society since stakeholders, i.e. workers, volunteers and users, are as a rule involved in management.

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

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

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

Measures to help meet needs for *social services and assistance* include: reinforced community-based social services for the most vulnerable (BG); investment subsidies for the construction of cooperative flats targeting Roma communities and vulnerable children (CZ); involving voluntary social organisations in tackling substance abuse (DK); integrated services to support the immigrant population and involvement of third-sector associations in anti-discrimination activities (PT); joint efforts on a range of inclusion issues by local authorities, social organisations and foundations, and service companies (FI).

Addressing obstacles to young people's labour market entry

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

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

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

Immigrants, ethnic minorities and Roma

There remain gaps, often considerable, between immigrants and ethnic minorities and the rest of the population with respect to employment and unemployment, income, education, early school-leaving, health and poverty. In recognition of this fact, most Member States have made the social inclusion of immigrants and ethnic minorities a priority.

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

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

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

Some Member States (AT, BE, CY, DK, IE, NL) focus on labour market participation as a key element in integrating migrants into a new society which potentially brings benefits such as facilitating the acquisition of language skills and closer interaction with the host society. An increasing concern appears to be the acquisition of language abilities and civic orientation as means for successful integration. DE, for example, plans wide-ranging integration courses for newly arrived immigrants and for those already living in the country. FI and EE focus on the need for language training and NL is introducing pre-departure training. Other reports focus on issues such as improved access to services in general (EL) or better housing conditions (SI), while IE is taking measures to strengthen the labour market situation for female migrant workers.[39]

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

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

The lack of data on immigrants and ethnic minorities remains a problem[40] (UK, IE, DK, and NL are exceptions). As set out in the IE report, breaking down data between different ethnic groups would allow variations in the degree of social inclusion and vulnerability to be documented. At present, the reports typically do not distinguish specific target groups (i.e. the immigrants/ethnic minorities concerned).

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

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

Inclusion of disabled people in society and in the labour market

Promoting the inclusion of disabled people is more extensively covered than in previous National Action Plans, with all Member States highlighting measures targeted at disabled people; AT, EL and PT have made it one of their priority objectives. Most Member States identify the need to mainstream disability issues into all relevant policies, but there are considerable variations in the degree to which they explain how this will be done in practice

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

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

(HU, SE and IE present advanced mechanisms). The UK is introducing a new Disability Equality Duty requiring all public bodies to promote equality of opportunity for disabled people and to publish and implement Disability Equality Schemes.

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

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

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

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

3.1.3. *Strengthened governance of social inclusion policies*

Mobilising stakeholders and raising awareness

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

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

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

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

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

While the key role played by regional and local authorities tends to be emphasised, only a few Member States (including RO and BG) reported on new or additional arrangements to better articulate the priorities set at national level with the responsibilities of regional or local authorities. Examples are: building on the experience of financially rewarding local authorities for their contribution to government outcomes (through local public service

agreements (LPSAs)) by establishing Local Area Agreements setting multi-annual outcome targets for numerous national policy priorities (UK); developing a methodology for creating local and regional action plans for social inclusion by August 2007 (CZ); implementing Social Cohesion Urban Contracts (FR); improving information exchange between local/regional authorities and national government on the outcomes of social inclusion policies (BG, NL, SE, PT).

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

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

Mainstreaming social inclusion

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

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

The **FR** strategy comprises a political and administrative framework, a targeted approach, and cross-cutting policy objectives directly built into the budgetary process, with indicators to monitor progress. FR plans to draw on the expertise of people experiencing poverty. An interministerial committee (CILE) coordinating social inclusion policies is in place at political level, supported by a permanent committee with representatives of 13 ministries which prepares the work and promotes the implementation of CILE decisions in the relevant ministries. Key activities are national conferences to prevent and combat social inclusion (since July 2004), preceded by five thematic regional conferences and a regular report (DPT) setting out state funding for social inclusion, together with objectives and indicators. It includes cross-cutting objectives such as reducing child poverty, integrating young people, combating illiteracy, eradicating sub-standard housing, and mobilising both institutional stakeholders and sectoral stakeholders organised around the common objectives of the National Plan for Social Inclusion. [1]

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

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

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

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

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

Gender mainstreaming

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

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

IE presents a consistent awareness of gender equality issues in all policy priorities. The measures under the priority to improve access to quality services, for example, include promoting gender equality across all government services, policies and programmes. This is to be achieved by developing, implementing and monitoring appropriate policies including programmes for *Positive Actions to Promote Gender Equality* (including the implementation of the National Women's Strategy) and *Equality Proofing*. The National Women's Strategy, due to be published in the first semester of 2007, will be a cross-departmental strategy aimed at enhancing the socio-economic status of women, their well-being and their participation in decision-making and civil society.

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

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

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

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

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

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

Use of indicators, targets, monitoring and evaluation

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

programme, the number of homes built in the social housing sector, etc. In many cases, these policy-related indicators are accompanied by targets.

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

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

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

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

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

The need for effective monitoring and evaluation is acknowledged more than previously in the reports, and although often very little concrete information about the arrangements is provided, it can be concluded that there is a basis for mutual learning. Almost half the Member States indicate that they have working NAP or social inclusion monitoring systems, and some others plan to develop them in the near future. In other Member States, implementation of the strategy on social inclusion is to be monitored as part of broader strategies or through other existing processes and reports (e.g. by statistical institutes). In addition, often specific monitoring systems exist for each policy priority. Many Member States provide a list of monitoring indicators for each political priority.

Typically, a social inclusion coordinating unit in the Ministry responsible is charged with coordinating monitoring activities. A number of Member States have appointed social inclusion liaison officers in the ministries and organisations involved (IE, PT) to facilitate the process. In some Member States, monitoring is the responsibility of the government alone, while in others a specific monitoring committee involving NGOs and social partners, for

example, is in place to assist the government in developing the monitoring framework and to assess results. Where specific monitoring systems for each policy area have been developed, specific stakeholders are often involved. So in LU, for example, there is tripartite participation in monitoring labour market policies (government, unions and employers) and education (teachers, parents, pupils).

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

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

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

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

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

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

Use of structural funds, in particular the European Social Fund

Member States have, to large extent, made progress towards better coordination between social inclusion measures and use of the Structural Funds, notably the European Social Fund (for example NL, DE, AT, SK). However, there is considerable room for improvement,

particularly in increasing the visibility and importance of the ESF, as well as the ERDF, in achieving social inclusion. The new programming round (2007-2013) presents an exceptional opportunity for upgrading. Member States and Regions now have at their disposal a financial instrument which is both more precise and simpler to use.

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

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

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

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

3.1.4. Annexes to section on social inclusion

Annex 1: Good Practice Examples in Social Inclusion Policies in the 2006 National Reports

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

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

Tackling child poverty

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

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

Access to services

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

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

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

Housing/homelessness

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

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

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

Migrants and minorities[41]

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

Addressing financial exclusion and over-indebtedness

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

Labour market integration and fighting poverty

Employability and integration of people furthest from the labour market

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

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

LT's *Programme on Professional Skills Training for Individuals Addicted to Drugs* is designed to motivate persons addicted to drugs to take an active role in the labour market and to receive legal income, and to receive training in the field of public catering services through their involvement in the *Mano Guru Salad Bar.* This project has been run since 2004 by the

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

Social Aid division of Vilnius City Municipality and Vilnius Centre for Addictive Disorders. Since 2004, 29 people from six rehabilitation centres across Lithuania have participated in the programme, and 11 participants have successfully completed the programme and found new jobs. This programme obtained funding from EQUAL for further development of its activities.

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

Roma

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

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

Governance

Mobilising stakeholders

SE – *University courses for student social workers and former clients together -*

Three university courses run by the Basta Work Cooperative and the Department of Social Work at Lund University under the EQUAL Programme. The courses, of 6 weeks duration, bring together students of social work and course participants who are either former social worker clients or marginalised and have no former university education. The aim of the courses is to give both groups an understanding of the working and living conditions of the

other, to show how clients can be empowered to overcome social exclusion, and to demonstrate in what ways social work can contribute to this. All of the students are awarded 5 European Credit Transfer points at the end of the course, which is to be put on a permanent footing.

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

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

Mainstreaming

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

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

List of examples of good practice highlighted in the main text

CY: *Educational Priority Zones*

FR: *Réussite Educative*

RO: *Gata, Dispus si Capabil*

EE: *Community Services in a Village*

AT: *Laender programmes to prevent eviction*

DE: *Handlungsprogram "Soziale Stadt NRW"*

FI: *Labour Force Service Centre*

BE: *Management de la diversité*

HU: *Study Hall "Tanoda" Programme*

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

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

UK: *Get Heard!*

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

Member State	Example
Austria	**Initiatives of the social partners to improve labour market opportunities of disadvantaged groups**
Austria	**Training support and assistance schemes under integration-type vocational training**
Austria	**Prevent eviction/retain lodging**
Austria	**Anti-poverty conference**
Belgium	**Management de la diversité**
Belgium	**Accès direct de la rue au logement pour les personnes sans abri**
Belgium	**Plan stratégique en matière d'intégration des technologies de l'information et de la communication dans les établissements scolaires de l'enseignement obligatoire de l'enseignement de promotion sociale**
Belgium	**Insertion de médiateurs de terrain en pauvreté et exclusion sociale au sein de l'administration fédérale**
Bulgaria	**Employment for the Roma**
Bulgaria	**National Programme for Employment and Vocational Training of persons with permanent disabilities**
Bulgaria	**Care Leavers Integration Programme**
Bulgaria	**Social Investments in Children**
Bulgaria	**Child Welfare Reform**
Cyprus	**Life Education Centres**
Cyprus	**Educational Priority Zones**
Czech Republic	**Comprehensive approach by the city of Ostrava to eradicate discrimination against socially excluded Roma and Roma at risk of social exclusion.**

Czech Republic	**Support from ESF for the provision of social services for the benefit of homeless persons**
Czech Republic	**Stop Social Exclusion Information Campaign**
Denmark	**Employment initiatives aimed at mentally ill people**
Denmark	**Programme board strategy against ghettoisation**
Denmark	**Debt Remission Pilot Project**
Denmark	**Alternative residential facilities**
Denmark	**Upper Secondary School Reform**
Denmark	**Combating men's domestic violence against women and children**
Denmark	**Employment, participation and equal opportunities for all**
Denmark	**Prostitution: a new life**
Denmark	**Speech recognition in Danish**
Estonia	**Pilot project of home care workers**
Estonia	**Training unemployed persons to become call centre operators**
Estonia	**Community Services in a Village**
Finland	**Social Guarantee**
Finland	**Labour Force Service Centre model**
Finland	**Social Credit**
Finland	**Advisory Board on Romani Affairs**
France	**Développer l'égalité salariale entre les hommes et les femmes**
France	**Création de l'Agence Nationale de Rénovation Urbaine**
France	**Eradiquer l'habitat indigne**

France	**Programme "réussite educative"**
Germany	**Betrieb und Schule**
Germany	**Handlungsprogramm "Soziale Stadt"**
Germany	**"Sozialrauemliche Familien- und Jugendarbeit"**
Greece	**Safeguarding – Promotion of health and social inclusion of Greek gypsies**
Hungary	**Integrated Roma Central Employment Programme**
Hungary	**Study Hall (Tanoda) Programme**
Hungary	**"Place of Correction" Attendance Centre**
Hungary	**Card Operated Consumption Meters**
Ireland	**Disability Sectoral Plans**
Ireland	**Social Inclusion Units in Local Authorities**
Ireland	**Poverty Impact Assessment**
Italy	**Local plans for social inclusion**
Italy	**ESF global grants for social inclusion**
Italy	**Database of social needs**
Italy	**Labour market insertion of people with disabilities**
Latvia	**Improvement of infrastructure and equipment of social care and social rehabilitation institutions**
Lithuania	**"Mano Guru" Bar**
Lithuania	**Elderly Women's Activity Centre**
Lithuania	**Window to the future alliance**
Luxembourg	**Location des logements par l'intermédiaire ONG**
Luxembourg	**Suive des décrocheurs scolaires**

Malta	Social Policy Information Centre
Malta	Care and Repair Service
Malta	Home Support Service
Malta	NWAR Programme
Netherlands	Synergy between Work and Social Assistance Act (WWB) and the Social Support Act (Wmo) in neighbour home care service (Tilburg).
Netherlands	Poverty and health intervention by municipal health service in West Brabant
Netherlands	Linking of databases for the Reimbursement of Exceptional Expenses Scheme
Netherlands	De-bureaucratising in Houten
Netherlands	The Amsterdam Form Brigade
Netherlands	Work and Social Assistance Card
Poland	Social Employment
Poland	Civic Initiative Fund
Poland	System of Family Benefits
Portugal	National Support Centre for Immigrants
Portugal	Active Participation
Portugal	Methodology of the Integrated
Romania	"Gata, Dispus si Capabil"
Romania	Building a model of Integrated Community Support Services for young drug addicts
Romania	Samusocial din Romania
Slovenia	Activation and employment of Roma and people with disabilities
Slovenia	Residential Groups in the area of mental health

Slovenia	**Foster Care**
Slovenia	**Temporary Housing Units**
Slovakia	**Programme in support of the development of community social work in municipalities**
Slovakia	**Increase of employability of groups affected and threatened by social inclusion through local social inclusion partnerships**
Slovakia	**Crisis intervention in Banska Bystrica city**
Spain	**Common Fund for Immigrants**
Spain	**Integrated Programmes in autonomous regions**
Spain	**The experience of private management of the Structural Funds in the fight against discrimination**
Sweden	**University course for student social workers and former clients together**
Sweden	**Komet programme – Social inclusion through prevention**
Sweden	**Good housing in Bergsjon – Project to prevent eviction**
United Kingdom	**A New Approach to Homelessness**
United Kingdom	**Child Poverty Accord**
United Kingdom	**Working for Families**
United Kingdom	**Get Heard!**

3.2. Strategies in Health Care and Long-Term Care

3.2.1. Introduction

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

Common objectives for health care and long-term care

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

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

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

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

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

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

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

Moreover, whilst, according to most empirical findings, health care systems have largely contributed to significant improvements in health across the EU, there is considerable scope for improvement. All EU countries are faced with substantial inequalities in health within their populations, which have widened in the latter part of the 20th century (Mackenbach, 2005 for UK Presidency[42]). National reports document significant differences in the health outcomes within each country between different sections of the population based on socio-economic status, place of residence and ethnic group (e.g. Roma, travellers or migrants). On average, less advantaged groups have shorter lives, suffer more disease and illness and feel their health to be worse than more advantaged groups. A gradient exists for most health indicators in which those with higher levels of education or wealth, or those in professional employment, have better health on average than their counterparts.

These health inequalities arise because of systematic differences between people according to social group: in the quality of their physical and social environments (e.g. at home, school, workplace), material conditions (poverty and material deprivation, exclusion and marginalisation) and in their exposure to factors which influence health, such as quality of nutrition, level of physical activity, tobacco and alcohol use, sexual behaviour and psychosocial factors (negative life events and a combination of high effort and demands with low reward and low control). Addressing health inequalities requires action to increase social protection and tackle social exclusion, to ensure that socio-economically disadvantaged people are not subject to additional disadvantages in relation to access to health services, and to protect and promote health – particularly in specific disadvantaged groups.[43] Given its clear significance and implications for EU citizens, this is an area of potential EU level exchange.

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

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

The OMC investigated how social protection systems – including access to care – contribute to reducing health inequalities by means of a peer review in January 2007.

3.2.2.1. Lack of insurance coverage of the population

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

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

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

Member States recognise the problem and many have implemented or plan to implement policies to enhance health care coverage. France has created the Couverture Maladie Universelle Complémentaire to cover the full costs of care of more vulnerable groups. This programme also provides financial aid to those on low incomes to help acquire complementary insurance. The Netherlands have introduced mandatory health insurance for the whole population[44] whereas Belgium is increasing risk coverage of the self-employed to align it with the rest of the population. Cyprus is to introduce universal residence-based coverage within the National Health Scheme. Estonia has recently extended coverage to those on unemployment benefits and is pursuing funding options to include those groups not currently covered. Germany has proposals for a new law that aims to ensure that all citizens are covered by health insurance and in Austria social assistance schemes under the responsibility of the Länder are used to pay for the costs of the non-insured. Despite such measures, in a large majority of EU countries much remains to be done in order to extend health insurance coverage to illegal immigrants and asylum seekers.

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

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

The objective in the health care systems of Member States is for access to health care not to depend on the ability to pay, income or wealth and for the need for care not to lead to individual poverty and financial dependency. It is striking therefore to observe that private health care financing has increased substantially throughout the EU, both in absolute and in relative terms. The growth in private expenditure (in part made possible by a general increase in income and wealth) is related to increased cost-sharing45 for public benefit packages, growing out-of-pocket payments for services excluded from insurance packages and, to a lesser (but not negligible) extent, to premiums for voluntary private insurance with a complementary or supplementary role. Indeed, the large increase in health care expenditure in recent decades has led to fiscal pressure to control the costs of publicly covered or provided care. The bulk of cost-containment policies developed in the 1980s and 1990s included the prioritising of services and the exclusion or non-coverage of particular types of care. These measures were coupled with increased patient cost-sharing (co-payments or co-insurance). This had the dual aim of not only increasing funds to the sector but also improving patient cost awareness and incentivising a behavioural change with regard to the use of health care services. This was expected to reduce unnecessary consumption.

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

According to OECD and WHO data (see Table 1), between 1990 and 2004 the share of private health care expenditure within total health care expenditure increased in almost all countries except DK (constant at 17%), UK, IE and PT. These countries showed a decrease from 16 to 14.1%, from 28 to 21.5% and from 35 to 30.3% respectively. In 2004, private health care expenditure ranged from 9.8% (LU) and 9.3% (CZ) of total health care expenditure to about 48.3% (EL) and 52.2% (CY). The figure is more than 20% in all Member States except LU, CZ, DK, SE, UK and SK and at 30% or more in AT, BE, CY, EL, LV, NL, PL and PT.

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

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

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

Source: WHO health for all database

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

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

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

Pharmaceuticals are a major area of cost-sharing. Typically, a percentage of costs are charged to individuals, varying from nothing to up to 80% depending on the type and category of medicine (MISSOC, 2005). Drugs used to treat life-threatening diseases or drugs with major therapeutic effects are typically subject to lower rates of cost-sharing than those offering only

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

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

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

3.2.2.3. Geographical inequity in access to care

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

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

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

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

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

3.2.2.4. Long waiting times and disparities in waiting times

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

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

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

facilities (e.g. FI, IE, UK, NL, DK), or even facilities abroad (e.g. UK, SE) for those waiting longer than agreed time limits. Implementing staff incentives such as additional payments to physicians to conduct extra interventions where waiting times are lengthy (e.g. UK, NL, SI) are further policy examples.

3.2.2.5. Lack of information

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

3.2.3. Global challenges in the area of quality

European citizens value health as a key factor in achieving a good quality of life. Monitoring and improving the quality of health care systems is therefore an essential part of social protection. Europeans expect their health to be protected, and to be provided with access to the best care possible by modern scientific standards.[46] Monitoring and improving quality also provides further potential benefits by increasing (cost-) effectiveness (it should be noted that the relation between quality and expenditure of health care is not necessarily directly proportional). Finally, only through the monitoring of the level of quality can policy-makers identify and avoid unwanted negative effects in policy implementation. In their reports, Member States present a valuable collection of tools that have been developed to increase and maintain high quality care. These can be categorised as effectiveness; evidence-based medicine; and integrated care.

3.2.3.1. Improving effectiveness

The National Strategy Reports acknowledge the priority all Member States attach to the *effectiveness* of their health systems. The WHO has defined effectiveness as the degree of convergence between outlined goals or standards and actual care provided.[47] Achieving a high level of care effectiveness is a complex task composed of several layers of interacting components. These are subject to regular updating in the light of both technological development and the evolution of demand. *Quality standards* define *what* "high" or "good" quality entails in relation to the requirements that should be met; they can be classified as structural, procedural or outcome-oriented standards. *Quality systems* relate to health care institutions introducing processes that describe *how* predefined standards are to be met and how they will be monitored and ensuring that appropriate action is taken to meet the objective of high quality care. Achieving and obtaining a high quality of care is an ongoing process of setting goals, taking action and evaluating results. Furthermore, it also provides a basis for programmes designed to ensure patient safety, including the facilitation of the reporting of problems, learning from mistakes and developing effective interventions to improve patient safety and quality of care overall.

Member States are addressing these important aims with a variety of specific policies or programmes, such as quality-assured treatment programmes for the chronically ill (e.g. DE, UK), a prioritised vaccination programme (e.g. LT, RO, BG), and a prioritised cancer screening

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[46] See Eurobarometer 63 at http://ec.europa.eu/public_opinion/archives/eb/eb63/eb63_en.htm
[47] Arah et al., 2003, WHO 2000

programme (e.g. FR, UK, IE, LT). Owing to the complexity of the quality assurance task, several Member States are working to find the most efficient approach and are restructuring and consolidating the growing number of specific activities. Government framework laws are one such approach to implementation (e.g. CY, FR, NL, AT, DE, UK, IE, PT, DK, SK) while the creation of new agencies whose main responsibility is the development of quality standards and systems is another (e.g. FR, DE, AT, UK, IE, NL). Some Member States rely more heavily on external and independent reports and monitoring of quality (e.g. UK, IE, SE, FR, NL, LT), where others rely on health care providers self-reporting on the quality of the service provided. Furthermore, most Member States have created (or plan to create) national (or regional) accreditation institutes tasked with the setting of standards and the certification of hospitals and doctors who meet these standards (e.g. DK, LV, BG, CZ, FR). The National authorities of only a few Member States routinely plan inspection visits to health care institutions and providers to gain direct impressions of structures, procedures, hygiene, etc., and to provide direct feedback and guidance (e.g. UK, FR, PT).

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

3.2.3.2. Applying evidence-based medicine

Another subject receiving considerable attention within the Member States' reports is the development of evidence-based medicine and clinical guidelines. According to the Centre for Evidence-Based Medicine in Oxford, "Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."[48] Health care authorities have started formulating guidelines for best practice to enable easier implementation of evidence-based clinical decisions for health care providers. The process of health-technology assessment is a useful tool for both policy-makers and health professionals to make evidence-based decisions on the utilisation of different treatments and technologies. In practice, when a product enters the market, all available scientific data (evidence) is collected and analysed to evaluate whether the intervention is medically justifiable and safe, whether it will have the intended clinical effect (effectiveness) and, finally, whether there are alternatives at a lower cost (efficiency). In particular, where *new* technologies that promise less intrusive, more effective and efficient treatment are available, this assessment process is key as the widespread introduction of new technologies has been identified as a central driver of increased costs, if they are not assessed properly (see also chapter 2.4 – sources of expenditure pressure). Health technology assessments help to increase care quality, improve financial sustainability and engender greater access to health systems. Finally, the patient safety perspective should not be overlooked when evaluating the introduction of new technologies.

As with quality standards and systems, some Member States are relying on designated national agencies to assess new - and in part, existing - health technology. Most Member States report the existence of health technology assessment agencies (e.g. DE, UK, SE, FI, and ES). The

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

complexity and costs of these assessments are high and some Member States point out that they are already benefiting from international and European cooperation in this field (e.g. CZ, FI). For example, the Commission is facilitating cooperation between Member States by supporting the European Health Technology Assessment Network. Within this project, 24 Member States are working together to develop common activities and improve methodological approaches. To help carry out health technology assessments, clinical guidelines have been established on how to manage diseases and have proven their worth for several years in some Member States (e.g. SE, FI, UK). There have also been European-level projects on clinical guidelines (GIN network) but none of the Member States has reported on cross-European cooperation in this area. Nevertheless, most Member States have clinical guidelines in place and plan to (or have already begun) to build up guideline databases (e.g. DE, EE, BG, PT, FR, BE). Further evaluation is required to evaluate the extent to which these guidelines are used by, and are helpful for, health care professionals and the extent to which they improve the system's effectiveness. From a European perspective, this area may also provide elements for further cooperation between Member States.

Patient safety should be an essential factor when considering evidence-based medicine and overall quality of care. Patient safety means ensuring that safety forms an integral part within health care systems and processes. Member States across the European Union are implementing measures to reduce the level of unsafe care, e.g. reducing hospital-acquired infections is a target in many Member States. Reporting mechanisms and training provide the basis for developing effective patient safety and quality programmes. Several Member States, including FI, DK and the UK, have set up national reporting and training systems to identify adverse events in an attempt to establish an understanding of the causes and to develop solutions and interventions. The challenge at European level is to create mechanisms by which good practice in those areas is shared across Member States. Action on this front is currently being taken forward by the patient safety working group of the High Level Group on Health Care Services and Medical Care.[49] Reducing the rate of medical complications will not only improve the quality of care overall, it will also reduce costs and increase access by lowering the frequency and shortening the length of hospitalisations.

3.2.3.3. Developing better integration, choice and coordination of care

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

For example, health care providers and purchasers have an interest in optimising care coordination. The coordination of different levels of care, the flow of information and efficiency can all be increased while improving access and financial sustainability. However, the majority of Member States raise concerns on the efficacy of their referral systems and as such are trying to establish the GP as a gatekeeper to other services (such as secondary care or social services (e.g. DE, FR, BE, HU)). However, in this context free choice of treatment is only preserved when patients can choose and change their GP freely and reasonably often and when they can freely choose providers of any necessary secondary care. Member States that have traditionally limited freedom of choice of health services (e.g. UK, LT, FI) are investing a lot of effort into increasing patient choice, in part to enable patient empowerment and more patient-centred care. The Netherlands pursue a different approach to applying the rules of a free market to their health care

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

system. It is hoped that patients will make smart choices in terms of “value for money” and care pathways will be optimised by the health care providers without regulator interventions. However, in choosing health insurance the choice of contracted health care providers is subsequently limited.

Further measures aimed at improving care coordination include the concentration of specialised care within treatment centres. Through this approach Member States hope to increase quality of care whilst liberating resources for better primary and social care (e.g. SE, LV, CY, CZ), which is of particular importance due to the shortage of GPs in rural areas in most Member States. To address this, some Member States report the development of incentive schemes for GPs willing to practise in these areas (e.g. DE, LV, HU), whereas Spain reports that the strengthening of primary care has led to higher patient satisfaction. Furthermore, GP networks and primary care health centres have also been established in some Member States (e.g. DE, CY, UK) to ensure coordination of efforts without affecting patients' choice. Similarly, the introduction of electronic patient record systems is receiving great attention (e.g. AT, NL, SE, MT, UK). These systems aim to reduce bureaucracy, increase patient safety and care cooperation and simplify data collection for the monitoring of health care quality. If implemented correctly it is projected to play a central role in assuring quality, safety, access and financial sustainability of health systems. In order to achieve well coordinated and integrated care, health-related data should be accessible between the different services, standardised and ideally a part of a more general IT system.

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

3.2.3.4. Summary of findings

In the National Strategy reports on Social Protection and Social Inclusion, Member States stress the importance of “high quality health care”. Action has been taken to develop tools to meet the challenges and a lot of progress has been made in recent years. High quality care also supports financial sustainability and improves access to the health system. Well coordinated referral systems staffed with well trained health care professionals can lead to a higher rate of early diagnosis and therapy, with the subsequent costs and health care utilisation being reduced over time. The same is true for the development and implementation of best practice and clinical

guidelines which reduce unnecessary diagnostic or therapeutic interventions. The risk of harm is reduced and the frequency and duration of cost-intensive hospitalisation can also be decreased.

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

3.2.4. Global challenges in the area of sustainability

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

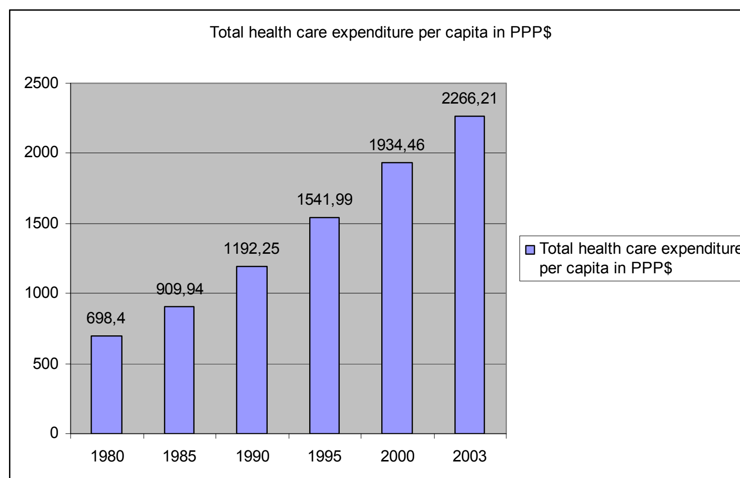
3.2.4.1. Financial sustainability

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

Moreover, **total health care expenditure has consistently increased** in the EU in recent decades (see Figures 1 and 2). On average, it was 698.4 per capita PPP$ in 1980 and 2376.33 in 2004. On average, it was about 5% of GDP in 1970 and 8.87% in 2004, i.e. a rise of more than 3 percentage points of GDP in three decades. In most countries it **has often increased at**

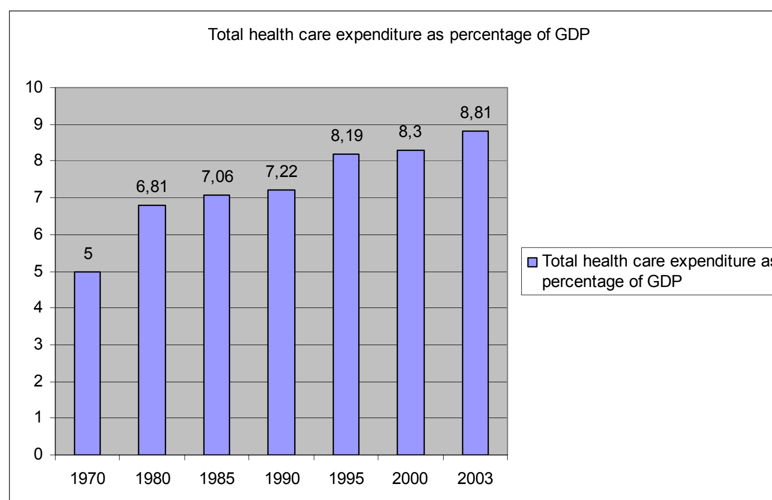
a faster rate than economic growth. Different periods can be identified. In the 1970s, the large increase in total health care expenditure was due to increasing population coverage and thus rising public health care expenditure. In the 1980s and 1990s, the increase in total health care expenditure was related to an increase in private expenditure as a result of increases in per capita income, and the implementation of cost-containment policies (exclusion of some treatments from the public benefits basket and increased cost-sharing), which shifted the burden to private users in an attempt to control public expenditure. In the period 1992-1997 health expenditure and notably public expenditure grew at a similar or even slower rate than economic growth. In the late 1990s and early 2000s (1997-2003) public and private expenditure rose again (OECD, WHO data) with public expenditure increasing more quickly than economic growth. This was a period where health expenditure continued to grow while there was an economic slowdown; hence, the share of expenditure on GDP became higher (with some exceptions such as ES and FI). Data for some countries (e.g. DE) suggests that expenditure growth slowed down after 2003.

Figure 1



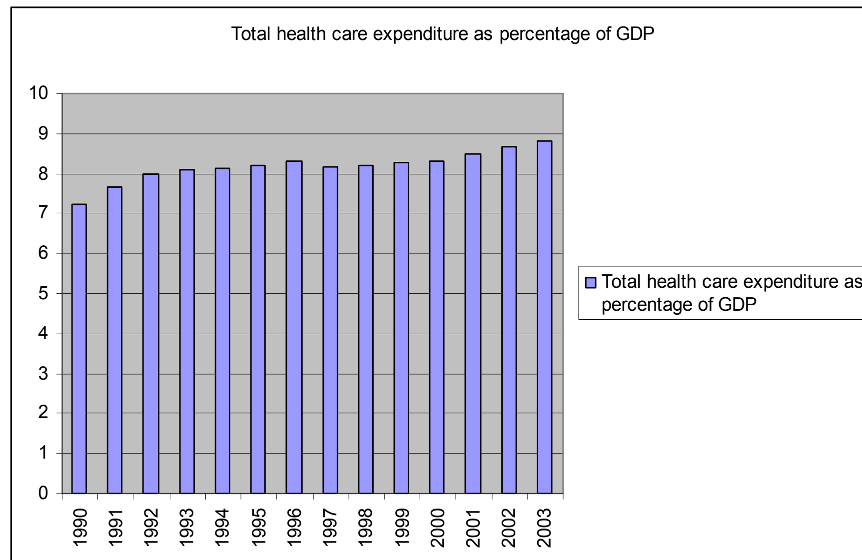
Source: WHO Health for all database. EU averages

Figure 2



Source: WHO Health for all database. EU averages.

Figure 3



Source: WHO Health for all database. EU averages.

Similar insights can be drawn from looking at price indices and their annual average rates of change. It can be seen (table 2) that for the EU and all years from 1997 to 2005 the health care price index has consistently registered greater annual average rates of change than the general consumer price index, with the exception of the year 2001.

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

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

Source: ESTAT

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

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

money. Overall, this suggests that financial sustainability is indeed an area to exchange best-practice experience under the OMC framework.

Sources of expenditure pressure

The main sources of expenditure pressures appear to be an ageing population, the continuous development and introduction of technology and patient expectations. Whilst **ageing** appears to have had a weak impact in the past (OECD 2005) it is probably fair to say that, as more people live longer and the baby boom generation reaches retirement age, ageing will have a greater impact on expenditure. This relates to the fact that ageing results in new patterns of morbidity (including multi-morbidity) potentially presenting themselves over a longer period of time, thus increasing the pressure on services to provide more care than is currently provided and to adjust current provision. Moreover, expenditure for the 65+ age bracket is greater than for the under 65s.[50] Ageing can also have other negative implications, such as reducing the supply of staff and increasing staff wages, thus resulting in higher production costs. Similarly, a smaller proportion of the working population may result in a lower contribution/tax base. According to the 2006 EPC/EC projections (see EPC/EC 2006), public health care expenditure in the EU is set to increase by 1.6 percentage points of GDP by 2050 (with ES, IE and CZ registering an increase of 2.2 and 2%) due to population ageing (and accounting for the general macroeconomic situation). The same projections predict an increase in public long-term care expenditure of 0.6 percentage points of GDP (with FI, SE and SI showing 1.8, 1.7 and 1.2 percentage increases), although the increases may be higher as most Member States are only now developing comprehensive long-term care provision. OECD projections show an average increase of 0.8 percentage points of GDP for public health care (although PL and SK register 1.6 and 1.7% increases) due to ageing. A 1.5 percentage points of GDP increase for long-term care (although CZ, HU, PL, SK register a 2.3, 2, 2.4 and 3.2% of GDP increases) due to ageing is also projected for OECD Member States (OECD 2005).

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

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

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

Average real annual growth rates of total pharmaceutical expenditure for 1997-2003														
IE	HU	SK	FR	NL	AT	SE	FI	DK	EL	ES	DE	IT	LU	CZ
11.3	8.3	7.7	5.8	5.4	5.3	4.9	4.6	4.3	4.2	3.7	3.7	3.3	3.2	1.7

Source: OECD health data 2005

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

Table 4: Pharmaceutical expenditure as a percentage of total expenditure

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

Source: WHO health for all database

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

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

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

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

Raising the effectiveness and efficiency of provision

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

Encouraging the use of primary care and strengthening referral systems

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

Enhancing ambulatory care/day case surgery

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

Reforming inpatient hospital care

Changes are also planned in the inpatient setting. Reducing the average length of stay (e.g. EE, HU, LT, PL, SI, DE, CZ), increasing bed occupancy rates (e.g. LT, SI), and reducing the number of beds (e.g. EE, HU, LT, LV, PL, SI, DE, IT, LV, CZ) are all measures designed to

enhance the effectiveness and efficiency of hospital care. These are coupled with the creation of transition wards to prepare long-term care patients to be discharged from acute to long-term care facilities, thus reducing the use of more expensive care settings. Other measures include: hospital conglomerates (e.g. LV), hospital mergers (e.g. LU), division of tasks between hospitals in the same area to avoid duplications (e.g. LU, PT, LV, FI, HU) and the concentration of more specific and specialised services at regional or even national level, notably through centres of excellence (e.g. ES, FI, LU, DK, LV).

Care Coordination

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

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

Contracts and payments for providers

An important policy pursued/planned by some Member States is to separate the provision and funding role in this sector (creating a provider-purchaser split) and to have the funding authorities establish contracts with providers for the supply of health services (e.g. UK, CY, MT, NL, PT). Another policy is to establish new types of contracts in the hospital setting, including prospective budgets (e.g. UK, BE, CZ, SK), activity-based financing (e.g. DK, FR, NL, LU, AT) and DRG-based payments (e.g. UK, BE, FR, HU, IE, LU, PT, DE, FI, SE, SK, EE). The purchaser-provider split and the new contracts aim to raise transparency and cost-awareness among providers and provide an incentive for providers to be efficient. It does however require an increased role of regulation.

Whilst capitation and salaries for staff are seen as more effective in controlling staff costs vis-à-vis a fee-for-service system, some element of activity-based remuneration is being added to the basic capitation or salary: of GPs to conduct preventive care services or of specialists to increase activity and attain greater value for money whilst helping to reduce waiting times. Fee negotiation and posting of fees for doctors (e.g. BE) are other means of controlling and

ensuring the transparency of prices in a fee-for-service context. Competition between insurers (e.g. NL, DE) and in general (e.g. SK) is expected to lead to better and cost-saving contracts. In BE, insurers can turn surpluses into reserves and must use this to cover their debt as an incentive to control costs.

Controlling pharmaceutical expenditure

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

Extra funding

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

3.2.4.2. Human resources for health

Human resources are an essential factor in the provision of health and long-term care, directly influencing access, quality and financial sustainability of health care and long-term care systems. Accessible care systems require well-trained and highly motivated physician and nurse workforces of an adequate size that are able to deliver safe, high quality medical and nursing services. Health and social sectors in most of the EU countries have experienced or are undergoing considerable transformations, requiring their workforce to work on new skills with new technologies and to adapt to the increasing pace of change (ageing population, changes in the structure of provision, patient's expectations and resource constraints). Health care and long-term care employ a significant proportion of the population, many of whom are highly skilled. Numbers vary however between 3% and 10% of working age population. Although technology plays an important role, the sector is labour-intensive. Although it represents an opportunity for job creation it has often been seen as a recurring burden rather than a capital asset and an investment for the future. As a consequence, most countries face

chronic problems caused by supply–demand imbalances, misallocation of health workers, skill imbalances and poor working environments; reflecting weak human resource management and regulation. While most of the national reports identify the challenges concerning medical staff in the long term, they do not specify what strategies they intend to employ to ensure adequate and sustainable care provision.

Main challenges

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

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

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

Today, there are reports of nurse shortages in almost all EU countries. Nursing has been exposed to increasing pressure over the last 25 years. Health care systems have had to adjust to an economic environment focused on efficiency. This development has very often resulted in intensified work, increasing patient turnover and in deteriorating working conditions combined with an increase in demand for nurses. Providing more education facilities at

nursing schools could be one way of addressing this issue, although it seems unlikely that an increase in provision of nursing training alone will solve the future demand for nursing staff. This is due, among other things, to the relative unattractiveness of the nursing professions for young people. The most effective way of ensuring nursing in the future, therefore, seems to be to promote the retention of existing nursing staff.

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

Intra-Community mobility

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

Socio-economic challenges

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

Quality

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

3.2.4.3. Health promotion and disease prevention

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

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

The national reports present a variety of **promotion initiatives that relate to risks factors** such as tobacco use, obesity versus healthy diet, sedentary life versus physical activity, alcohol consumption, drug use and antibiotics use, lack of breast feeding and hazardous physical, chemical and biological factors. Various initiatives **are disease-specific**: cancer diseases, cardiovascular diseases, respiratory diseases, diabetes, mental health, HIV/AIDS, sexually transmitted diseases, accidents, particularly traffic accidents, work accidents, home accidents and suicide, tuberculosis, osteoporosis, Alzheimer's and rare diseases. **Disease prevention initiatives** include: implementing screening programmes for the early detection of diseases such as breast, cervix, prostate and colorectal cancer, cholesterol, sugar, and blood pressure, sometimes coupled with remuneration incentives to conduct such preventive care practices; ensuring vaccination of target groups; implementing home nursing visits where nurses have a prevention and health education role; provision of maternal and infant care; and developing/ strengthening systems of epidemiological surveillance and health alerts. These initiatives include information campaigns, education, legislation, changes in health service provision or health at work policies. Importantly, Member States identified the **need to develop information systems and monitor data on health status**. Only in this way can it be established if and where there is a problem, its extent and the impact of policy.

3.2.5. *Long-term care*

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

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

It is important to note that different definitions of long-term care coexist. Long-term care brings together a range of services needed for persons who are dependent on help with basic Activities of Daily Living[51] (ADLs) over an extended period of time. Elements of long-term care include rehabilitation, basic medical services, home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with Instrumental activities of daily living (IADLs).[52] Long-term care is usually provided to persons with physical or mental handicaps, the frail elderly and particular groups that need support in conducting their daily life activities. Long-term care needs are most prevalent in the oldest age groups, who are most at risk of long-standing chronic conditions causing physical or mental disability.[53]

Provision and financing of long-term care

Long-term care provision varies across Member States, both in terms of coverage of the population and extent of provision and also in terms of the schemes used. Countries use in-kind benefits or cash allowances and budgets or a mix of the two. Several countries have a

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

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

53 OECD 2005 Long-Term Care for Older People

mixed financing system (e.g. BE, FR, EL), combining resources from insurance schemes and taxes, with different budgets and institutions responsible for the provision and purchasing of long-term care. Some countries provide comprehensive public programmes financed through social insurance (e.g. DE, LU, ES), whereas others fund their programmes through taxation (Nordic countries, LT) or means-tested schemes (e.g. UK, CY).

3.2.5.1. Access to adequate long-term care

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

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

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

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

Tailor-made community and home care services (provision)

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

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

3.2.5.2. Quality of long-term care

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

integrated long-term care provision, allowing uninterrupted care continuum for care users and evaluation and monitoring mechanisms by multidisciplinary teams (e.g. UK).

Care coordination

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

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

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

3.2.5.3. Sustainability of long-term care systems

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

Financial sustainability

A shared perception that came to light in the national reports and the AARP conference is that long-term care expenditure will increase in the near and distant future in order to meet growing demand. For example, the 2006 EPC/EC projections predict an increase in public long-term care expenditure of 0.6 percentage points of GDP (with FI, SE and SI showing a 1.8, 1.7 and 1.2 increase) due to population ageing. It must be noted, however, that this increase may be higher as the projections are based on current institutional and policy settings, whilst many Member States are only starting to develop a comprehensive framework for long-term care provision. In this context there is increasing recognition of the need to create a solid financing basis for long-term care and ensure the availability of much needed resources. Several Member States are moving in this direction, either through the establishment of dedicated additional and compulsory social insurance schemes and contributions (e.g. DE, PL, SI) or through taxation in order to put long-term care on a sound financial footing. Moreover, both the EU and the US recognise that it is necessary to find an adequate mix between public and private sources of finance. Independently of the country's public financial arrangement, private direct payments will also play a role, although EU Member States are committed to designing funding schemes that do not hinder universal and comprehensive access to quality long-term care. The 2005 Luxembourg Presidency Conference had already concluded that a social insurance or tax-based system appeared to be more efficient than private financing solutions. In terms of provision the national reports and both conferences point to a potential mix of public and private (notably social sector) provision.

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

Human resources

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

In view of the looming shortages in the trained medical (particularly nurses and geriatric doctors) and social workforce in the US and the EU, many Member States have introduced

policies to increase nursing staff in order to deal with the increased demand for services in this field (e.g. ES, FR, LT, SE, CZ) and prevent their emigration because of better working conditions and better pay (e.g. PL, LV, EE). Also, how to keep good care workers is a common challenge. Continuous training and evaluation can be significant in maintaining quality of staff. Most Member states have introduced or are introducing training and lifelong learning schemes in order to maintain the staff's expertise and enhance their capacity in dealing with specific long-term care specialties such as geriatrics.

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

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

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

Prevention and rehabilitation policies

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

Similarly, rehabilitative care is to be promoted (e.g. PT, CZ, EL, FI, FR) with a view to restoring patients' skills and thus helping them to regain maximum self-sufficiency and to function in a normal or as near normal a manner as possible. Rehabilitative care can be provided in an institutional and a community setting. More importantly, rehabilitative services should be provided in order to help, where possible, the patient reintegrate in the labour market. The promotion of rehabilitative care depends to a large extent on the efficient use and promotion of ICT products and services for independent living. The Commission will address the possible benefits the information society can have on the ageing population and its activation in a forthcoming Communication. The national reports and the EU/AARP conference highlighted the importance of active ageing, healthier ageing and the adjustment of the environment where people live. These are presented as necessary complements to long-term care provision from a service-user point of view.

3.2.5.4. Summary of findings

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

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

3.2.6. Conclusions on health care and long-term care

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

Member States identified as priorities within their health care systems the need to: ensure equal access for all; reduce health inequalities; guarantee the provision of safe and high

quality care; and manage the introduction of new technology for healthy and independent living. More rational use of resources is an essential factor in rendering health care systems sustainable and maintaining high quality.

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

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

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

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

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

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

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

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

social inclusion strand could also be applied for some of the priority topics. Three major areas can be identified:

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

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

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

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

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

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

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

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

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

Initiatives for enhancing long-term care, especially coordination between health and social care sectors: integrated coordination of health care and social services (CZ, DE, PT), agreement establishing the budgetary and organisational framework for long-term care between regions and communities (BE), provision of social services within a city for people with disabilities by way of support, self-actualisation and therapeutic functions (SK). Initiatives for promoting home care: ensuring conditions for assisted living (AT), long-term care insurance giving priority for assistance for care at home (DE), home support service offered by a foundation (MT), a 7 days/24 hours reachable phone line to help the elderly to

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

∉ Improving the quality of services.

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

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

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

3.3. Progress in the Field of Pensions since 2006

3.3.1. Introduction

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

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

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

Common objectives for pensions

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

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

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

adequate pensions for all citizens. The report also confirmed that the reform of pension systems cannot be conducted within a vacuum and must be considered alongside labour market reforms and overall public spending plans.

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

3.3.2. Recent developments in pension reforms

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

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

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

individual is entitled to a state pension, from 65 to 67, and both are pursuing measures designed to reduce instances of early retirement.

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

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

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

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

This chapter reflects the current state of assessment of the future adequacy of pension systems within the Open Method of Coordination for pensions. Following the adoption by the European Council in March 2006 of the streamlined common objectives, a set of agreed indicators for pensions was adopted by the Social Protection Committee in June 2006. These included theoretical replacement rates to provide a prospective picture of adequacy of pensions.[54]

The long-term adequacy of pensions

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

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

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

and profile. This highlights that while many reforms can reduce the average level of pensions, Members States pay attention to guaranteeing a decent minimum to all.

Indeed, reforms are generally aimed at curbing the rise in pension expenditures. This is well reflected in the latest set of pension expenditures produced by the Economic Policy Committee's Working Group on Ageing (AWG), which show that drops in the benefit ratio[55] play a major part in decoupling public pension expenditure growth from the increase in the old-age dependency ratio.

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

Current and prospective theoretical replacement rates

The first three primary indicators on the adequacy of pensions provide information on the current income situation of older people, as regards monetary poverty (poverty risk of people aged 65+), and the relative income situation of older people. The latter can be assessed either on the basis of household income[56] (relative income) or on the basis of individual incomes (aggregate replacement rate). These indicators need to be complemented by another type of information, focusing more specifically on the pension systems themselves and their future evolution.

The Indicators Sub-Group of the Social Protection Committee responded to the need for prospective adequacy indicators by developing a methodological framework for calculating theoretical replacement rates. The first results of this work were presented to the Council in March 2003, while further refining of the methodology and a peer review in April 2005 helped to prepare a second wave of calculations that were used in the National Strategy reports and the Synthesis Report on adequate and sustainable pensions of 2006. These elements were synthesised in a report of the ISG of May 2006.[57]

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

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

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

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

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

Several factors will actually determine future adequacy, the replacement of previous income provided by public pension schemes being a determining factor, but not the only one. Future income replacement levels will depend first of all on the pace of accrual of pension entitlements, which is linked to developments in the labour market and to the actual coverage of pension schemes. Increased female labour force participation will lead to higher pensions for women, while longer careers (later retirement) should allow people to accrue more adequate pension rights. Supplementary private pensions may make a larger contribution to old-age income. Also, accumulated wealth – particularly home ownership – is a major determinant of living standards in old age. Unfortunately, it is not currently possible to assess the long-term overall impact of all these factors on the incomes of older people (and their distribution).

Representativeness, assumptions used and interpretation of results

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

The base case representativeness can differ considerably between Member States and it is essential to have information concerning representativeness.[58] Differences in the representativeness of the base case (Table A1) suggest that comparisons of levels of theoretical replacement rates among Member States should only be made with caution. For the sake of a more accurate interpretation of results, levels of theoretical replacement rates are thus not displayed (they are provided in country sections of the ISG 2006 report).

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

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

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

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

Information on assumptions used is also essential, in particular as regards contribution rates.[59] Total contribution rates used (Table A2) are generally in the range of 20 percentage points (between 15 and 25). In some Member States, contribution rates can of around 30 percentage points (CZ, ES, IE, PT, SE) or between 35 and 40 percentage points (IT, PL, UK). Representativeness is well achieved as regards assumptions on levels of contributions to first pillar. For second pillar schemes, it should be noted that calculations generally rely on an assumption of increase of contribution rates for this type of pension provision (Table 2).

The general economic assumptions used have been chosen to be as consistent as possible with the AWG assumptions (see 2006 ISG report for detailed description of assumptions used). It should be noted that the common assumption used on long-run real rates of return is 2.5% (3% gross real rates of return minus 0.5% administrative charges; the NL and DK used 0.25% administrative charges, reflecting lower administrative costs enabled by large-scale pension schemes).[60]

Trend towards a decline in replacement rates at a given age

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

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

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[59] The following aspects were considered: contributions by the employer and the employee to the different schemes included in the calculations (as well as the other social contributions, with the possible addition of any public contributions), and, where a Member States chooses to use a DB framework for 2nd pillar schemes, contribution rates assumed (both employee and employer contributions).

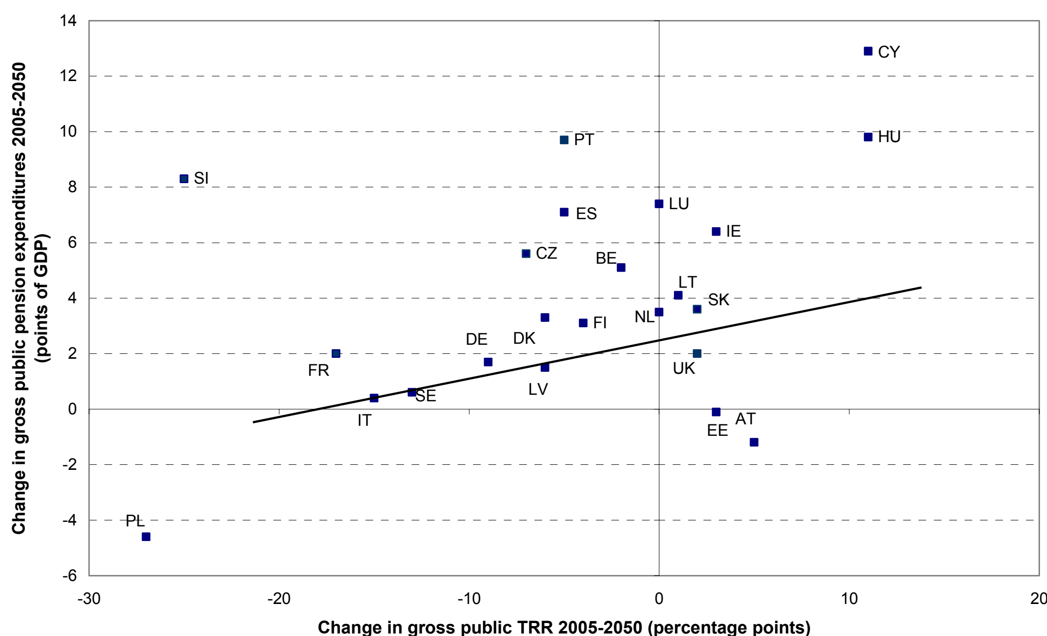
[60] The assumption on contribution rates is linked for defined benefit schemes to the rate of return assumption. The common assumption of 2.5% for real long-run rates of returns (3% gross minus 0.5% administrative costs) may not necessarily reflect the circumstances of some countries, notably those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

more significant when focusing on the evolution of gross replacement rates of first pillar statutory schemes: gross theoretical replacement rates are projected to decline in 14 Member States, while the situation would not change significantly in 8 other Member States (a change of +/- 3 percentage points) and an increase is projected for only 3 Member States.[61]

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

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

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



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

The trend towards a drop in prospective replacement rates at a given age results in various adjustments not only in statutory schemes (pay-as-you-go and possibly including a funded tier) but also in private pension schemes in some Member States. In the latter case, this

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

contribution will benefit people who are actually covered and thus a significant share of pensioners will rely only on the contribution provided by statutory schemes (see coverage levels, Table A 1).

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

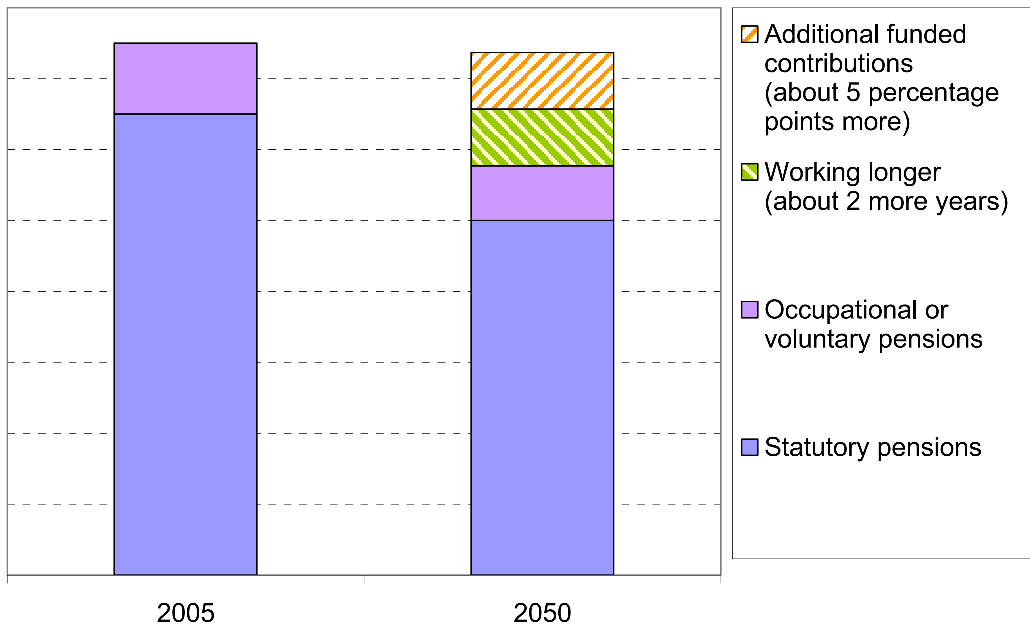
How can working longer and the development of privately managed pensions influence replacement rates ?

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

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

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

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



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

Increasing incentives to work longer

A number of reforms have recently strengthened the benefit-contribution link of pension systems. In defined-benefit schemes, the link can been strengthened through a longer contribution period required for a full pension, while applying actuarial reductions for early pensions and increases in pension rights for deferred retirement (in a number of Member States, such as AT, FR, FI, while the link had already been strengthened by previous reforms in a number of Member States). Some Member States have pushed through major reform packages, and have changed their statutory schemes appreciably (DE, FR, AT, FI, IT). Notional defined contribution schemes (such as in SE and PL) also build on a strong link between contributions and benefits. Since the end of the 1990s, a number of Member States have also introduced statutory funded pension schemes (e.g. PL, HU, EE, LV, LT, SK, SE).

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

Development of privately managed pension provision

In Member States where statutory pensions provide a relatively low income replacement for average wages earners and are geared more to the goal of poverty prevention, the ability to maintain one's living standard after retirement depends to a large extent on access to the funded tier of the statutory scheme, and to private occupational or personal pension provision (as in DK, NL, IE, UK). Moreover, in some Member States the funded tier of the statutory

scheme is expected to contribute significantly to the future income of pensioners (PL, EE, LV, LT, HU, SK). A number of countries have increased provisions for occupational or private schemes that complement public pensions (DE, IT).

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

The current coverage of the second pillar schemes taken into account varies, and this should be borne in mind when considering the contribution from these schemes to replacement rates results for the base case (current estimates of coverage range from 11% in IT to 90% in SE, see Table A2). As regards contribution rates, some Member States assumed in the calculations of theoretical replacement rates that workers will contribute more than 10% of their wage to private funds (DK, NL[62], SE) and in some cases more than 20% (IE, UK).[63] Furthermore, the assumptions used indicate that contribution rates are generally expected to rise in comparison to current levels to enable the projected levels of income replacement to be achieved (see Table A2).

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

Summary of findings

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

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

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

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

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

3.3.4. Minimum income provision for older people

Background

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

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

Design

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

Broadly speaking, minimum provisions can be divided into 3 types (although it should be noted that some systems combine parts of 2 or 3 of these broad categories): (i) minimum pensions within the earnings-related pensions systems that rely on contributions throughout a working life. These often offer a strong degree of solidarity, and are generally available with a fairly low threshold of contributory years and are subsequently almost universal in their coverage; (ii) Minimum pension schemes. They can provide flat-rate benefits for all older people, without regard to the accumulation of own pension rights. Usually, the residency for a certain period of time is the core criteria for receipt (for instance DK or NL). Other minimum pension schemes can guarantee a certain level of income to all elderly persons but are means

tested against earnings related pensions, thus complementing earnings related pensions. Entitlement is usually based on residency test (for instance FI and SE) (iii) separate social assistance benefits for older people, usually paid to people who do not meet residence criteria and/or have made too few contributions to the general system and subsequently have little or no income in old age. Usually, these benefits are subject to some form of means testing, often broader than minimum pensions. They ensure that individuals have the basics for an adequate living. Sometimes the social assistance rate is higher for the elderly, and may be referred to as a minimum pension, or minimum income. Older people also generally enjoy other types of benefits, which make an important contribution to their living standards (in particular health care services, housing benefits).

Poverty

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

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

Reforms

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

than a pre-set subsistence level. Other Member States have introduced supplements to existing benefits, as in Denmark (Supplementary Pension Benefit in 2003) and in Hungary (supplement for those aged 75 or more introduced in 2006), or made access to benefits easier (Basic Insurance for old age people in Germany).

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

Incentives

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

Future

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

Summary of findings

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

The effects of minimum incomes are reflected in the generally lower poverty gaps of older people in comparison to the general population, although relative poverty is still more likely among the elderly than among their younger counterparts. The conclusion can be drawn that minimum incomes are effective in alleviating relative poverty but not necessary in eliminating

it altogether. Therefore, consideration should be given to the levels of minimum incomes and their adjustment mechanisms to the rises in prices and living standards. . Evidence suggests that in some Member States reliance on such provision is declining, reflecting the maturation of earnings related pension systems. There is clear tendancy that the need for minimum incomes will decrease, as, more women (who traditionally have been the main recipients of such benefits) are entering the labour market and accruing future pension rights. On the other hand, in particular for those with broken work records and part-time or low paid jobs, the development of stricter rules on the accrual of pension rights and tighter access to or actuarial reductions for early retirement is likely to result in lower retirement incomes. The uncertain outcome of recent pension reforms makes it essential to develop tools to monitor future developments of minimum incomes and their interaction with the wider pension system, through, for instance, theoretical replacement rates or dynamic (panel) micro-simulation models.

3.3.5. Flexibility of retirement age

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

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

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

A first key question for the design of flexibility in retirement age is the strength of incentives. In this context, a benchmark for earlier/later retirement could be the concept of actuarial equivalence, which would also ensure a sustainable financing of the system. However, incentives to postpone retirement appear to differ significantly between Member States, being sometimes below actuarial equivalence. If incentives to retire later are too low, this can be seen as encouragement to retire earlier. Conversely, high bonuses can involve dead-weight costs by subsidising individuals who would in any case have postponed retirement. Elements of evaluation available suggest that incentives to postpone the age of withdrawal from the labour market beyond the legal retirement age generally amount to an increase in pensions of between 5 and 10% per year (depending on age, careers and mortality tables).

Furthermore, it is essential to note that the strength of incentives can also directly impact on adequacy, as an increase of a few years in retirement age can translate into substantial differences in pension levels. For lower wage earners in particular, incentives have to be reviewed and linked to the interaction between minimum incomes for pensioners and standard

earnings-related schemes. The strength of incentives also needs to be considered in respect of different eligibility criteria. In particular, it is essential to set a minimum retirement age, as well as to take into account of the length of contributions (for instance, the strength of incentives can depend on the length of contributions).

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

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

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

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

3.3.6. Next steps within the Open Method of Coordination

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

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

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

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

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

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

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

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

(a) For Belgium, this refers to the overall Social Security contribution rate, due to its global management.

(b) For Denmark, this refers to contributions, to the ATP (statutory Supplementary Labour Market Pension, though it should be recalled that the financing of the first pillar mainly comes from the general budget. (c) For Cyprus, a quarter (4%) comes from the general State budget.

(d) For Luxembourg, one third (8%) also comes from the general State budget.

(e) For Malta, this amounts to 10% from the employee, 10% from the employer and 10% from the State.

(f) For Poland, this amounts to old-age contributions (19.52 per cent of wage) and disability and survivors contribution (13 per cent of wage).

(g) For Portugal, this is a general estimate (ratio between overall contributions and aggregate wages declared to social security). The total contribution rate used as an assumption in simulations is 34.75 (legal statutory contribution rate).

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

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

Source: Member States' calculations of theoretical replacement rates.

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

4. ANNEXES

4.1. Annex IA – Overarching Indicators

BACKGROUND

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

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

In June 2006, the Social Protection Committee adopted the report on indicators to be used in the context of the streamlined OMC on social protection and social inclusion[64]. The adopted set of indicators consists of a portfolio of 14 overarching indicators (+11 context indicators) meant to reflect the newly adopted overarching objectives (a) "social cohesion" and (b) "interaction with the Lisbon strategy growth and jobs objectives"; and of three strand portfolios for social inclusion, pensions, and health and long-term care.

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

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

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

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

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

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

DEFINITION OF THE OVERARCHING INDICATORS

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

Title	*Definition*
In-work poverty risk	Individuals who are classified as employed (distinguishing between "wage and salary employment plus self-employment" and "wage and salary employment" only) and who are at risk of poverty This indicator needs to be analysed according to personal, job and household characteristics. It should also be analysed in comparison with the poverty risk faced by the unemployed and the inactive. Source: EU-SILC
Activity rate	Share of employed and unemployed people in total population of working age 15-64 Source: LFS
Regional disparities – coefficient of variation of employment rates	Standard deviation of regional employment rates divided by the weighted national average (age group 15-64 years). (NUTS II) Source: LFS
SELECTED HEALTH INDICATORS	
Total expenditure on health	Sum of general government health expenditure and private health expenditure in a given year, calculated in national currency units in current prices. It comprises the outlays earmarked for health maintenance, restoration or enhancement of the health status of the population, paid for in cash or in kind. It is expressed in $PPP. International dollars are derived by dividing local currency units by an estimate of their Purchasing Power Parity (PPP) compared to US dollar, i.e. the measure which minimizes the consequences of differences in price levels between countries. Source: NHA (WHO)
General government expenditure on health as a % of Total health expenditure	Comprises the direct outlays earmarked for the enhancement of the health status of the population and/or the distribution of medical care goods and services among population by the following financing agents: central/federal, state/provincial/regional, and local/municipal authorities; extrabudgetary agencies, social security schemes; parastatals and public firms. Expenditures on health include final consumption, subsidies to producers, and transfers to households (chiefly reimbursements for medical and pharmaceutical bills). It includes both recurrent and investment expenditures (including capital transfers) made during the year. Besides domestic funds it also includes external resources (mainly as grants passing through the government or loans channelled through the national budget). Source: NHA (WHO)
Private health expenditure as a % of total health expenditure	Sum of expenditures on health by the following entities: - Prepaid plans and risk-pooling arrangements: the outlays of private insurance schemes and private social insurance schemes (with no government control over payment rates and participating providers but with broad guidelines from government) - Firms' expenditure on health: the outlays by private enterprises for medical care and health enhancing benefits other than payment to social security or other pre-paid schemes. - Non-profit institutions serving mainly households: outlays of those entities whose status do not permit them to be a source of financial gain for the units that establish, control or finance them. This includes funding from internal and external sources. - Household out -of-pocket spending: the direct outlays of households, including gratuities and in-kind payments made to health practitioners and to suppliers of pharmaceuticals, therapeutic appliances and other goods and services. This includes household direct payments to public and private providers of health care services, non-profit institutions, and non-reimbursable cost sharing, such as deductibles, co-payments and fee for services. Source: NHA (WHO)

Title	*Definition*
CONTEXT INDICATORS	
GDP growth	Growth rate of GDP volume - percentage change on previous year Source: Eurostat STRIND
Employment rate, by sex	The employment rate is calculated by dividing the number of persons aged 15 to 64 in employment by the total population of the same age group. Source: LFS
Unemployment rate, by sex, and key age groups	Unemployment rates represent unemployed persons as a percentage of the labour force. The labour force is the total number of people employed and unemployed. Unemployed persons comprise persons aged 15+ who were: a. without work during the reference week, b. currently available for work, i.e. were available for paid employment or self-employment before the end of the two weeks following the reference week, c. actively seeking work, i.e. had taken specific steps in the four weeks period ending with the reference week to seek paid employment or self-employment or who found a job to start later, i.e. within a period of, at most, three months. Source: LFS
Long term unemployment rate, by sex and key age groups	Long-term unemployed (12 months and more) persons are those aged at least 15 years who are without work within the next two weeks, are available to start work within the next two weeks and who are seeking work (have actively sought employment at some time during the previous four weeks or are not seeking a job because they have already found a job to start later). The total active population (labour force) is the total number of the employed and unemployed population. The duration of unemployment is defined as the duration of a search for a job or as the length of the period since the last job was held (if this period is shorter than the duration of the search for a job). Source: LFS
Life expectancy at birth and at 65	LE at birth: The mean number of years that a newborn child can expect to live if subjected throughout his life to the current mortality conditions (age specific probabilities of dying). LE at 65: The mean number of years still to be lived by a person who have reached 65, if subjected throughout the rest of his life to the current mortality conditions (age specific probabilities of dying). Source Eurostat – Demography
Old age dependency ratio, current and projected	Ratio between the total number of elderly persons of an age when they are generally economically inactive (aged 65 and over) and the number of persons of working age (from 15 to 64). Source Eurostat – Demography
Distribution of population by household types, incl. collective households	Number and % of people living in private resp. collective households. Source Eurostat - Census 2001 data collection
Public debt, current and projected, % of GDP	Government debt is the consolidated gross debt of the whole general government sector outstanding at the end of the year (in nominal value). These data are reported to the European Commission in the framework of the Excessive Deficit Procedure (EDP). Projections are produced by the Commission Services in the context of the assessment of the long-term sustainability of the public finances based on the 2005/06 updates of Stability and Convergence Programmes (SCPs). http://ec.europa.eu/economy_finance/publications/european_economy/2006/ee306_en.pdf
Social protection expenditure, current, by function, gross and net (ESPROSS)	Total social protection expenditures broken down in social benefits, administration cost and other expenditure. In addition, social benefits are classified by functions of social protection. Net expenditures are not presented here since they are not available in ESSPROS yet. Source: Eurostat – ESSPROS
Jobless households by main household types	Breakdown of jobless households by main household types Source: EU-SILC

Title	*Definition*
Making work pay indicators (unemployment trap, inactivity trap (esp. second earner case), low-wage trap.	Unemployment trap: Marginal effective tax rate (METR) on labour income taking account of the combined effect of increased taxes and benefits withdrawal as one takes up a job. Calculated as the ratio of change in gross income minus (net in work income minus net out of work income) divided by change in gross income for a single person moving from unemployment to a job with a wage level of 67% of APW. Inactivity trap: METR on labour income taking account of the combined effect of increased taxes and benefits withdrawal as one takes up a job while previously inactive. Calculated as the ratio of change in gross income minus (net in work income minus net out of work income) divided by change in gross income for a single person moving from inactivity to a job with a wage level of 67% of APW. Low wage trap: METR on labour income taking account of the combined effect of increased taxes on labour and in-work benefits withdrawal as one increases the work effort (increased working hours or moving to a better job). Calculated as the ratio of change in personal income tax and employee contributions plus change (reductions) in benefits, divided by increases in gross earnings, using the "discrete" income changes from 34-66% of APW. Breakdown by family types: one-earner couple with two children and single parent with two children. Source: Joint Commission -OECD project using tax-benefit Models
Net income of social assistance recipients as a % of the at-risk of poverty threshold for 3 jobless household types	This indicator refers to the income of people living in households that only rely on "last resort" social assistance benefits (including related housing benefits) and for which no other income stream is available (from other social protection benefits – e.g. unemployment or disability schemes – or from work). The aim of such an indicator is to evaluate if the safety nets provided to those households most excluded from the labour market are sufficient to lift people out of poverty. This indicator is calculated on the basis of the tax-benefit models developed jointly by the OECD and the European Commission. It is only calculated for Countries where non-categorical social benefits are in place and for 3 jobless household types: single, lone parent, 2 children and couple with 2 children. This indicator is especially relevant when analysing MWP indicators. Source: Joint EC-OECD project using OECD tax-benefit models, and Eurostat (see Chapter I and Annex I)
Change in projected theoretical replacement ratio for base case 2004-2050 accompanied with information on type of pension scheme (DB, DC or NDC), and change in projected public pension expenditure 2004-2050. (results should systematically be presented collectively in one table).	Change in the theoretical level of income from pensions at the moment of take-up related to the income from work in the last year before retirement for a hypothetical worker (base case), percentage points, 2004-2050, with information on the type of pension scheme (DB, DC or NDC) and changes in the public pension expenditure as a share of GDP, 2004-2050. This information can only collectively form the indicator called Projected theoretical replacement ratio. Results relate to current and projected, gross (public and private) and total net replacement rates, and should be accompanied by information on representativeness and assumptions (contribution rates and coverage rate, public and private), and calculations of changes in replacement rates for 1 or 2 other cases, if suitable (e.g. OECD) Specific assumptions agreed in the ISG. For further details, see 2006 report on Replacement Rates. http://ec.europa.eu/employment_social/social_protection/docs/isg_repl_rates_en.pdf Source: ISG and AWG

4.2. Annex IB - Data Sources – specific notes

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

For the first time this year, EU-SILC data is available for 25 EU Countries. The newly implemented reference source of statistics on income and social exclusion is the European Survey on Income and Living Conditions (EU-SILC) framework regulation (No.1177/2003). Technical aspects of this instrument are developed through Commission implementing regulations, which are published in the Official Journal. The data for Bulgaria and Romania are still based on the national household budget surveys following the transitional arrangements agreed by the European Statistical System[65].

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

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

It should also be noted that the definition of income currently used excludes non monetary income components, which include the value of goods produced for own consumption[66] and non-cash employee income. This component will be available for all countries from the SILC(2007) exercise onwards, and therefore included in the indicators that will be published in January 2009.

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

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

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

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

Limitations

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

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

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

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

AGE-RELATED EXPENDITURE PROJECTIONS

Long-term budgetary projections were prepared in 2006 by the Economic Policy Committee and the European Commission (DG ECFIN) - see European Policy Committee and European

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[67] See specific footnotes in each country profile

Commission (2006), "The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050)", European Economy, Special Report No.1/2006.

The projections are made on the basis of a common population projection and agreed common underlying economic assumptions that have been endorsed by the EPC. The projections are made on the basis of "no policy change", i.e. only reflecting enacted legislation but not possible future policy changes (although account is taken of provisions in enacted legislation that enter into force over time). The pension projections are made on the basis of legislation enacted by mid-2005. They are also made on the basis of the current behaviour of economic agents, without assuming any future changes in behaviour over time: for example, this is reflected in the assumptions on participation rates, which are based on the most recently observed trends by age and gender. While the underlying assumptions have been made by applying a common methodology uniformly to all Member States, for several countries adjustments have been made to avoid an overly mechanical approach that leads to economically unsound outcomes and to take due account of significant country-specific circumstances. The pension projections were made using the models of national authorities, and thus reflect the current institutional features of national pension systems. In contrast, the projections for health care, long-term care, education and unemployment transfers were made using common models developed by the European Commission in close cooperation with the EPC and its Working Group on Ageing Populations. The projection results show the combined impact of expected changes in size and demographic structure of the population, projected macroeconomic developments and assumed neutral evolution in health status of the population in each Member State of the European Union.

PENSION EXPENDITURE

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

REPLACEMENT RATES

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

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

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

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

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

4.3. Annex 1C: Statistical tables – Overarching indicators

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: Eurostat - Demography; e: estimate

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

Source: Eurostat - Demography

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

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

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

Source: Eurostat - Demography

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

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

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

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

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

Source: Eurostat - Demography

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

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

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

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

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

Source: Eurostat - Demography

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

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

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

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

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

Source: Eurostat - Demography

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

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

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

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

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

Source: Eurostat - Demography

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

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

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

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

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

Source: Eurostat - Demography

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

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

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

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

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

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

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

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

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

Source : Eurostat, Labour Force Survey - Quarter 2 results

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

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

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

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

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

Source : Eurostat, Labour Force Survey - Quarter 2 results

6 Projected total public social expenditures

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

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

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

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

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

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

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

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

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

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

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

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

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

* BG National HBS 2004, income data 2004 and RO National HBS 2005, income data 2005

7b Aggregate replacement ratio (%)

These data are currently being checked by Estat and will be available within the coming weeks

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Total		0.54 s	0.42		0.51 b	0.35		0.45 b	0.47	0.43	0.49	0.56	0.66	0.58 b	0.28 b	0.61 b	0.47 b	0.63	0.61 b	0.55 b	0.43 b	0.67	0.59 b	0.63		0.42 pb	0.55 b	0.46	0.58	:

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

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

8 Inequalities in access to health (not yet agreed upon)

9 At-risk of poverty rate anchored at a point in time

Not available yet

10 Employment rate of older workers (% of people aged 55-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	total	:	35,8	22,9	:	37,1	52	37,7	50,2	41,7	39	35,1	28,3	27,7	:	36,3	39,5	25,1	17,3	:	33,9	28,4	32,1	49,6b	51,5	23,9	22,8	36,2	63	49
	male	:	46,6	32,1	:	53,2	61,3	47,2	62	60,2	56	52,6	32,5	41,4	:	48,1	54,4	35,2	27	:	47,5	40,5	41,5	62,9b	59,5	31,8	39,1	38,4	66,1	59,1
	female	:	25,5	14	:	22,9	42	28,3	41,6	23,1	23,5	18,8	24,4	15	:	27,5	28,3	15,5	9,6	:	20,3	17,1	24,1	38b	44,5	16,1	9,4	34,1	60	39,2
2000	total	36,9	36,6	26,3	20,8	36,3	55,7	37,6	46,3	45,3	39	37	29,9	27,7	49,4	36	40,4	26,7	22,2	28,5	38,2	28,8	28,4	50,7	49,5	22,7	21,3	41,6	64,9	50,7b
	male	47,1	46,9	36,4	33,2	51,7	64,1	46,4	55,9	63,2	55,2	54,9	33,6	40,9	67,3	48,4	50,6	37,2	33,2	50,8	50,2	41,2	36,7	62,1	56	32,3	35,4	42,9	67,8	60,1b
	female	27,4	26,9	16,6	10,3	22,4	46,6	29	39	27,2	24,3	20,2	26,3	15,3	32,1	26,7	32,6	16,4	13,3	8,4	26,1	17,2	21,4	40,6	43,8	13,8	9,8	40,4	62,1	41,7b
2002	total	38,5	38,7	26,6	27	40,8	57,9	38,9	51,6	48	39,2	39,6	34,7	28,9	49,4	41,7	41,6	28,1	25,6	30,1	42,3	29,1	26,1	51,4	37,3b	24,5	22,8	47,8	68	53,4
	male	48,4	48,8	36	37	57,2	64,5	47,3	58,4	65	55,9	58,4	38,7	41,3	67,3	50,5	51,5	37,7	35,5	50,8	54,6	39,6	34,5	61,9	42,7b	35,4	39,1	48,5	70,4	62,6
	female	29,1	29,2	17,5	18,2	25,9	50,4	30,6	46,5	30,8	24	21,9	30,8	17,3	32,2	35,2	34,1	18,4	17,6	10,9	29,9	19,3	18,9	42,2	32,6b	14,2	9,5	47,2	65,6	44,5
2004	total	40,6	41	30	32,5	42,7	60,3	41,8	52,4	49,5	39,4	41,3	37,3	30,5b	49,9	47,9	47,1	30,4	31,1	31,5	45,2	28,8b	26,2	50,3	36,9	29	26,8	50,9	69,1	56,2
	male	50,3	50,7	39,1	42,2	57,2	67,3	50,7	56,4	65	56,4	58,9	41	42,2b	70,8	55,8	57,6	38,3	38,4	53,4	56,9	38,9b	34,1	59,1	43,1	40,9	43,8	51,4	71,2	65,7
	female	31,6	31,7	21,1	24,2	29,4	53,3	33	49,4	33,7	24	24,6	33,8	19,6b	30	41,9	39,3	22,2	25	11,5	33,4	19,3b	19,4	42,5	31,4	17,8	12,6	50,4	67	47
2005	total	42,2	42,5	31,8	34,7	44,5	59,5	45,4b	56,1	51,6	41,6	43,1b	37,9	31,4	50,6	49,5	49,2	31,7	33	30,8	46,1	31,8	27,2	50,5	39,4	30,7	30,3	52,7	69,4b	56,9
	male	51,5	51,8	41,7	45,5	59,3	65,6	53,5b	59,3	65,7	58,8	59,7b	40,7	42,7	70,8	55,2	59,1	38,3	40,6	50,8	56,9	41,3	35,9	58,1	46,7	43,1	47,8	52,8	72b	66
	female	33,5	33,7	22,1	25,5	30,9	53,5	37,5b	53,7	37,3	25,8	27,4b	35,2	20,8	31,5	45,3	41,7	24,9	26,7	12,4	35,2	22,9	19,7	43,7	33,1	18,5	15,6	52,7	66,7b	48,1

(b) break in data series

Source : Eurostat - Labour Force Survey, Annual averages.

11 At-risk-of-poverty rate by most frequent activity status and by gender (Age 18+)

			EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
-	Total	Total		15	14	14 i	8b	12	10	12b	17	18	19	19	13	18	17b	19b	19b	11	12pb	13b	9b	12	18b	19	:	12pb	12b	12	9	:
		Men		14	13	12 i	8b	12	10	11b	15	17	18	17	12	16	15b	17b	18b	11	12pb	12b	9b	10	19b	19	:	10pb	11b	10	8	:
		Women		16	15	17 i	9b	12	11	14b	19	20	21	20	13	20	19b	20b	20b	11	12pb	14b	9b	13	17b	20	:	14pb	12b	13	10	:
-	At work	Total		8	4	7 i	3b	5	5	5b	7	6	13	10	6	9	7b	9b	10b	9	10pb	6b	6b	7	14b	14	:	5pb	9b	4	5	:
		Men		9	5	7 i	3b	5	5	5b	7	6	14	11	7	11	6b	9b	10b	9	10pb	7b	6b	7	15b	14	:	5pb	9b	4	6	:
		Women		7	3	6 i	4b	5	5	6b	8	5	12	9	5	6	7b	9b	10b	9	9pb	3b	5b	6	12b	12	:	4pb	9b	4	5	:
-	Not at work	Total		23	23	19 i	15b	22	18	19b	31	34	26	28	20	25	32b	31b	29b	13	15pb	19b	14b	18	22b	27	:	19pb	15b	22	15	:
		Men		22	24	15 i	15b	24	19	18b	30	37	25	28	19	23	33b	32b	28b	14	14pb	22b	15b	17	23b	26	:	17pb	16b	20	13	:
		Women		23	23	22 i	15b	21	17	19b	31	32	26	28	20	27	31b	31b	29b	13	15pb	18b	13b	18	21b	27	:	21pb	15b	23	16	:
	* Unemployed	Total		40	31	34 i	51b	26	25	42b	60	47	32	35	29	44	37b	59b	63b	46	48pb	48b	27b	48	46b	28	:	25pb	39b	36	26	:
		Men		44	30	36 i	57b	39	37	41b	62	53	38	41	34	50	46b	64b	65b	45	52pb	55b	27b	53	48b	33	:	24pb	41b	39	33	:
		Women		38	32	32 i	47b	14	14	44b	58	35	28	31	25	39	31b	53b	60b	48	45pb	23bu	27b	42	43b	24	:	26pb	38b	31	19	:
	* Retired	Total		17	18	15 i	6b	16	8	14b	23	30	25	25	13	16	49b	24b	17b	6	10pb	17b	5b	12	11b	25	:	17pb	7b	17	10	:
		Men		16	19	7 i	4b	15	8	12b	11	30	22	25	13	15	46b	19b	8b	7	9pb	17b	4b	10	11b	25	:	11pb	4b	11	7	:
		Women		18	18	20 i	7b	16	8	16b	28	30	29	23	14	17	51b	26b	22b	4	10pb	12b	5b	14	10b	25	:	21pb	8b	21	13	:
	* Other inactive	Total		25	26	17 i	16b	31	28	18b	31	34	25	28	27	28	19b	31b	29b	14	17pb	18b	19b	22	26b	29	:	22pb	19b	27	26	:
		Men		25	26	13 i	17b	33	28	19b	35	38	26	25	25	25	16b	31b	26b	19	12pb	19b	26b	26	25b	25	:	23pb	18b	29	26	:
		Women		25	25	21 i	15b	30	28	18b	29	32	25	29	28	29	21b	31b	31b	13	20pb	18b	16b	21	27b	30	:	21pb	19b	25	26	:

Distribution of at-risk-or-poverty population

			EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
-	Total	Total		100	100		100	100	:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	:	100	100	100	100	:
		Men			44		43	47	:	41	39	46	45	45	45	42	42	40	42	48	47	46	49	44	50	46	:	41	45	42	45	:
		Women			56		57	53	:	59	61	54	55	55	55	58	58	60	58	52	53	54	51	56	50	54	:	59	55	58	55	:
-	At work	Total		28	14		23	23	:	20	24	18	33	29	26	23	22	27	28	46	46	20	36	32	34	40	:	19	41	17	35	:
		Men			9		13	13	:	10	11	11	21	19	16	17	13	13	15	28	26	17	22	20	20	23	:	11	21	9	21	:
		Women			5		10	11	:	10	13	7	12	9	10	6	10	13	14	18	21	3	15	12	14	17	:	7	20	8	15	:
-	Not at work	Total		72	86		77	77	:	80	76	82	67	71	74	77	78	73	72	54	54	80	64	68	66	60	:	81	59	83	65	:
		Men			35		30	34	:	31	28	35	23	25	29	26	30	27	27	20	21	29	27	24	29	23	:	30	23	33	24	:
		Women			51		46	42	:	48	48	47	43	46	45	52	48	47	44	34	32	51	36	44	36	37	:	52	35	50	40	:
	* Unemployed	Total		15	21		38	9	:	21	19	11	8	13	14	14	5	22	27	8	17	10	17	9	29	8	:	4	26	19	8	:
		Men			11		18	7	:	10	12	8	4	6	8	7	3	12	15	4	8	9	7	5	15	4	:	2	13	12	6	:
		Women			11		20	3	:	11	7	3	4	8	6	7	3	9	11	4	8	1	10	4	14	4	:	2	13	7	3	:
	* Retired	Total		27	29		20	29	:	31	30	15	28	20	28	18	47	34	22	8	28	18	10	27	17	28	:	42	16	39	31	:
		Men			13		5	12	:	13	4	11	14	14	13	10	20	9	3	6	10	16	4	11	7	13	:	11	4	11	9	:
		Women			16		15	17	:	18	26	3	15	6	15	9	26	26	19	2	18	2	6	17	10	15	:	31	12	28	22	:
	* Other inactive	Total		29	36		19	38	:	28	27	57	31	38	32	45	26	17	23	38	9	53	37	31	20	25	:	35	17	24	26	:
		Men			11		7	16	:	8	11	15	6	6	8	8	6	5	9	9	3	5	16	8	7	6	:	17	7	10	10	:
		Women			25		12	23	:	19	16	41	25	32	24	36	19	11	14	28	6	48	20	23	13	19	:	18	10	15	16	:

1) Including imputed rent. See methodological note for an explanation

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

p = provisional. s = estimated by Eurostat. u = result based on small sample (20-49 observations)

12 Activity rates (% of population aged 15-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	68	63,5	:	72	79,7	70,8	72,2	65,6	63,2	63	68,4	59	:	69,8	72,1	62,1	58,7	:	73	71	65,7	70,6b	68,9	68,2	69,3	72,3	76,2	75,4
	Male	:	77,4	72,8	:	80	83,8	79,2	79	78,2	77,6	77,3	75,2	73,6	:	76,4	78,2	75,9	66,6	:	82,6	80,3	72,8	79,3b	75,7	72,6	77,2	75,6	79	83,2
	Female	:	58,7	54	:	64	75,6	62,2	66,4	52,9	49	48,9	61,9	44,6	:	63,9	66,5	48,1	51,2	:	63,2	61,7	58,8	62,3b	62,3	63,6	61,7	69,1	73,5	67,4
2000	Total	68,6	68,7	65,1	60,7	71,3	80	71,1	70,2	68,2	63,8	65,4	68,7	60,1	69,1	67,2	70,8	64,1	60,1	58	75,2	71	65,8	71,4	68,4	67,5	69,9	74,5	77,3	75,4b
	Male	77,1	77,4	73,7	66,2	79,1	84,2	78,9	75,6	79,9	77,4	78,8	75,2	74,1	81,4	72,7	74,5	76,3	67,9	80,5	84,1	80,1	71,7	79,2	75	71,9	76,8	77,2	79,8	82,8b
	Female	60,1	60	56,4	55,6	63,6	75,6	63,3	65,3	56,3	50,5	52	62,4	46,3	57,7	62,1	67,3	51,6	52,7	35,2	66	62	59,9	63,9	61,9	62,9	63,2	71,9	74,8	68,2b
2002	Total	68,6	69	64,8	61,9	70,6	79,6	71,7	69,3	68,6	64,2	66,2	69,1	61,1	71,2	68,8	69,6	65,2	59,7	58,5	76,5	71,6	64,6	72,7	63,4b	67,8	69,9	74,9	77,6	75,2
	Male	76,8	77,3	73,2	66,4	78,6	83,6	78,8	74,6	79,2	77,6	79,1	75,5	74,3	81,3	74,1	73,6	76,7	67,1	80,1	84,5	79,6	70,6	80	70,4b	72,5	76,7	77	79,4	82,3
	Female	60,5	60,7	56,3	57,5	62,7	75,5	64,4	64,4	57,8	51	53,1	63	47,9	61,8	63,9	65,8	53,6	52,7	36,7	68,3	63,7	58,7	65,6	56,6b	63	63,2	72,8	75,8	68,3
2004	Total	69,3	69,7	65,9	61,8	70	80,1	72,6	70	69,5	66,5	68,7	69,5	62,7b	72,6	69,7	69,1	65,8	60,5	58,2	76,6	71,3b	64	73	63	69,8	69,7	74,2	77,2	75,2
	Male	77	77,5	73,4	66,4	77,9	84	79,2	74,4	79,9	79	80,4	75,3	74,9b	83	74,3	72,8	75,6	67,2	80,2	83,9	78,5b	70,1	79,1	70	74,5	76,5	76,4	79,1	82
	Female	61,6	62	58,2	57,2	62,2	76,2	65,8	66	59	54,1	56,8	63,9	50,6b	62,8	65,3	65,6	55,8	54	36	69,2	64,2b	57,9	67	56,2	65	63	72	75,2	68,6
2005	Total	69,7	70,2	66,7	62,1	70,4	79,8	73,8b	70,1	70,8	66,8	69,7b	69,5	62,5	72,4	69,6	68,4	66,6	61,3	58,1	76,9	72,4	64,4	73,4	62,3	70,7	68,9	74,7	78,7b	75,3
	Male	77,3	77,8	73,9	67	78,4	83,6	80,6b	73,6	80,6	79,2	80,9b	75,1	74,6	82,9	74,4	72,1	76	67,9	79,1	83,7	79,3	70,8	79	69,4	75,1	76,5	76,6	80,9b	81,9
	Female	62,1	62,5	59,5	57,3	62,4	75,9	66,9b	66,9	60,8	54,5	58,3b	64,1	50,4	62,5	65,1	64,9	57	55,1	36,9	70	65,6	58,1	67,9	55,3	66,1	61,5	72,8	76,3b	68,8

Source : Eurostat - Labour Force Survey, Annual averages.

(b) break in series

13 Dispersion of regional employment rates*, selected years (%)

	EU 25	BE	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SL	SK	FI	SE	UK
1999	13,4	8	5,6	-	5,4	-	-	5,2	10,7	7,1	17,4	-	-	-	-	9,1	-	2,3	2,3	4,8	2,6	-	8,1	6,7	5	7,1
2004	12,2	8,7	5,6	-	6,2	-	-	4,1	8,7	7,1	15,6	-	-	-	-	9,4	-	2,3	3,5	6,4	3,5	-	9	5,5	4,4	5,8

* Coefficient of variation of employment rates across regions at NUTS2 level

e = estimate; p = provisional figure

Source : Eurostat - Labour Force Survey, Annual averages

Context indicators

Context 1: Growth rate of GDP at constant prices (2000) - percentage change over previous year

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2004	2,4	2,4	3	5,6	4,2	2,2	1,2	8,1	4,3	4,7	3,2	2,3	1,1	4,2	8,6	7,3	3,6	4,9	0,8	2	2,4	5,3	1,2	8,4	4,4	5,4	3,5	4,1	3,3
2005	1,7	1,7	1,1	5,5	6,1	3	0,9	10,5	5,5	3,7	3,5	1,2	0	3,9	10,2	7,6	4	4,2	2,2	1,5	2	3,5	0,4	4,1	4	6	2,9	2,9	1,9
2006	2,9	2,9	2,7 f	6,0 f	6,0 f	3,0 f	2,5	10,9 f	5,3 f	3,8 f	3,8 f	2,2 f	2	3,8 f	11,0 f	7,8 f	5,5 f	3,9	2,3 f	3,0 f	3,1 f	5,2 f	1,2 f	7,2 f	4,8 f	6,7 f	4,9 f	4,0 f	2,8

Context 1a: GDP per capita in Purchasing Power Standards (PPS), (EU-25 = 100)

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1996		100	118,1	:	70,0 (e)	123,8	118,1	34,8 (e)	69,8	87,0	112,9	102,3	115,6	79,6 (e)	30,2 (e)	34,7 (e)	196,7	48,5 (e)	:	119,2	126,5	42,1 (e)	74,9	69,0 (e)	:	45,5 (e)	103,9	115,7	109,1
2000		100	116,5	26,5	64,7	126,0	111,7	42,1	126,1	72,7	92,1	113,3	113,1	82,2	35,3	37,9	222,0	53,9	78,0	124,0	125,5	46,7	80,3	24,9	72,7	47,4	114,0	118,8	111,8
2004		100	119,4	31,8	72,1	120,1	111,1	53,4	135,7	81,4	96,6	107,7	103,0	87,7	43,6	49,0	240,8	61,3	71,3	124,7	123,4	48,7	71,8	32,6	79,9	54,4	110,8	115,4	118,0
2005		100	118,1	33,0	73,7	122,1	110,0	59,8	138,9	84,1	98,0	108,2	100,4	88,9	48,0	52,1	251,2	62,5	70,5	125,6	123,1	49,8	71,1	34,1	81,9	57,1	110,7	114,8	117,6
2006		100	118,1 f	34,2 f	76,1 f	122.4 f	110,2 f	65,0 f	139,2 f	84,9 f	98,0 f	107,3 f	99,6 f	88,3 f	52,3 f	55,0 f	257,1 f	63,6 f	69,7 f	126,1 f	123,2 f	51,1 f	69,8 f	35,8 f	83,6 f	59,4 f	112.9 f	116,0 f	117,3 f

f = forecast r = revised value e = estimate

Source : Eurostat, Structural indicators database

Context 2a: Employment rate (% of population aged 15-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	total	:	61,2	57,4	:	67,3	75,1	63,9	64,6	60,6	56	51,3	60,2	51,9	:	59,9	62,3	60,5	53,7	:	70,2	67,9	59	66,8b	64,2	62,9	60,6	64,6	70,3	70,5
	male	:	70,6	67,1	:	76	79,9	71,9	69,6	72,1	71,7	66,8	67,4	66,8	:	65,1	66,2	74,5	60,5	:	80,2	77	66,5	75,9b	70,4	67,2	67,8	67,8	72,8	77,3
	female	:	51,8	47,6	:	58,7	70,2	55,8	60,3	49	40,5	35,8	53,1	37,3	:	55,1	58,6	46,2	47,2	:	60,1	58,8	51,7	58,2b	58,2	58,6	53,5	61,2	67,9	63,6
2000	total	62,2	62,4	60,5	50,4	65	76,3	65,6	60,4	65,2	56,5	56,3	62,1	53,7	65,7	57,5	59,1	62,7	56,3	54,2	72,9	68,5	55	68,4	63	62,8	56,8	67,2	73	71,2b
	male	70,8	71,2	69,5	54,7	73,2	80,8	72,9	64,3	76,3	71,5	71,2	69,2	68	78,7	61,5	60,5	75	63,1	75	82,1	77,3	61,2	76,5	68,6	67,2	62,2	70,1	75,1	77,8b
	female	53,7	53,6	51,5	46,3	56,9	71,6	58,1	56,9	53,9	41,7	41,3	55,2	39,6	53,5	53,8	57,7	50,1	49,7	33,1	63,5	59,6	48,9	60,5	57,5	58,4	51,5	64,2	70,9	64,7b
2002	total	62,3	62,8	59,9	50,6	65,4	75,9	65,4	62	65,5	57,5	58,5	63	55,5	68,6	60,4	59,9	63,4	56,2	54,4	74,4	68,7	51,5	68,8	57,6b	63,4	56,8	68,1	73,6	71,3
	male	70,3	71	68,3	53,7	73,9	80	71,8	66,5	75,4	72,2	72,6	69,5	69,1	78,9	64,3	62,7	75,1	62,9	74,7	82,4	76,4	56,9	76,5	63,6b	68,2	62,4	70	74,9	77,6
	female	54,4	54,7	51,4	47,5	57	71,7	58,9	57,9	55,4	42,9	44,4	56,7	42	59,1	56,8	57,2	51,6	49,8	33,9	66,2	61,3	46,2	61,4	51,8b	58,6	51,4	66,2	72,2	65,2
2004	total	62,9	63,3	60,3	54,2	64,2	75,7	65	63	66,3	59,4	61,1	63,1	57,6b	68,9	62,3	61,2	62,5	56,8	54	73,1	67,8b	51,7	67,8	57,7	65,3	57	67,6	72,1	71,6
	male	70,3	70,9	67,9	57,9	72,3	79,7	70,8	66,4	75,9	73,7	73,8	69	70,1b	79,8	66,4	64,7	72,8	63,1	75,1	80,2	74,9b	57,2	74,2	63,4	70	63,2	69,7	73,6	77,8
	female	55,4	55,7	52,6	50,6	56	71,6	59,2	60	56,5	45,2	48,3	57,4	45,2b	58,7	58,5	57,8	51,9	50,7	32,7	65,8	60,7b	46,2	61,7	52,1	60,5	50,9	65,6	70,5	65,6
2005	total	63,4	63,8	61,1	55,8	64,8	75,9	65,4b	64,4	67,6	60,1	63,3b	63,1	57,6	68,5	63,3	62,6	63,6	56,9	53,9	73,2	68,6	52,8	67,5	57,6	66	57,7	68,4	72,5b	71,7
	male	70,8	71,3	68,3	60	73,3	79,8	71,2b	67	76,9	74,2	75,2b	68,8	69,9	79,2	67,6	66,1	73,3	63,1	73,8	79,9	75,4	58,9	73,4	63,7	70,4	64,6	70,3	74,4b	77,6
	female	56	56,3	53,8	51,7	56,3	71,9	59,6b	62,1	58,3	46,1	51,2b	57,6	45,3	58,4	59,3	59,4	53,7	51	33,7	66,4	62	46,8	61,7	51,5	61,3	50,9	66,5	70,4b	65,9

Source : Eurostat - Labour Force Survey, Annual averages.

(b): break in series

Context 2b: Unemployment rate (% of labour force aged 15+)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	9,3	9,3	:	6,4	4,9	8,8	9,2	7,5	10,8	15	11,1	11,3	:	14,3	13,2	2,7	8,4	:	3,8	4,5	10,2	5,1	5,4	7,4	12,6	11,4	8,2	6,1
	Males	:	8	7,7	:	5	3,9	7,1	9,9	7,7	7	11,2	9,5	8,8	:	15,1	14,6	1,9	9	:	3	3,8	8,5	4,1	5,5	7,3	12,2	10,9	8,4	6,8
	Females	:	11,2	11,6	:	8,1	6	11,1	8,3	7,3	16,7	21,1	12,9	15,4	:	13,6	11,7	4	7,8	:	5	5,4	12,2	6,3	5,3	7,5	13,1	12	8	5,3
2000	Total	8,7	8,6	6,9	16,4	8,7	4,3	7,2	12,8	4,2	11,2	11,1	9,1	10,1	4,9	13,7	16,4	2,3	6,4	6,7	2,8	3,6	16,1	4	7,2	6,7	18,8	9,8	5,6	5,5
	Males	7,5	7,4	5,6	16,7	7,3	3,9	6	13,8	4,3	7,4	7,9	7,6	7,8	3,2	14,4	18,6	1,8	7	6,4	2,2	3,1	14,4	3,2	7,8	6,5	18,9	9,1	5,9	6
	Females	10,1	10,2	8,5	16,2	10,3	4,8	8,7	11,8	4,2	17,1	16	10,9	13,6	7,2	12,9	14,1	3,1	5,6	7,4	3,6	4,3	18,1	4,9	6,4	7	18,6	10,6	5,3	4,9
2002	Total	8,9	8,7	7,5	18,1	7,3	4,6	8,2	10,3	4,5	10,3	11,1	8,7	8,6	3,6	12,2	13,5	2,7	5,8	7,5	2,8	4,2	19,9	5	8,4	6,3	18,7	9,1	4,9	5,1
	Males	8	7,8	6,7	18,9	5,9	4,3	7,1	10,8	4,7	6,8	8,1	7,8	6,7	2,9	13,3	14,2	2	6,2	6,6	2,5	4	19,1	4,1	9,1	5,9	18,6	9,1	5,3	5,6
	Females	10	10	8,6	17,3	9	5	9,4	9,7	4,1	15,6	15,7	9,8	11,5	4,5	11	12,8	3,7	5,4	9,3	3,1	4,4	20,9	6	7,7	6,8	18,7	9,1	4,6	4,5
2004	Total	9,1	9,1	8,4	12	8,3	5,5	9,5	9,7	4,5	10,5	10,6	9,6	8b	4,6	10,4	11,4	5,1	6,1	7,4	4,6	4,8b	19	6,7	8,1	6,3	18,2	8,8	6,3	4,7
	Males	8,2	8,1	7,5	12,5	7,1	5,1	8,7	10,4	4,9	6,6	8	8,7	6,4b	3,6	10,6	11	3,7	6,1	6,6	4,3	4,4b	18,2	5,8	9,1	5,8	17,4	8,7	6,5	5
	Females	10,1	10,2	9,5	11,5	9,9	6	10,5	8,9	4,1	16,2	14,3	10,6	10,5b	6	10,2	11,8	7,1	6,1	9	4,8	5,3b	19,9	7,6	6,9	6,8	19,2	8,9	6,1	4,2
2005	Total	8,7	8,8	8,4	10,1	7,9	4,8	9,5b	7,9	4,4	9,8	9,2	9,7	7,7	5,2	8,9	8,3	4,5	7,2	7,3	4,7	5,2	17,7	7,6	7,2	6,5	16,3	8,4	7,8p	4,8
	Males	7,9	7,9	7,6	10,3	6,5	4,4	8,8b	8,8	4,6	6,1	7	8,8	6,2	4,3	9,1	8,2	3,5	7	6,5	4,4	4,9	16,6	6,7	7,8	6,1	15,5	8,2	7,9p	5,1
	Females	9,7	9,8	9,5	9,8	9,8	5,3	10,3b	7,1	4,1	15,3	12,2	10,7	10,1	6,5	8,7	8,3	5,8	7,4	9	5,1	5,5	19,1	8,7	6,4	7	17,2	8,6	7,7p	4,3

Source: Eurostat - Harmonised unemployment series, Annual average

Context 2c: Youth unemployment rate (% of labour force aged 15-24)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	19,5	22,1	:	12,8	7,3	15	15,2	11,3	29,9	33,1	25,6	29,9	:	26,8	25,5	6,9	15	:	7,6	6,4	22,5	10,7	15,8	17,8	25,1	23,5	16,1	13,1
	Males	:	17,7	20,2	:	11,5	7,1	12,3	16,7	11,6	21,3	25,9	23,3	25,4	:	27,4	30,1	6,5	16,6	:	7,4	5	20,2	8,5	15,6	16,9	26,6	22,8	16,4	14,8
	Females	:	21,6	24,5	:	14,4	7,4	17,9	13,1	11	40,2	42,4	28,3	35,5	:	26	18,4	7,3	13	:	7,9	7,9	25,1	13,2	16,1	18,8	23,4	24,3	15,8	11,3
2000	Total	17,9	17,6	16,7	33,7	17,8	6,2	10,6	23,9	6,8	29,1	24,3	20,1	27	10,1	21,4	30,6	7,1	12,4	13,7	5,7	5,3	35,1	8,8	20	16,3	36,9	21,4	10,5	12,6
	Males	16,7	16,2	14,5	36,1	18,5	6,6	9,4	23,8	6,8	21,5	18,1	18	23,1	6,9	21,2	32,3	6,5	13,6	14,9	4,9	4,7	33,3	6,6	22,2	14,6	39,7	21,1	11	13,7
	Females	19,3	19,3	19,5	30,7	17	5,7	11,9	24,1	7	38,1	32,5	22,5	31,9	13	21,6	28,3	7,9	10,8	12,3	6,5	6	37,2	11,5	17,2	18,3	33,8	21,6	9,9	11,4
2002	Total	18,9	18,5	17,7	37	16,9	7,4	14,2	17,6	8,5	26,8	24,2	19,7	23,1	8,1	22	22,5	7,7	12,7	17,1	5	6,7	42,5	11,6	23,2	16,5	37,7	21	11,9	12
	Males	18,1	17,5	17,2	40,1	16,6	7,3	13	14,3	9,3	19,9	19,2	18,2	19,4	7,9	20,4	22,6	6,1	13,2	17,6	5,2	6,4	41,9	9,8	24,3	15	39,5	21,2	12	13,7
	Females	19,8	19,6	18,3	33,2	17,2	7,5	15,4	22,5	7,6	35,3	31,1	21,7	27,8	8,3	24,3	22,2	9,6	11,9	16,7	4,8	7,1	43,3	13,9	21,8	18,6	35,5	20,9	11,8	10,2
2004	Total	19,2	19	21,2	25,8	21	8,2	15	21,7	8,9	26,9	23,9	21,8	23,5b	10,5	18,1	22,7	16,8	15,5	16,8	8	9,4b	39,6	15,3	21,9	16,1	33,1	20,7	16,3	12,1
	Males	18,7	18,4	20,2	27	22,2	8,9	15,2	21,2	9,3	19,1	19,4	20,8	20,6b	9,4	16	22,5	12	16,2	16,3	7,9	9b	37,7	13,5	24,2	13,9	34,7	22	15,7	13,4
	Females	19,8	19,7	22,4	24,3	19,5	7,4	14,8	22,4	8,5	36,3	30,1	23	27,2b	11,6	21,3	22,9	22,3	14,4	17,4	8,1	9,8b	41,9	17,6	18,9	19,2	31	19,4	16,9	10,7
2005	Total	18,6	18,5	21,5	22,3	19,2	8,6	14,8b	15,9	8,7	26	19,7	22,7	24	13	13,6	15,7	13,7	19,4	16,4	8,2	10,3	36,9	16,1	20,2	15,9	30,1	20,1	22,6p	12,9
	Males	18,4	18,2	21	23,4	19,3	8,6	15,4b	16,6	9,2	18,7	16,7	21,3	21,5	11,9	11,8	15,9	11,7	19,6	16,8	8	10,5	35,7	13,6	21,6	14,5	31	20,6	23p	14,5
	Females	18,9	18,9	22,1	21	19,1	8,6	14,1b	14,9	8,1	34,8	23,5	24,4	27,4	14,2	16,2	15,3	16,2	19	16	8,4	10,1	38,3	19,1	18,4	17,8	28,8	19,5	22,1p	11,1

Source: Eurostat, Harmonised unemployment series - Annual average

Context 2d: Long-term unemployment rate by gender, selected years (% of the labour force 15+)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	4,4	5,6	:	2	1,3	4,5	4,2	3,9	5,8	7,5	4,5	6,8	:	7,9	7,5	0,9	4,2	:	1,5	1,3	4,7	2,2	2,3	3,3	6,5	4,1	2,6	1,9
	Males	:	3,6	4,5	:	1,5	0,9	3,4	4,4	4,7	3,1	4,9	3,8	5,3	:	8,3	7,9	0,7	4,5	:	1,3	1	3,5	1,7	2,2	3,3	6	4,3	3,2	2,4
	Females	:	5,5	7,1	:	2,6	1,7	6	4,1	2,8	10	11,6	5,3	9,1	:	7,5	7	1,1	3,8	:	1,8	1,8	6,3	2,8	2,5	3,3	7,1	3,9	1,8	1,2
2000	Total	4,1	3,9	3,7	9,4	4,2	0,9	3,7	5,9	1,6	6,2	4,6	3,5	6,3	1,2	7,9	8	0,6	3,1	4,4	0,8	1	7,4	1,7	3,5	4,1	10,3	2,8	1,4	1,4
	Males	4,2	3,3	3	9,6	3,5	0,8	3	6,7	2	3,6	2,8	2,9	4,8	0,5	8,3	9,4	0,5	3,5	4,5	0,6	0,9	6	1,4	3,6	4,1	10,3	2,8	1,7	1,9
	Females	4	4,8	4,6	9,2	5,2	1,1	4,6	5	1	10,2	7,4	4,3	8,4	2,2	7,5	6,5	0,6	2,5	4,2	1	1,2	9,1	2	3,4	4,2	10,2	2,7	1	0,9
2002	Total	4,6	3,9	3,7	12	3,7	0,9	3,9	5,4	1,4	5,3	3,7	3,1	5,1	0,8	5,5	7,2	0,7	2,5	3,3	0,7	1,1	10,9	1,7	4	3,5	12,2	2,3	1	1,1
	Males	4,6	3,3	3,2	12,5	3	0,7	3,3	6,3	1,8	3,1	2,3	2,6	4	0,5	6,4	7,6	0,6	2,8	3,5	0,6	1	9,7	1,4	4,1	3,4	11,9	2,5	1,2	1,4
	Females	4,5	4,6	4,3	11,4	4,6	1	4,8	4,4	0,8	8,6	5,9	3,5	6,9	1	4,6	6,8	0,9	2,2	2,4	0,9	1,2	12,3	2,1	4	3,6	12,5	2	0,8	0,7
2004	Total	4	4,1	4,1	7,2	4,2	1,2	5,4	5	1,6	5,6	3,4	3,9	4b	1,2	4,6	5,8	1,1	2,7	3,4	1,6	1,3b	10,3	3	4,5	3,2	11,8	2,1	1,2	1
	Males	4,3	3,6	3,7	7,3	3,4	1,1	4,8	5,6	2	3	2,2	3,5	2,9b	0,9	4,8	5,5	0,8	2,8	3,7	1,5	1,3b	9,6	2,6	5,2	3,1	11,3	2,3	1,4	1,2
	Females	3,6	4,7	4,7	7	5,3	1,3	6,1	4,4	1	9,4	5,1	4,3	5,5b	1,6	4,3	6,2	1,4	2,6	3	1,6	1,4b	11	3,4	3,6	3,4	12,4	2	1	0,6
2005	Total	3,8	3,9	4,4	6	4,2	1,1	5b	4,2	1,5	5,1	2,2b	4	3,9	1,2	4,1	4,3	1,2	3,2	3,4	1,9	1,3	10,2	3,7	4,4	3,1	11,7	2,2	1,2p	1
	Males	3,9	3,5	3,8	6	3,4	1,1	4,7b	4,2	1,9	2,6	1,4b	3,5	2,9	0,8	4,4	4,2	1,2	3,2	3,4	1,9	1,2	9,3	3,2	4,7	2,9	11,2	2,4	1,4p	1,3
	Females	3,7	4,5	5	6	5,3	1,2	5,4b	4,2	0,8	8,9	3,4b	4,6	5,2	1,8	3,7	4,5	1,2	3,2	3,2	1,9	1,4	11,4	4,2	3,9	3,3	12,3	1,9	1p	0,7

Source : Eurostat - Labour Force Survey, Annual averages

Context 4: Old age dependency ratio (current and projected) - ratio between the total number of people aged 65 and over and the number of persons of working age (from 15 to 64)

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2005	24,9	26,3	24,9	19,8	22,6	27,8	24,1	16,5	26,8	24,5	25,3	29,4	17,7	24,1	22,5	21,2	22,8	19,2	20,7	23,6	18,7	25,2	21,1	21,7	16,3	23,7	26,4	24,4
2010	26,3	26,4	25,6	21,9	24,8	31	24,7	17,5	28	25,4	25,9	31,3	19,1	25,2	23,4	21,6	24,3	20,4	22,2	26,3	18,8	26,5	21,2	23,6	16,9	25,4	28	25,1
2020	32,1	32,2	33,0	31,8	31,2	35,1	28,7	22,5	32,5	30	33,2	36,6	25,5	28	26	24,7	31,2	30	29	30,3	27,1	31,5	25,1	30,8	23,5	37	34,4	30,3
2030	40,3	41,3	40,4	37,1	37,1	46	33,4	28,3	39,1	38,9	40,7	45,2	32,9	33,4	33,4	31,5	35,1	36	36,7	40,8	35,7	39	29,6	40,4	31,7	45	38,5	37,4
2040	48,5	47,2	48,8	43,8	42,1	54,6	36,6	35,9	49,8	54,3	46,9	59,8	36,1	37,4	39,3	36,7	40,3	35,9	41,6	50,4	39,7	48,9	39,6	47,7	38,1	46,1	41,5	43,8
2050	52,8	48,1	60,9	54,8	40	55,8	43,1	45,3	58,8	67,5	47,9	66	43,2	44,1	44,9	36,1	48,3	40,6	38,6	53,2	51	58,1	51,1	55,6	50,6	46,7	40,9	45,3

Source : Eurostat - EUROPOP2004 Trend scenario - baseline variant

Context 5a: Distribution of households by age and household type (private/institutional)

		EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Total	Total ('000)	441467	10296	7904	10230	5349	82277	1370	10628	40847	58514	3852	56996	690	2377	3484	440	10198	0	15986	8033	38230	10356	21681	1964	5379	5181	0	58789
	Private households (%)	98,7	98,6	99,3	99,3	98,7	99,0	98,8	96,6	99,4	97,8	98,4	99,3	99,4	99,0	99,3	98,3	97,5	-	98,6	98,9	98,9	99,0	98,5	99,3	98,4	98,1	-	98,2
	Institutional household (%	1,3	1,4	0,7	0,7	1,3	1,0	0,9	3,4	0,6	2,2	1,6	0,7	0,6	1,0	0,7	1,7	2,4	-	1,4	1,1	1,1	1,0	1,5	0,7	0,8	0,7	-	1,8
Children	Total ('000)	90525	2162	1531	2057	1161	15251	312	2011	7341	13426	1009	9833	180	541	846	98	2087	0	3532	1639	8851	2053	4847	376	1277	1135	0	13346
(0-17)	Private households (%)	99,4	99,9	97,9	99,8	99,4	99,7	99,2	97,8	99,9	99,2	99,6	99,9	99,9	99,4	99,3	99,0	96,9	-	99,7	99,7	99,2	99,5	98,3	:	98,3	99,1	-	99,3
	Institutional household (%	0,6	0,1	2,1	0,2	0,6	:	0,6	2,2	0,1	0,8	0,4	0,1	0,1	0,6	0,7	1,0	3,1	-	0,3	0,3	0,8	0,5	1,7	:	0,4	0,4	-	0,7
18-64	Total ('000)	279593	6390	5586	6759	3396	52516	852	6824	26547	35788	2420	36517	428	1485	2148	281	6565	0	10279	5152	24522	6610	15420	1299	3444	3269	0	36103
	Private households (%)	99,0	99,5	99,4	99,5	98,9	99,6	98,9	96,0	99,7	98,2	98,9	99,5	99,7	99,0	99,4	99,0	97,7	-	99,4	99,4	98,8	99,6	98,0	:	98,7	98,4	-	98,5
	Institutional household (%	1,0	0,5	0,6	0,5	1,1	:	0,9	4,0	0,3	1,8	1,1	0,5	0,3	1,0	0,6	1,0	2,2	-	0,6	0,6	1,2	0,4	2,0	:	0,6	0,3	-	1,5
65+	Total ('000)	71306	1744	1322	1411	792	14510	205	1792	6974	9299	423	10646	80	352	489	61	1546	0	2174	1242	4853	1693	3050	289	611	777	0	9341
	Private households (%)	96,4	93,9	99,6	97,7	96,7	96,3	98,1	97,5	97,7	94,3	92,8	97,9	96,4	98,7	98,9	93,7	97,5	-	93,5	95,8	98,8	96,4	99,6	:	97,0	95,1	-	95,4
	Institutional household (%	3,6	6,1	0,4	2,3	3,3	:	1,7	2,5	2,3	5,7	7,2	2,1	3,6	1,3	1,1	6,3	2,5	-	6,5	4,2	1,2	3,6	0,4	:	2,7	3,1	-	4,6
75+	Total ('000)	30917	774	481	570	379	6191	75	642	3036	4133	184	4762	34	126	178	25	619	0	972	582	1841	701	1063	110	238	340	0	4405
	Private households (%)	93,3	88,4	99,3	95,7	94,2	92,5	96,9	96,7	96,1	89,5	87,6	96,5	92,7	98,1	98,3	87,0	95,8	-	87,2	92,4	98,1	93,1	99,4	88,4	95,4	90,8	-	91,5
	Institutional household (%	6,7	11,5	0,7	4,3	5,8	7,5	2,9	3,3	3,9	10,5	12,4	3,5	7,3	1,9	1,7	13,0	4,2	-	12,8	7,6	1,9	6,9	0,6	5,3	4,2	6,0	-	8,5
	Hospitals (%)	19,9	5,3	14,0	4,9	:	:	3,6	20,4	12,5	13,8	27,8	1,5	5,8	2,0	5,2	9,8	11,8	-	20,8	19,4	18,5	3,3	30,7	:	13,3	27,9	-	44,6
	Old people's homes (%)	68,0	85,1	83,8	86,3	:	:	95,4	34,3	56,6	79,5	56,4	73,2	91,0	97,7	89,1	69,2	83,4	-	75,9	76,3	65,8	85,8	59,4	:	75,1	58,5	-	46,0

Source: Eurostat Census data collection 2000-01

Context 5b: Population living in private households by household type, 2005 (percentage of total population)

	EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
- Single adults, no children	14,6	12,5		10,3	14,9	17,2	9,7	9,9	5,8	13,1	7,6	11,4	5,1	7,8	8,5	7,7	9,7	4,2	14,1	14,9	0,0	5,9	9,1	5,5	15,7	:	13,5
of which:																										:	
- Single men	6,1	5,4		3,8	7,7	7,3	3,9	3,7	2,4	5,3	3,4	4,4	1,6	2,8	2,4	3,2	3,0	1,6	6,4	6,3	0,0	2,0	3,1	1,6	6,9	:	6,0
- Single women	8,5	7,1		6,5	7,2	9,8	5,8	6,1	3,4	7,8	4,2	7,1	3,5	4,9	6,2	4,5	6,7	2,6	7,8	8,6	0,0	4,0	6,0	3,9	8,9	:	7,5
																										:	
- Under 65	8,8	7,7		5,3	12,0	10,6	6,7	5,4	2,7	7,8	4,1	5,2	2,8	4,5	3,6	4,3	4,4	1,6	9,3	9,6	0,0	2,4	4,2	2,3	12,0	:	7,9
- 65 and over	5,9	4,8		5,0	2,9	6,5	3,0	4,5	3,0	5,2	3,6	6,3	2,2	3,3	4,9	3,4	5,3	2,6	4,9	5,3	0,0	3,5	4,9	3,2	3,7	:	5,6
- Single parents	4,5	6,6		4,6	4,9	4,4	6,4	1,6	1,9	5,3	3,4	2,0	2,1	4,8	4,2	3,3	3,8	1,8	3,5	3,8	0,0	2,5	2,3	2,4	2,4	:	8,4
- 2 adults below 65, no children	14,4	14,1		13,6	21,7	16,9	11,5	10,3	9,2	14,7	11,4	9,1	10,3	9,6	6,8	12,1	11,5	7,1	18,6	13,8	0,0	8,4	8,9	7,3	17,8	:	16,7
- 2 adults, at least one aged 65+, no children	11,5	11,3		9,6	9,7	12,9	11,0	12,5	9,3	10,9	6,6	11,0	9,5	9,2	7,2	9,7	9,4	8,3	9,7	9,2	0,0	10,3	8,8	7,1	10,3	:	10,6
- 3 or more adults, no children	14,9	10,3		13,5	6,3	9,7	11,6	20,0	23,0	7,2	25,8	19,2	15,5	17,4	11,7	9,3	14,6	21,3	10,9	14,1	0,0	19,8	21,7	17,4	13,0	:	11,3
- 2 adults, 1 child	12,4	10,5		12,5	10,2	11,5	14,3	11,2	12,2	12,4	6,8	13,3	10,6	11,0	10,7	12,6	11,4	10,1	9,2	11,0	0,0	16,7	10,9	8,7	9,6	:	9,6
- 2 adults, 2 children	17,1	16,9		20,0	17,8	14,3	16,1	18,6	17,3	18,9	10,8	17,2	16,8	10,8	15,4	23,0	15,8	18,4	16,6	14,2	0,0	15,7	17,0	15,9	13,2	:	13,8
- 2 adults, 3 or more children	7,4	10,0		5,5	8,2	6,1	5,5	5,4	4,1	11,0	9,9	5,2	12,3	4,9	5,8	12,5	8,1	8,5	8,3	5,9	0,0	4,0	5,0	8,7	9,0	:	7,7
- 3 or more adults, with children	12,4	7,8		10,4	6,4	7,0	13,8	10,5	17,2	6,5	17,6	11,7	17,9	24,6	29,6	9,7	15,6	20,2	9,1	13,2	0,0	16,7	16,3	27,1	9,0	:	8,4

EU aggregates based on available country data

Source : Eurostat - European Labour Force Survey 2005, Spring results. Annual averages for DK and FI.

Context 6a: General government debt - General government consolidated gross debt as a percentage of GDP

	EUR-25	BE	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
2000	62	107,7	18,5	51,7	59,7	5,2	37,8	111,6	59,2	56,7	109,1	59,5	12,3	23,7	6,4	53,4	55,4	53,8	65,5	35,9	50,4	27,6	50,2	43,8	52,3	41,2
2001	61,1	106,3	25,1	47,4	58,8	4,8	35,5	113,2	55,5	56,2	108,7	61,4	14	22,8	6,5	50,7	61,3	50,7	66	35,9	52,9	28,3	48,9	42,3	53,8	38
2002	60,5	103,3	28,5	46,8	60,3	5,6	32,2	110,7	52,5	58,2	105,6	64,7	13,5	22,2	6,5	55,6	60,1	50,5	65,8	39,8	55,5	29,1	43,3	41,3	52	37,5
2003	62	98,6	30,1	44,4	63,9	5,7	31,1	107,8	48,7	62,4	104,3	69,1	14,4	21,2	6,3	58	70,2	52	64,6	43,9	57	28,5	42,7	44,3	51,8	38,9
2004	62,4	94,3	30,7	42,6	65,7	5,2	29,7	108,5	46,2	64,4	103,9	70,3	14,5	19,4	6,6	59,4	74,9	52,6	63,8	41,8	58,6	28,7	41,6	44,3	50,5	40,4
2005	63,3	93,2	30,4	35,9	67,9	4,5	27,4	107,5	43,1	66,6	106,6	69,2	12,1	18,7	6	61,7	74,2	52,7	63,4	42	64	28	34,5	41,3	50,4	42,4
2006	*62,2*	*89,4*	*30,9*	*28,5*	*67,8*	*4*	*25,8*	*104,8*	*39,7*	*64,7*	*107,2*	*64,8*	*11,1*	*18,9*	*7,4*	*67,6*	*69,6*	*50,5*	*62,1*	*42,4*	*67,4*	*28,4*	*33*	*38,8*	*46,7*	*43,2*
2007	*61,1*	*86,3*	*30,8*	*24,5*	*67,7*	*2,7*	*24,4*	*101*	*37*	*63,9*	*105,9*	*62,2*	*10,6*	*19,6*	*7,3*	*70,9*	*69*	*47,8*	*60,9*	*43,1*	*69,4*	*28*	*31,6*	*37,3*	*42,6*	*44,1*
2008	*60,1*	*83,2*	*31*	*22*	*67,3*	*2,1*	*23,6*	*96,4*	*34,7*	*63,3*	*105,7*	*59,6*	*10,3*	*19,8*	*7,1*	*72,7*	*68,6*	*45,4*	*59,8*	*42,7*	*70,7*	*27,6*	*31*	*35,8*	*38,7*	*44,7*

Source: Eurostat - General Government data (2000 to 2005) and ECFIN forecasts (2006-2008)
http://ec.europa.eu/economy_finance/indicators/general_government_data/government_data_en.htm

Context 6b: Projected evolution of debt levels up to 2050 (in % of GDP)
http://ec.europa.eu/economy_finance/publications/european_economy/2006/ee306_en.pdf p.60

	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
Programme scenario																												
2005	-	94.3	:	37.4	36.8	67.3	4.6	28.0	107.9	43.1	65.8	108.5	70.5	13.1	19.2	6.4	57.7	76.7	54.4	63.4	42.5	65.5	:	29.0	33.7	42.7	50.9	43.3
2010	-	75.3	:	39.6	21.5	65.6	2.5	24.6	91.0	31.5	61.1	99.1	51.5	11.7	18.0	8.9	62.5	60.6	50.0	54.9	51.3	64.4	:	28.4	35.9	37.3	39.0	44.4
2030	-	36.1	:	79.0	-15.1	57.9	-28.2	36.7	122.0	9.6	64.2	51.4	70.6	-0.4	19.9	20.9	76.0	-1.8	88.6	15.0	6.2	89.2	:	76.3	48.1	38.8	9.6	54.0
2050	-	63.5	:	280.2	-37.3	99.4	-93.2	156.2	346.0	95.8	121.2	30.7	189.5	11.1	69.8	109.7	119.3	-106.3	218.1	-21.2	-76.3	262.5	:	302.7	130.4	117.3	52.0	110.3
2005 budget scenario																												
2010	-	73.4	:	43.2	14.4	73.6	0.9	13.6	96.9	25.7	69.2	108.9	64.3	13.0	22.4	11.5	76.1	80.2	44.2	58.9	53.2	76.3	:	25.1	38.7	23.7	30.3	47.0
2030	-	33.6	:	95.7	-61.2	116.2	-39.3	7.9	165.2	-13.5	132.8	127.6	116.3	14.9	46.7	56.1	143.6	92.9	67.8	54.9	20.0	195.4	:	68.5	66.8	7.9	8.0	90.1
2050	-	60.2	:	320.3	-135.5	232.4	-117.0	100.4	451.3	42.6	269.9	208.9	269.9	49.6	135.7	179.1	247.6	79.6	177.7	67.5	-42.5	517.4	:	287.2	176.9	61.6	58.8	186.7

* Adjusted gross debt.

Source: Commission services, 2005/06 updated stability and convergence programmes.

Context 7a: Social protection benefits by group of functions (as a percentage of total benefits) - 2004

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
Old age and survivors benefits	45,9e	44,1	:	41,1p	37,2	43,5p	43,7	43,6p	23,3	50,9	43,7p	61,3p	48,3	50p	47,3p	36,5p	42,5	51,2	41,6p	48,2	60,1p	47,2p	:	44,7p	40,1p	36,9	40,1p	44,6e
Sickness, health care	28,3e	27,7	:	35,3p	20,6	27,2p	31,5	30p	42,1	26,5	30,8p	25,9p	24,1	24,5p	29,5p	25p	29,5	27	30,4p	25	19,5p	30,4p	:	32,7p	30,1p	25,5	25,4p	30,4e
Disability	8,1e	6,8	:	7,9p	13,9	7,7p	9,1	5,8p	5,3	5	7,5p	6,1p	4,3	9,8p	10,2p	13,5p	10,3	6,7	10,9p	8,3	11,5p	10,4p	:	8,1p	9,6p	13,2	14,8p	9,2e
Unemployment	6,5e	12,5	:	3,9p	9,5	8,6p	1,6	7,8p	8,3	5,9	12,9p	2p	4,9	3,4p	1,6p	4,7p	2,9	6,9	6,3p	6	3,5p	5,7p	:	3,1p	6,2p	9,8	6,2p	2,6e
Family and children	7,8e	7,1	:	8,4p	13	10,5p	12,7	8,5p	15,5	6,9	3,5p	4,4p	11,4	10,5p	8,8p	17,4p	12,1	5,2	4,8p	10,7	4,6p	5,3p	:	8,6p	10,7p	11,5	9,6p	6,7e
Housing and social exclusion n.e.c.	3,4e	1,8	:	3,4p	5,8	2,5p	1,5	4,4p	5,5	4,7	1,7p	0,3p	6,9	1,8p	2,6p	2,9p	2,6	2,9	6p	1,8	0,8p	1p	:	2,8p	3,3p	3,1	3,9p	6,4e

e: Eurostat estimate; p: provisional

Context 7b: Social protection benefits by group of functions (as a percentage of GDP) - 2004

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
Total	**26,2e**	**27,9**	**:**	**18,9p**	**29,7**	**28,4p**	**13,3**	**16,3**	**25,2**	**19,5p**	**29,4p**	**25,1p**	**17,6**	**12,2p**	**12,8p**	**22p**	**20,3**	**18,5**	**26,7p**	**28,2**	**19,7p**	**23,2p**	**:**	**23,7p**	**16,5p**	**25,9**	**31,6p**	**25,8e**
Old age and survivors	12e	12,3	:	7,8p	11,1	12,4p	5,8	3,8	12,8	8,5p	12,8p	15,4p	8,5	6,1p	6,1p	8,1p	8,6	9,5	11,1p	13,6	11,8p	11p	:	10,6p	6,6p	9,6	12,7p	11,5e
Sickness/Health care	7,4e	7,7	:	6,7p	6,1	7,7p	4,2	6,9	6,7	6p	8,8p	6,5p	4,2	3p	3,8p	5,5p	6	5	8,1p	7,1	3,8p	7,1p	:	7,8p	5p	6,6	8p	7,8e
Disability	2,1e	1,9	:	1,5p	4,1	2,2p	1,2	0,9	1,3	1,5p	1,7p	1,5p	0,8	1,2p	1,3p	3p	2,1	1,2	2,9p	2,3	2,3p	2,4p	:	1,9p	1,6p	3,4	4,7p	2,4e
Unemployment	1,7e	3,5	:	0,7p	2,8	2,4p	0,2	1,3	1,5	2,5p	2,3p	0,5p	0,9	0,4p	0,2p	1p	0,6	1,3	1,7p	1,7	0,7p	1,3p	:	0,7p	1p	2,5	2p	0,7e
Family/Children	2,1e	2	:	1,6p	3,9	3p	1,7	2,5	1,7	0,7p	2,5p	1,1p	2	1,3p	1,1p	3,8p	2,5	1	1,3p	3	0,9p	1,2p	:	2p	1,8p	3	3p	1,7e
Housing and Social exclusion n.e.c.	0,9e	0,5	:	0,6p	1,7	0,7p	0,2	0,9	1,2	0,3p	1,3p	0,1p	1,2	0,2p	0,3p	0,6p	0,5	0,5	1,6p	0,5	0,2p	0,2p	:	0,7p	0,5p	0,8	1,2p	1,7e

e: Eurostat estimate; p: provisional

Context 8a: Adults aged 18-59 living in jobless households by household types, 2005, in % of total number of adults living in jobless households

	EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Alone without children	25,9	30,5	:	23,8	:	38,4	24,8	19,1	12,4	27,7	:	17,6	17,4	21,4	17,8	29,8	15,9	7,3	40,6	35,5	16,0	13,6	:	31,2	9,7	47,7	:	27,9
Alone with child(ren)	9,7	13,2	:	11,6	:	10,4	13,1	3,2	4,5	9,8	:	3,2	8,5	9,0	8,1	7,0	6,0	7,2	11,3	5,4	3,8	5,8	:	4,7	4,2	4,1	:	24,1
Couple without children	21,2	23,9	:	25,1	:	17,8	12,9	27,2	14,4	27,0	:	18,4	29,1	12,5	10,3	39,0	21,6	22,3	26,4	26,8	28,5	20,8	:	27,3	16,6	26,1	:	16,3
Couple with child(ren)	14,6	12,6	:	13,9	:	13,8	11,7	12,0	18,8	18,0	:	15,2	15,8	11,3	14,0	11,4	20,7	24,2	14,4	13,9	9,0	14,1	:	7,0	16,7	11,5	:	15,5
Other households without childr	21,6	14,2	:	18,7	:	14,4	29,8	32,4	38,6	12,6	:	36,1	24,4	33,8	31,0	10,3	22,8	29,3	6,0	13,2	34,6	35,0	:	24,8	25,1	10,0	:	11,7
- without elderly (65+)	11,1	8,6	:	8,2	:	9,2	10,6	13,4	13,9	6,6	:	17,2	12,5	14,5	8,4	5,0	9,8	13,8	3,8	6,0	19,5	14,6	:	8,5	12,6	4,3	:	6,9
- with at least 1 elderly (65+)	10,6	5,6	:	10,5	:	5,2	19,2	19,0	24,7	5,9	:	18,9	11,9	19,3	22,7	5,3	13,0	15,5	2,1	7,2	15,0	20,4	:	16,3	12,5	5,7	:	4,8
Other households with child(ren)	6,9	5,6	:	6,9	:	5,2	7,8	6,1	11,4	5,0	:	9,4	4,7	12,1	18,9	2,5	12,9	9,7	1,3	5,1	8,1	10,7	:	5,0	27,8	0,7	:	4,5
- without elderly (65+)	5,4	5,0	:	5,7	:	4,8	5,1	3,1	7,1	4,2	:	7,3	3,2	4,2	8,4	1,7	10,5	5,4	1,1	3,7	6,1	7,0	:	4,5	22,4	0,5	:	3,5
- with at least 1 elderly (65+)	1,5	0,6	:	1,1	:	0,4	2,7	3,0	4,2	0,8	:	2,1	1,6	7,9	10,5	0,8	2,4	4,3	0,2	1,5	2,0	3,8	:	0,5	5,4	0,2	:	1,0
Total number in 1000	24.629,2	758,2	:	443,6	:	5.023,3	61,2	490,2	1.636,2	3.403,3	:	3.004,9	20,9	102,2	120,8	16,3	679,4	18,3	733,6	395,7	3.202,6	315,7	:	78,9	322,6	306,5	:	3.494,8

Source : Eurostat - European Labour Force Survey 2005, Spring results. Annual averages for FI.

Context 8b: Children aged 0-17 living in jobless households by household types, 2005, in % of total number of children living in jobless households

	EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Alone with child(ren) - no elderl	41,3	55,5	:	47,9	:	48,6	48,3	25,7	25,2	43,3	:	20,4	41,7	34,7	32,5	60,3	22,8	38,5	52,1	33,3	:	28,4	:	42,4	12,3	35,3	:	66,7
Alone with child(ren) - at least 1	0,3	0,6	:	0,4	:	0,2	4,0	0,3	0,6	0,3	:	0,3	1,0	0,0	2,4	0,0	0,1	0,0	0,2	1,0	:	1,3	:	0,0	0,0	0,1	:	0,4
Couple with child(ren) - total	34,9	32,6	:	38,9	:	39,0	33,6	56,3	51,8	47,4	:	59,2	43,6	27,0	32,1	36,1	51,3	42,3	44,4	54,3	:	46,9	:	36,4	41,7	62,3	:	26,0
- without elderly (65+)	33,9	31,4	:	38,7	:	38,2	33,6	51,4	48,5	46,1	:	57,5	42,4	27,0	31,5	35,4	50,8	38,7	43,3	53,5	:	40,7	:	32,9	40,9	62,0	:	25,1
- with at least 1 elderly (65+)	1,0	1,2	:	0,2	:	0,7	0,0	4,9	3,2	1,3	:	1,6	1,2	0,0	0,6	0,7	0,5	3,6	1,1	0,8	:	6,2	:	3,5	0,8	0,3	:	0,8
Other households with child(ren)	7,8	10,0	:	9,9	:	10,8	8,4	5,6	10,4	6,5	:	11,9	7,9	18,7	14,8	2,1	20,1	8,8	2,6	6,9	:	12,3	:	19,3	36,7	1,6	:	4,9
- without elderly (65+)	7,8	10,0	:	9,9	:	10,8	8,3	5,4	10,3	6,5	:	11,8	7,8	18,5	14,6	2,1	20,1	8,7	2,6	6,9	:	12,2	:	19,3	36,6	1,6	:	4,9
- with at least 1 elderly (65+)	0,0	0,0	:	0,0	:	0,0	0,1	0,1	0,1	0,0	:	0,1	0,1	0,2	0,2	0,0	0,1	0,1	0,0	0,0	:	0,1	:	0,0	0,1	0,0	:	0,0
Total number in 1000	8510,94	278,6	:	149,74	947,2	1579,9	24,581	75,568	396,62	1262,5	123,69	545,12	6,2511	34,278	42,297	2,6934	265,85	8,387	248,19	98,13	:	81,444	:	9,4717	159,55	70,899	:	2100

Source : Eurostat - European Labour Force Survey 2005, Spring results. Annual averages for FI.

Context 9.a Unemployment traps, 2004

For unemployed persons (previous work at 67% of APW, full-time) returning to full-time work at 2 different wage levels. Including social assistance where applicable.

	Single person, no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
moving to % of APW	50	67	50	67	50	67	50	67
Belgium	96%	88%	83%	79%	82%	76%	81%	77%
Czech Republic	79%	65%	71%	69%	97%	78%	78%	65%
Denmark	105%	89%	98%	89%	86%	89%	103%	92%
Germany	100%	87%	100%	93%	100%	84%	114%	98%
Greece	96%	76%	106%	83%	106%	83%	70%	56%
Spain	97%	80%	100%	79%	100%	78%	100%	81%
France	100%	82%	100%	90%	99%	90%	101%	82%
Ireland	88%	73%	-3%	12%	94%	87%	59%	52%
Italy	67%	59%	63%	54%	63%	52%	84%	74%
Luxembourg	99%	85%	103%	88%	103%	104%	100%	82%
Hungary	77%	66%	86%	68%	86%	68%	80%	63%
Netherlands	93%	87%	90%	85%	92%	88%	86%	76%
Austria	87%	73%	98%	81%	100%	96%	88%	75%
Poland	99%	83%	83%	73%	100%	95%	85%	78%
Portugal	110%	87%	95%	97%	82%	82%	110%	85%
Finland	88%	80%	92%	86%	92%	94%	89%	76%
Slovak Republic	56%	43%	45%	34%	46%	31%	62%	47%
Sweden	105%	87%	103%	91%	100%	100%	105%	87%
United Kingdom	78%	71%	55%	64%	67%	73%	70%	61%

1 The wage level of the second earner is fixed at 67% of the APW.

Context 9b. Inactivity Trap at 67% of APW,

with and without childcare costs,

Lone parents and two-earner couples with two children, in percent

	Lone Parents with two children, no childcare	Lone Parents with two children, with childcare	Two-earner Couple with 2 chdren, no childcare	Two-earner Couple with 2 children, with childcare
Austria 2001	82%	95%	24%	62%
Belgium 2002	76%	82%	50%	64%
Denmark 2001	88%	93%	69%	90%
Finland 2001	78%	81%	55%	80%
France 2002	99%	112%	24%	59%
Germany 2001	85%	88%	50%	59%
Greece 2001	16%	21%	16%	27%
Hungary 2001	49%	67%	62%	80%
Ireland 2001	54%	131%	24%	106%
Netherlands 2001	80%	85%	33%	58%
Portugal 2001	70%	95%	17%	82%
Slovak Republic 2001	123%	141%	64%	121%
Sweden 2002	59%	64%	28%	42%
United Kingdom 2002	59%	84%	25%	89%

Transition for lone parent is from non-UB recipient to full-time employment at 67% of APW. Transition for married couple is from a family with one full-time earner employed at 67% of APW to two full-time earners, each at 67% of APW. Both family types are assumed to have two children, **aged 2 and 3**, and are assumed to use full-time childcare after transition. Childcare in public or publicly sanctioned facilities, where applicable.

Calculations for Finland, Hungary, and the Slovak

Source: Joint Commission -OECD project using tax-benefit Models

Context 9c. Inactivity traps

For inactive persons entering work at 2 different wage levels[1], 2004

	Single person, no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
moving to % of APW	50	67	50	67	50	67	50	67
Belgium	66%	66%	75%	73%	70% *66%*	67% *66%*	38%	45%
Czech Republic	66%	56%	71%	69%	97%	78%	44%	39%
Denmark	103%	88%	90%	84%	90% *95%*	92%	63% *95%*	61%
Germany	89%	79%	90%	85%	90%	76%	49%	49%
Greece	16%	16%	16%	16%	16%	16%	16%	16%
Spain	47%	42%	63%	52%	69%	54%	16%	19%
France	80%	67%	87% *58%*	81%	100% *55%*	90%	28% *54%*	27%
Ireland	88%	73%	-3%	12%	94% *45%*	87%	30%	30%
Italy	14%	19%	-10%	0%	-17% *0%*	-8%	39% *-4%*	41%
Luxembourg	89%	76%	85%	83%	75%	84%	48%	40%
Hungary	51%	47%	51%	42%	51%	42%	13%	13%
Netherlands	93%	87%	83%	79%	93%	89%	40%	42%
Austria	87%	73%	98%	81%	100%	96%	22%	25%
Poland	70%	61%	54%	51%	100%	95%	47%	50%
Portugal	54%	45%	56%	55%	74%	70%	63%	50%
Finland	81%	75%	62%	63%	92%	94%	35%	36%
Slovak Republic	27%	28%	37%	35%	52%	42%	20%	22%
Sweden	98%	83%	68%	65%	100%	100%	37%	36%
United Kingdom	78%	71%	55% *79%*	64%	67% *57%*	73% *65%*	60% *70%*	53%

1 In Italics are indicated values of the METR for entering half time work when they differ from the METR for full-time work at 50%

Context 9d. Low wage traps - 2004

METR as wage increases by 33% of the APW wage level from two starting low wages

	from 33 to 67% of APW				*from 67 to 100% of APW*			
Income ranges:	Single person, no children	Lone parent	One-earner couple, 2 children	Two-earner couple, 2 children	Single person, no children	Lone parent	One-earner couple, 2 children	Two-earner couple, 2 children
Belgium	58%	57%	43%	59%	57%	57%	50%	55%
Czech Republic	33%	39%	57%	30%	28%	52%	54%	34%
Denmark	81%	72%	89%	58%	52%	62%	59%	43%
Germany	75%	86%	69%	50%	53%	52%	51%	52%
Greece	16%	16%	16%	16%	18%	16%	16%	16%
Spain	24%	18%	15%	19%	29%	26%	24%	29%
France	37%	59%	75%	22%	40%	40%	40%	32%
Ireland	47%	53%	74%	25%	30%	84%	48%	30%
Italy	29%	0%	-12%	50%	42%	52%	60%	47%
Luxembourg	74%	94%	110%	14%	33%	14%	67%	20%
Hungary	32%	20%	20%	13%	39%	28%	28%	39%
Netherlands	76%	59%	79%	37%	47%	60%	64%	48%
Austria	47%	63%	92%	33%	45%	45%	45%	45%
Poland	65%	41%	91%	56%	35%	115%	47%	35%
Portugal	15%	92%	82%	12%	24%	20%	91%	23%
Finland	62%	60%	100%	32%	43%	59%	68%	43%
Slovak Republic	22%	25%	39%	31%	30%	29%	14%	30%
Sweden	66%	45%	100%	33%	36%	57%	52%	36%
United Kingdom	62%	77%	76%	51%	33%	73%	79%	33%

Context 10: Net income of social assistance recipients as % of the at-risk of poverty rate threshold for 3 jobless households types

	HU	PT	ES	CZ	BE	LU	FR	AT	PL	SE	UK	FI	DE	IE	DK	NL
Single person	35,0	42,7	57,3	66,6	76,6	76,8	78,6	84,0	88,5	93,6	97,3	98,3	103,2	104,8	118,2	118,7
Lone parent, 2 children	40,9	73,0	57,7	89,1	89,9	76,1	81,7	89,6	100,6	82,9	104,3	96,0	99,3	93,2	121,3	101,3
Married couple, 2 children	29,1	76,0	48,1	85,9	68,5	74,4	69,9	79,2	103,5	76,4	90,5	88,2	80,7	90,0	91,8	81,5

Source : Joint EC-OECD project using OECD tax-benefit models, and Eurostat (see Chapter I and Annex I).

Context 11: At-risk-of-poverty rate before social transfers by gender and selected age group (income reference year 2004)

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Before all social transfers except old-age/survivors' pensions																														
Total population		26	28	:	21b	31	30	24b	24	32	23	24	26	24	22b	26b	26b	23	29pb	21b	22b	24	30b	26	:	:	22b	28	29	:
Children aged 0-17 years		34	33	:	34b	26	27	31b	31	40	23	29	34	31	20b	31b	34b	35	44pb	30b	28b	36	39b	32	:	:	30b	31	35	:
People a Total		24	26	:	18b	32	30	22b	22	30	23	23	24	22	22b	25b	24b	20	26pb	18b	20b	21	27b	25	:	:	20b	27	27	:
Men		23	25	:	17b	31	29	20b	20	27	21	21	23	20	20b	22b	23b	20	26pb	17b	20b	20	29b	24	:	:	19b	26	24	:
Women		25	28	:	20b	33	32	24b	24	32	24	25	25	24	24b	26b	25b	20	25pb	19b	20b	23	26b	25	:	:	20b	29	29	:
People a Total		25	27	:	20b	29	29	24b	23	28	20	21	25	21	17b	25b	25b	22	30pb	18b	22b	23	31b	24	:	:	22b	27	28	:
Men		23	25	:	19b	28	28	22b	22	25	19	20	24	20	15b	24b	25b	22	30pb	17b	21b	22	32b	23	:	:	21b	27	27	:
Women		25	28	:	21b	31	31	26b	23	29	21	22	25	22	18b	24b	24b	23	29pb	19b	23b	23	30b	24	:	:	22b	27	29	:
People a Total		23	25	:	11b	43	35	17b	22	44	32	32	21	25	54b	27b	20b	10	11pb	21b	10b	16	11b	30	:	:	12b	27	23	:
Men		20	24	:	7b	45	37	14b	11	38	29	29	19	21	51b	15b	8b	12	7pb	20b	10b	11	8b	30	:	:	8b	19	13	:
Women		26	26	:	14b	41	33	19b	28	48	35	35	22	28	57b	32b	26b	9	14pb	21b	10b	20	13b	30	:	:	15b	32	30	:
Before all social transfers including old-age/survivors' pensions																														
Total population		43	42	:	39b	39	39	44b	39	40	39	39	45	43	29b	40b	42b	40	50pb	36b	37b	43	51b	42	:	:	40b	40	42	:
Children aged 0-17 years		36	34	:	35b	26	27	32b	34	41	25	32	36	34	21b	35b	38b	38	48pb	33b	28b	39	46b	35	:	:	35b	32	36	:
People aged 18 + Total		45	44	:	40b	42	42	46b	40	39	42	40	47	45	32b	42b	43b	41	50pb	37b	39b	44	52b	43	:	:	42b	43	44	:
Men		42	40	:	36b	39	39	44b	36	36	40	37	44	41	29b	38b	40b	38	48pb	34b	36b	40	51b	41	:	:	38b	40	40	:
Women		48	47	:	43b	46	45	49b	43	42	45	43	50	49	34b	44b	46b	43	53pb	39b	43b	48	54b	45	:	:	45b	46	47	:
People aged 18-64 Total		33	32	:	30b	30	30	33b	29	30	31	29	35	33	22b	32b	33b	31	41pb	27b	28b	33	45b	33	:	:	33b	31	30	:
Men		31	29	:	27b	28	28	29b	28	28	29	27	33	31	20b	31b	33b	29	40pb	25b	25b	30	45b	31	:	:	30b	30	28	:
Women		35	35	:	32b	32	32	36b	30	33	32	31	36	36	24b	33b	33b	33	42pb	30b	30b	36	45b	34	:	:	35b	31	32	:
People aged 65 + Total		90	92	:	88b	94	93	92b	83	88	83	83	96	85	88b	79b	86b	87	90pb	79b	95b	87	88b	82	:	:	91b	92	94	:
Men		89	92	:	91b	92	90	91b	83	87	81	84	96	83	87b	78b	85b	88	90pb	79b	95b	86	88b	83	:	:	88b	89	90	:
Women		90	91	:	87b	96	96	92b	83	88	85	83	95	86	88b	79b	87b	86	90pb	79b	95b	87	88b	82	:	:	93b	94	97	:

1) Including imputed rent. See methodological note for an explanation

Source: SILC(2005) Income data 2004; except for UK, income year 2005; * BG National HBS 2004, income data 2004 and RO National HBS 2005, income data 2005.

p = provisional. s = estimated by Eurostat. u = result based on small sample (20-49 observations)

Context 12: Theoretical replacement rates (see point 3.3 of the report)

Additional table: Employment gap of migrants

1. Employment rate gap by country of birth, 2005, annual averages

2005	Employment rate gap between persons born in country and …			Employment rates by country of birth (age group 15-64)			Distribution of the population aged 15-64 (by country of birth)		
	...born outside the country	...born in another EU25 country	...born outside the EU25	Born in the country	Born in another EU25 country (1)	Born outside the EU25 (1)	Born in the country	Born in another EU25 country	Born outside the EU25
BE	12,5	5,2	18,5	62,7	57,5	44,2	87,1	5,8	7,1
BG	17.1u		15.1u	55,8	0,0	40,7 u	99,8		0,2
CZ	3,4	5,9	-2,4	64,9	59,0	67,2	98,1	1,4	0,6
DK	13,6	4,6	16,8	76,9	72,2	60,1	93,1	1,8	5,1
DE	14,2	1,9	20,2	66,9	65,0	46,7	89,5	3,4	7,0
EE	-5,3	-0,4	-5,6	63,7	64,1	69,3	85,6	0,9	13,5
IE	-1,7	-5,7	7,7	66,9	72,7	59,3	88,7	7,9	3,4
EL	-6,4	4,6	-8,3	59,6	55,0	67,9	92,0	1,2	6,9
ES	-6,8	-1,7	-7,8	62,5	64,2	70,2	88,0	1,9	10,1
FR	7,9	0,5	10,6	64,1	63,5	53,5	88,3	3,1	8,5
IT				0,0	0,0	0,0			
CY	-2,2	10,7	-7,7	68,1	57,4	75,8	82,9	5,1	12,0
LV	-4,2	6,7	-5,6	62,8	56,1	68,4	88,0	1,4	10,7
LT	-5,1		-6,2	62,4	0,0	68,7	96,3	0,2 u	3,5
LU	-9,4	-10,9	-0,1	59,8	70,7	60,0	59,7	34,6	5,8
HU	-5,8	3,7	-7,7	56,8	53,1	64,5	98,2	0,3	1,5
MT	-4,1	4.8u	-8,3	53,7	48,9 u	61,9	95,3	1,5	3,2
NL	14,5	5,0	16,7	75,2	70,2	58,5	86,9	2,5	10,7
AT	7,7	4,5	8,9	69,9	65,3	61,0	83,7	4,7	11,5
PL	22,9	23,2	22,8	52,9	29,8	30,1	99,4	0,3	0,4
PT	-5,4	2,0	-7,4	67,1	65,1	74,5	92,9	1,5	5,6
RO				0,0	0,0	0,0			
SI	-1,3	6,4	-2,0	65,9	59,4	67,9	92,1	0,6	7,2
SK	6,4	8,8	-3,8	57,8	49,0	61,6	99,1	0,7	0,2
FI	11,7	3,4	17,9	68,8	65,4	50,8	96,9	1,3	1,8
SE	13,8	2,5	19,5	74,3	71,8	54,8	86,4	4,6	9,0
UK	7,7	0,4	10,3	72,5	72,1	62,2	88,9	3,0	8,2
EU-27	4,9	-0,5	6,8	64,9	65,4	58,1	90,8	2,5	6,7
EU-25	5,0	-0,3	7,0	65,1	65,4	58,1	90,6	2,6	6,8
EU-15	7,2	1,2	9,5	67,3	66,1	57,8	88,9	3,0	8,1

2. Distrbution of the population by age and country of birth

2005	Born in the country			Born in another EU25 country			Born in outside the EU25		
	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64
BE	19,4	53,3	27,3	8,3	54,1	37,6	14,2	67,4	18,4
BG	19,8	52,1	28,1						
CZ	18,9	51,8	29,3	6,7	50,7	42,6	13,3	71,0	15,7
DK	16,7	52,6	30,6	12,1	55,7	32,3	16,8	68,9	14,3
DE	17,7	53,7	28,7	13,3	59,4	27,3	19,5	61,2	19,3
EE	25,6	52,0	22,4				3,4	47,8	48,8
IE	23,3	52,8	23,9	16,5	68,8	14,7			
EL	17,1	55,0	27,9	19,2	66,9	13,9	18,4	67,4	14,2
ES	17,6	56,8	25,7	7,8	69,4	22,8	19,6	71,3	9,1
FR	20,5	53,0	26,5	6,4	50,2	43,4	10,7	56,6	32,8
IT									
CY	19,5	53,4	27,1	14,2	61,1	24,8	16,9	72,0	11,1
LV	25,2	52,6	22,2	11,3	38,7	50,0	3,4	45,3	51,3
LT	23,2	53,2	23,5				5,7 u	55,4	39,0
LU	21,5	52,2	26,4	9,7	64,9	25,3	14,8	70,4	14,7
HU	18,8	52,1	29,2	12,2 u	40,9	46,9	12,0	63,9	24,1
MT	22,5	50,4	27,1						
NL	18,4	52,7	28,9	8,9	60,8	30,3	13,1	66,2	20,7
AT	18,4	55,0	26,6	12,0	55,9	32,1	16,2	62,5	21,3
PL	22,6	51,7	25,7				5,8 u	27,6	66,6
PT	18,6	54,3	27,2	22,3	70,5	7,2	15,4	72,2	12,3
RO									
SI	20,2	54,0	25,8	6,3 u	53,1	40,6 u	5,0	58,0	37,0
SK	23,0	53,2	23,8						
FI	18,1	50,0	32,0	24,1	61,0	14,8	22,1	64,6	13,3
SE	19,7	49,8	30,5	4,8	48,3	46,9	18,7	63,6	17,7
UK	19,4	52,3	28,3	15,8	59,5	24,7	14,4	64,8	20,8
EU-27	19,3	53,2	27,5	11,2	57,4	31,4	15,6	63,4	21,0
EU-25	19,3	53,3	27,5	11,2	57,4	31,4	15,6	63,4	21,0
EU-15	18,7	53,6	27,8	11,3	58,1	30,5	16,0	63,9	20,1

3. Distribution of the 15-64 by sex and country of birth

2005	Born in the country		Born in another EU25 country		Born outside the EU25	
	Men	Wo men	Men	Wo men	Men	Wo men
BE	49,5	50,5	51,6	48,4	50,8	49,2
BG	50,5	49,5			55,4 u	44,6 u
CZ	49,9	50,1	49,6	50,4	45,8	54,2
DK	49,3	50,7	45,2	54,8	55,7	44,3
DE	49,8	50,2	47,5	52,5	49,1	50,9
EE	51,6	48,4	52,7	47,3	57,1	42,9
IE	49,8	50,2	48,1	51,9	48,3	51,7
EL	50,1	49,9	62,0	38,0	49,2	50,8
ES	49,4	50,6	53,2	46,8	50,1	49,9
FR	50,5	49,5	53,2	46,8	51,0	49,0
IT						
CY	50,1	49,9	53,3	46,7	60,6	39,4
LV	51,2	48,8	57,2	42,8	56,5	43,5
LT	51,7	48,3			53,9	46,1
LU	49,2	50,8	49,6	50,4	53,4	46,6
HU	51,1	48,9	56,3	43,7	53,3	46,7
MT	49,7	50,3	53,0 u	47,0 u	47,7	52,3
NL	49,3	50,7	56,1	43,9	50,1	49,9
AT	49,8	50,2	57,5	42,5	50,5	49,5
PL	50,5	49,5	46,8	53,2	53,8	46,2
PT	50,5	49,5	52,1	47,9	52,4	47,6
RO						
SI	49,2	50,8	54,9	45,1	49,0	51,0
SK	50,3	49,7	53,3	46,7	53,9	46,1
FI	49,7	50,3	48,3	51,7	53,8	46,2
SE	48,9	51,1	53,0	47,0	50,5	49,5
UK	50,6	49,4	53,1	46,9	51,6	48,4
EU-27	50,1	49,9	51,6	48,4	50,6	49,4
EU-25	50,1	49,9	51,6	48,4	50,6	49,4
EU-15	50,0	50,0	51,6	48,4	50,5	49,5

Source: EU labour Force Survey, quarter 2. Data marked 'u' lack reliabilty due to small sample size. Empty cells correspond to data not avaialble or not reliable due to smal sample size

(1) In case "born in another EU25 country" is not reliable due to small sample size, the cell "Born outside the EU25" refers to "Born outside the country".

(2) Country of birth is not available for BG, DE and RO. Nationality is used instead.