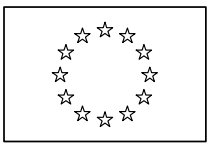

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Joint Report on Social Protection and Social Inclusion

COUNTRY PROFILES

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1. INTRODUCTION

These 27 country profiles aim at providing a synoptic view of key trends, major efforts and challenges ahead in each of the Member States with respect to their policies in the fields of social inclusion, pensions and health and long-term care. They are based on the integrated National Strategies for social protection and social inclusion that Member States have presented in 2006 for the first time. They complement the 2007 Joint Report on social protection and social inclusion [COM(2007) 13 final].

Each profile identifies those aspects of performance deserving to be highlighted in the context of the Open Method of Co-ordination or presenting greater risks and therefore calling for particular policy efforts from the viewpoint of social protection and social inclusion.

The social inclusion section describes and analyses major policy initiatives that will be undertaken in the context of the implementation of the National Action Plans for inclusion 2006-2008. The section on pensions draws upon the national strategy reports on pension reform presented in 2005 and their summary (Synthesis report on adequate and sustainable pensions, SEC(2006)304 of 27 February 2006). The section on health and long term care is based on the sectoral plans that the Member States presented for the first time in 2006. The concluding section of the country profiles lists for each country the key challenges that the Commission services have identified on the basis of the analysis carried out on the basis of the National Strategies. All sections have benefited from bilateral exchanges with the Member States.

The country profiles also make reference to the implementation reports that Member States presented in the framework of the Strategy for growth and jobs. These analyses should be considered in connection with the corresponding country chapters of the Annual Progress Report on the implementation of the Lisbon strategy.

Annex 1A to this document explains the overarching indicators which Member States have agreed to use in the context of the OMC on social protection and social inclusion. Annex 1B provides details on the data sources used.

2. COUNTRY PROFILES

2.1. BELGIUM

1. Situation and key trends

Belgium's economic growth slowed down to 1.2% in 2005 but is expected to strengthen in 2006 to 2.7%. While 39 000 new jobs were created, the unemployment rate remained at 8.4% in 2005 (8.8% in the EU 25). Significant regional disparities still exist in both employment[1] (64.9% in Flanders, 56.1% in Wallonia, 54.8% in Brussels) and unemployment[2] (5.4% in Flanders, 12.1% in Wallonia, 15.9% in Brussels). Youth unemployment has continued to rise (21.5% in 2005). The employment of older people (50-64) has improved over the last five years from 26.3% in 2000 up to 31.8% in 2005 but remains low and significantly below the EU average (42.5% in 2005). This increase mainly results from the 33.1% rise in female employment within this age group over the last five years. The total female employment rate has increased since 2000 from 51.5% to 53.8% in 2005, while the male employment rate decreased slightly over the same period (69.5% in 2000 compared to 68.3% in 2005).The at-risk-of-poverty rate was 15% in 2005, though with significant regional differences (11% in Flanders, 18% in Wallonia and an estimated 27% in Brussels). Life expectancy at birth (76.7[3] and 82.4[4] years for males and females respectively) is close to the EU average. However, Belgium has a higher healthy life expectancy than the EU average both for males (67.4 compared to 64.5[5] years) and for females (69.2 compared to 66[6] years). The fertility rate of 1.72[7] is above the EU average (1.52). The old-age dependency ratio was 26.3 in 2005 and is expected to increase to 41.3 by 2030. Total gross social protection expenditure has risen since 2000 and accounted for 29.3% of GDP in 2003. Pensions and health represent the bulk (44.1% and 27.7% respectively) of social protection expenditure.

2. Overall strategic approach

The report emphasises the rise in employment and job creation as main factors in helping to safeguard the future of social security. The strategy is based around three objectives: first of all, to secure in a structural manner the financial equilibrium of the social security system by maintaining a high level of social protection and linking social benefits (including pensions) to the development of well-being; secondly, to step up interaction between social inclusion policies and the development of employment, in particular through activation measures in favour of risk groups; and finally, to offer affordable quality healthcare.

The measures described in the report are closely linked to the priorities and objectives identified in the National Reform Programme (NRP) 2005-2008 with a view to achieving the aims of the Lisbon Strategy and the WTO's social objectives. Although the strategy proposed by Belgium presents numerous similarities with previous plans, it reflects a good understanding of the multidimensional nature of social exclusion.

[1] 2005 figures (source: FPS Economy - Directorate-General Statistics Belgium)
[2] 2004 figures (source: FPS Economy - Directorate-General Statistics Belgium)
[3] 2005 provisional estimate (source: Eurostat)
[4] 2005 provisional estimate (source: Eurostat)
[5] EU 15 figure (source: Eurostat)
[6] EU 15 figure (source: Eurostat)
[7] 2005 provisional estimate (source: Eurostat)

Gender mainstreaming is lacking in the report despite the availability of statistics broken down by sex. However, more women than men are likely to benefit from the measures proposed under the priority policy objectives, as they tend to be overrepresented among the target groups.

The preparation of each of the pillars of the report has seen consultation and coordination among the competent legislative authorities at all levels and has involved a wide range of stakeholders, including the social partners and associations of people living in poverty and social exclusion. However, cooperation between players from the three pillars remains limited, as a result of which the links between the pillars are inadequate. Better coordination and exchange of information between these players represents a challenge for future plans, in order to improve coherence and the "interrelatedness" aspect.

3. Social inclusion

3.1. Key trends. The at-risk-of-poverty rate after social transfers was 15% in 2004 with a higher risk for older persons (21%), single persons (21%), tenants (27%), persons living in a single-parent household (36%) and the unemployed (28%). The overall in-work poverty rate of 4% is well below the 8% EU average. Social transfers continue to play an important role, as they reduce by 46% the at-risk-of-poverty rate, which before social transfers (except old-age pensions) was 28% in 2004. The net income of social assistance recipients as a percentage of the poverty threshold is 76.6% for a single person, 68.5% for a married couple with two children and 89.9% for a lone parent with two children. The proportion of children aged 0-17 living in a jobless household decreased from 13.8% in 2002 to 13.5% in 2006 (9.5[8]% EU average). Only marginal progress has been made on early school leaving (13% in 2005), with an important gender gap (15.3% for males and 10.6% for females). While 81.8% of people aged 20-24 had completed at least upper secondary education in 2005, youth unemployment continued to rise to 21.5%, which is above the EU average (18.5%). Another important issue is the unemployment rate gap between non-EU and EU nationals (25.4% in 2005), which is three times higher than the average across the EU.

3.2. Key challenges and priorities. The 2006 plan, the result of a broad consultation process, focuses on three priorities, namely to ensure decent and affordable housing for everyone, to develop activation and diversity in employment and social integration, and finally to tackle child poverty. The first two challenges, already identified in the previous Inclusion NAPs, still require more political and financial commitment.

Despite the efforts of the Regions to increase the availability of social housing, the supply is still not enough to meet demand. Furthermore, the weakest social categories are still forced to spend too much of their household budget on housing.

The need to increase participation in the labour market by certain groups is still an essential challenge. The long-term unemployment rate for lone parents (14%), people from outside EU-25 (20%) and the disabled and low-skilled (8%) requires specific measures to help people into employment. The unemployment rates for both older and young people remain a cause for concern in Belgium. The risk of child poverty in Belgium is below the EU average (17% as against 19%), but the children of lone parents and those living in households where no one is employed are particularly at risk (36% and 70% respectively). These priorities correspond

[8] 2006 estimate (source: Eurostat)

to the challenges identified in the 2006 Joint Report, and the primary objectives are to increase participation in the labour market, ensure access to the resources and services people need in order to be able to live a dignified life, to prevent discrimination and to eliminate child poverty.

3.3. Policy measures. The first priority is to ensure decent and affordable housing for everyone. This policy will consist in improving the supply of modest housing, not only by increasing the availability of social housing, but also by stepping up checks and compliance with stricter quality standards. The aim would be for social housing for rent as a percentage of the total number of private households to rise from 6.3% in 2004 to 8% in 2010, an ambitious objective given that this figure has remained constant at around 6.3% since 1995. Financial measures such as the simplification of the rent allowances procedure and fine-tuning of a system for the payment of rent guarantees will make it easier for the most deprived to gain access to inhabitable and up-to-standard social housing. Another objective is to extend the right to energy by improving the supply of and access to gas, electricity and water, so as to improve protection for the most deprived. The budget of the social housing agencies will also be increased so that they have more scope for action and promotional activities as well as renovation or restoration work. Measures to help the homeless are also planned, with a view to integrating them by providing housing. Finally, cooperation will be established among the various bodies in order to increase awareness of the housing problem in Belgium. Most of these measures are not particularly innovative, and the report remains fairly discrete on how they will be implemented and financed. There is no mention of the gender perspective, with the exception of a wish to increase the number of accommodation places for homeless women in Brussels.

The second priority is to develop activation and diversity in employment and social integration. The goal of activation and diversity is to increase the employment rate and create jobs by devoting special attention to specific target groups, such as people from outside the EU, low-skilled and poorly educated people, and the disabled. The results aimed at by this measure are taken from the NRP and are consistent with the objectives laid down for 2010 by the Lisbon Strategy for the employment rate (70%), participation in lifelong learning (12.5%) and a reduction in early school-leaving (10%). The employment rate for women should also reach the Lisbon objective of 60% by 2010. Finally, the Belgian authorities are aiming to reduce the unemployment rate for people from outside the EU to the same level as for Belgian workers. In view of the scale of the problem (which is compounded if we take account of people of foreign origin who have taken Belgian nationality, for whom participation in the labour market remains difficult) and the ambitious objective that has been mapped out, it would have been appropriate for the problem of immigrant integration to be the subject of an overall approach under a specific measure. At federal level, a working group on discrimination ensures efficient harmonisation of the different employment measures designed to foster equal opportunity in access to employment for risk groups. Flanders devotes nearly €8 million a year to a number of diversity initiatives designed to prevent exclusion of older people, persons of foreign origin and the disabled from the labour market and grants an employment premium for the recruitment of people over the age of 50. The three Regions are intending to increase the availability of childcare facilities so that parents who want to work can gain access to the labour market. Several initiatives and instruments will be developed to promote employment for the target groups by offering them personalised guidance towards integration. The ESF will play an important part here. Development of the social economy and neighbourhood services will continue in both Flanders and Wallonia and will be accompanied by other, not necessarily professional, activities. In addition to various

research projects and studies which will be launched in order to assess the impact of activation measures, means of registering and monitoring will be harmonised and improved with regard to diversity.

The objective of the third priority is to tackle child poverty by breaking the poverty cycle. The emphasis placed on this target group in Belgium's policy on poverty is new. The aim is to reduce the percentage of children under 16 at risk of poverty to 12% by 2010 (compared with 17% in 2003) and to cut the proportion of children (aged up to 17) living in households where no one is in paid employment from 12.9% in 2005 to 7% in 2010. If these levels are to be achieved throughout Belgium, a considerable effort will be needed, in view of the regional differences. Nevertheless, a set of measures has been introduced. In addition to financial measures under the other two policies mentioned, the employment bonus system and the new family allowance at the start of the school year (introduced in August 2006) will contribute towards increasing families' incomes. The Belgian authorities will focus on measures to stop children leaving school early and encourage the participation in society of all children from a very young age. In the field of education, efforts will be made to reduce parental contributions to the cost of schooling and to diversify school attendance populations. Links between families and schools will be strengthened, and the involvement of parents in an educational role will be encouraged. Finally, the policy on special assistance for youth, including unaccompanied foreign minors, will be improved by various measures.

3.4. Governance. The plan was drawn up by two working groups on "actions" and "indicators" acting in close cooperation and coordinated by the Public Planning Service for Social Integration. The groups include representatives from the federal level and the various Communities and Regions, as well as delegates from other (primarily local) authorities (Union of Towns, Cities and Municipalities), the social partners (National Labour Council), experts and associations of persons living in poverty and social exclusion. The two working groups have been enlarged to take in representatives from all parts of civil society. In developing indicators and identifying targets, the "indicators" group has also made extensive use of the results of debates, research and reports. The plan will be implemented through coordinated federal and regional action plans. Monitoring of progress towards meeting targets will be the responsibility of the working groups, but the various competent authorities will themselves be able to enter data on the website of the Public Planning Service for Social Integration so that the implementation of their respective activities can be followed. In 2007 a public forum on the plan will be organised with a view to formulating recommendations for the future.

4. Pensions

In 2004, older people had a living standard of 3% of the general population, which is relatively low compared to other Member States, while the poverty risk among older people (21%) is estimated to be significantly higher than for the Belgian population below the age of 65.

In spite of recent increases, the employment rate among older workers remains low. The 2006 Sustainability Report assessed Belgium as a medium-risk Member State as regards the sustainability of public finances, due notably to the very high level of public debt. Belgium is facing substantial budgetary pressures due to an ageing population: according to the AWG projections in 2005, public pension expenditure will rise from 10.4% to 15.5% of GDP

between 2004 and 2050.[9] According to ISG projections, the net theoretical replacement rate in the statutory scheme (for a worker retiring at 65 after 40 years of employment on the average wage) is expected to decrease slightly from 63% in 2004 to 61% in 2050, while the overall net replacement rate is expected to rise from 67% to 74%, thanks to contributions of 4.25% of gross wages to occupational schemes (currently about 40-45% of the employed population are covered by occupational schemes).

Ensuring an adequate and sustainable strong public scheme is a main preoccupation of the Belgian pension policy. The 2006 Joint Report underlined the importance of improving the employment situation among older people in order to ensure adequate and sustainable pensions. The report at the same time highlighted efforts made to improve the adequacy of pensions (in particular, minimum pensions and occupational pensions). The Belgian Government has taken further steps to enhance the adequacy of pensions notably for women, through further increases in the minimum income for pensioners (*GRAPA*) to the at-risk-of-poverty level, the introduction of a mechanism to adjust pension benefits to welfare developments and better account taken of part-time work in determining minimum retirement income. The harmonisation of the statutory retirement age for salaried workers by 2009 for men and women is ongoing.

A reform of early retirement provision was adopted at the end of 2005, and should contribute to adequacy and financial sustainability in encouraging a higher labour-force participation among older people under what is termed the "*pact between the generations*", notably by raising the age for early retirement from 58 to 60 and strengthening incentives to work beyond 62 for a career of at least 44 years ("*bonus pension*"). However, further increases in the employment of older workers are of key importance.

Moreover, the strategy for securing financial sustainability continues to rely strongly on the global management of social security and on the reduction of public debt. Furthermore, the savings are transferred to a reserve fund (by the end of 2005, reserves amounted to 4.5% of GDP) and are thus earmarked for future expenditure on ageing-related needs.

The promotion of occupational pension schemes could raise replacement rates in the long run and hence the relative living standards of pensioners. While a guaranteed minimum return is provided on the contributions paid by the employee and the employer in all supplementary pension schemes, further efforts to ensure a high coverage of the working population (especially women) by occupational pension schemes might be needed.

5. Health care and long-term care

5.1. Health care

Description of the system. The Belgian healthcare system is based on a compulsory health insurance scheme which is an integral part of the social security system and covers 99% of the population. Around 70% of funding comes from the public sector (contributions plus State funding and taxes), 22% directly from families ("out of pocket"), and the rest is covered by supplementary insurance schemes. These remain marginal, and there is a consensus on the need to further consolidate the public compulsory insurance scheme in order to ensure its

[9] National projections included in the 2006 National Strategy Report on Social Protection and Social Inclusion and reflecting recent reforms and different methodology choices indicate that the increase in pension expenditure from 2005 to 2050 would represent 3.9% of GDP.

continuity. Patients have freedom of choice of care provider and direct access to specialists. Care providers are essentially paid directly by the patient on the basis of tariffs agreed between the social partners, mutual insurance funds and care providers. Patients then receive a reimbursement of around 75% from their mutual insurance fund (except in the case of hospitalisation, where the fund covers the costs directly). The range of healthcare services is extensive, and there are no waiting lists. The Federal State has sole responsibility for the compulsory healthcare insurance scheme, which is an integral part of the social security system. By contrast, the Federal State and Regions are jointly responsible for healthcare services and public health. Belgium's strategy is to lighten the financial burden for the poorest patients, improve the quality of care by making it user-focused and ensuring its continuity, and rein in the increase in costs by improving the cost/efficiency ratio.

Access. Although the Belgian healthcare scheme covers 99% of the population, the authorities fear that the contributions which patients are asked to pay for certain services (21.5% direct payments by households in 2004, a figure which is relatively high, although it has fallen in recent years) are likely to weigh heavily on the budgets of the most vulnerable social groups. To limit this risk, the authorities have adopted a range of measures, which include annual ceilings ("*maximum to be billed"*), a higher rate of reimbursement and free preventive care for all. The "*maximum to be billed"* is the basic tool for ensuring the financial accessibility of healthcare, given its very wide application. 500 000 Belgian households (11%) benefited from it in 2005, and its scope will be extended further. Several measures are envisaged in order to reduce the cost of medicines to patients (compulsory price reductions, incentives to use generic products, extension of reimbursement to certain innovative medicines). There are no problems as regards equality of access throughout the country. Attempts are being made to optimise the geographical distribution of healthcare availability, at hospital level by introducing "care areas" and at general practitioner level through premiums for doctors establishing a practice in an area where there is a shortage.

Quality. As regards the quality of service providers, the system is traditionally based on healthcare institution recognition standards. An agency analyses clinical practices, develops best practices and evaluates medical technologies. A peer review system is being developed, e.g. comparison of hospitals on the basis of a series of indicators allowing them to define their own objectives for improvement. In order to achieve a steady improvement in healthcare quality, the authorities plan to guarantee user-oriented benefits (geared to their needs) based on the continuity of healthcare, in particular by giving priority to primary care, prevention policies, patients' freedom of choice, and availability of information. Several vaccines which are free of charge are easily obtainable through preventive healthcare centres for children.

Long-term viability. Total healthcare spending, which amounted to PPP$ 2 922 per capita (9.3% of GDP) in 2004, is relatively high, having increased sharply in recent years. According to the Ageing Working Group's projections, public healthcare spending is likely to rise by 2.4 percentage points, while national projections foresee an increase of 3.7 percentage points by 2050. The Government plans to meet the challenge of rising healthcare costs by different approaches. At macro-economic level it will set a standard for the growth of public healthcare spending (4.5 % per annum, before inflation), broken down into partial budgetary objectives based on main headings (medical and paramedical). Continuous monitoring arrangements are being put in place to ensure compliance with the standard. At micro-economic level, Belgium has opted for policies designed to make all healthcare players take responsibility: patients' contributions, flat-rate amounts for certain hospital services (so as to discourage over-use), distribution of part of the budget among mutual insurance funds on the

basis of "theoretical expenditure" (i.e. as a function of the health risk profiles of insured persons).

Improving healthcare coordination and the rational use of resources are of major importance in improving the cost/efficiency ratio. Priority is therefore given to primary care and the use of patients' medical records. Other measures include technology assessment, a higher reimbursement rate for generic medicines, and better prescription practices. In 2005 and 2006 the annual budgetary objective of 4.5% growth in real terms was achieved. The development of health promotion policies and healthy lifestyles is also a priority for all authorities.

5.2. Long-term care

Description of the system. Long-term care can be provided by hospitals, specialised services, specialised institutions or at home. Despite the relatively high cost, the number of old people in institutions is also relatively high (6-7% of over-65s). The Communities and Regions have many responsibilities, and the services they offer therefore vary. Coordination takes place between federal, Community and regional levels, and also between general and long-term healthcare services, e.g. through integrated home-care services making it possible to exploit complementarity between different care providers and assistance services.

Access. The challenge to improve long-term care is linked to the priority given to keeping people at home. To achieve it, the principle of continuing care is being developed, together with day-care centres and short stays in institutions. However, keeping people at home also entails costs for the individual, such as transport to day-care centres or the need to continue to pay rent during a short stay in an institution. Special attention has been devoted in the Belgian report to the different services taking account of mental illness in a suitable and targeted manner. A recent development is a care circuit for patients in a persistent neurovegetative state, an attempt to respond to the lack of adequate facilities for this type of patient.

Quality. In the field of long-term care, accreditation, peer review (e.g. the geriatrics group) and the development of appropriate professional skills also guarantee the quality of the services offered. Special importance is attached to coordination in order to enable integrated, ongoing and multidisciplinary care and aid services to be provided, in line with the person's needs. The coming years will be devoted, among other things, to the development and implementation of care pathways for chronically ill patients.

Long-term viability. Many risks specific to long-term care are insured through the compulsory healthcare insurance scheme, which means that the challenges as regards ensuring financial viability are the same as for health care. One of those challenges for the coming years is to ensure the deployment of human resources, taking account of population ageing. Efforts will be made to strengthen the position of primary care providers and to ensure that there are sufficient aid and care providers by giving them an attractive status. It will also be necessary to develop different forms of care, taking account of people's degree of dependence (residential care, day care, night care, short stays in an institution). To this end, a multiannual protocol was concluded between the different competent authorities in 2005.

6. Challenges ahead

To raise employment rates, especially among older workers, young people, migrants and non-EU nationals and improve access to the labour market for the long-term unemployed, unqualified workers and single parents;

To step up efforts to bring affordable and decent housing within reach of more people;

To guarantee the sustainability and adequacy of pension schemes by further reducing the public debt and to continue making second-pillar pension schemes more accessible, especially to women;

To manage growing healthcare expenditure by improving the cost/efficiency ratio while guaranteeing access for vulnerable groups;

BELGIUM : data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.7	116.5	**2000**	60.5	69.5	51.5	29.1	26.3	**2000**	6.9	5.6	8.5	16.7
2002	1.5	117.6	**2002**	59.9	68.3	51.4	29.4	26.6	**2002**	7.5	6.7	8.6	17.7
2004	3.0	119.4	**2004**	60.3	67.9	52.6	27.8	30.0	**2004**	8.4	7.5	9.5	21.2
2006	2.7f	118.2f	**2005**	61.1	68.3	53.8	27.5	31.8	**2005**	8.4	7.6	9.5	21.5

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65 (2003 instead 2005)		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	73.4	80.2	14.8	19.1	63.3	66.4	5.9	**1995**	8.4	69.5	-	na	na
2000	74.6	80.8	15.5	19.5	65.7	69.1	4.8	**2000**	8.5	69.3	24.6	99	57.5a
2004	76.7ps	82.4sp	na	na	67.4e	69.2e	4.3	**2004**	9.3	70.9	21.5	na	na

s: Eurostat estimate; p: provisional **THE Total Health Expenditures* ***PHI Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age related projection of expenditure (AWG)					
Eurostat	Total expenditure* (% of GDP)	Old-age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in 2004 and changes since 2004			
										Total social expend.	Public pensions	Health care	Long-term care
1995	27.4	43.1	23.6	13	8.8	2.7	8.8	**2005**	26.3	25.4	10,4	6,2	0,9
2000	26.5	44.1	24.2	11.8	8.8	1.8	9.3	**2010**	26.4	-0,3	na	na	na
2004	29.3	44.1	27.7	12.5	7.1	1.8	6.8	**2030**	41.3	4,5	4,3	0,9	0,4
								2050	48.1	6,3	5,1	1,4	1

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate						Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	15	19	14	12	21	19	21	19	21	15	**Total**	4,1
Male	14	-	12	11	19	21	-	20	21	17	**Male**	-
Female	15	-	15	13	22	19	-	18	20	13	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	11.3b	13.0b	11.2b	14.8b	**1999**	4,8	4,0	5,9	**1999**	15.2b	17.7b	12.7b
2004	13,2	13,7	11,3	16,0	**2004**	4,1	3,7	4,7	**2004**	11.9b	15.6b	8.3b
2006	13,5	14,3	12,3	16,4	**2005**	4,4	3,8	5,0	**2005**	13,0	15,3	10,6

**: excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0,732	0,744	0,734	***Aggregate replacement ratio***	0,418	0,446	0,464

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
										Occupational & voluntary pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or Social Security)	Current estimate (2002)	Assumption
6		4	-2	DB	6	DC	68	40	45	46.3	Nd	4.25

** (DB / NDC/ DC); ** (DB / DC)*

2.2. BULGARIA

1. Situation and key trends

GDP has remained steady in recent years, well above the EU average: between 1998 and 2004, real GDP growth averaged 4.4% a year, reaching 5.6% in 2004, while inflation was contained to single-digit levels. Growth is expected to remain at levels of 5.5% to 6% throughout 2006-2008. However, these figures do not take account of informal economic activity. The total employment rate, which remains among the lowest 10 in the EU, increased from 54.2% (2004) to 55.8% (2005), with increases in rates for both women and men from 50.6% and 57.9% (2004) to 51.7 % and 60% (2005) respectively. In the 55-64 age group, the employment rate rose from 32.5% (2004) to 34.7% (2005). In the 15-24 age group, however, employment rose only from 21.5% (2004) to 21.6% (2005). Over the period 2004-2005, total unemployment decreased from 12% to a record of 10.1%. Female unemployment decreased from 11.5% (2004) to 9.8% (2005) while male unemployment decreased from 12.5% to 10.3%. A negative rate of population growth (-5.4% in 2005) and continuing out-migration contribute to one of the most challenging demographic situations in Europe: the share of persons aged 0-14 was 13.6% in 2005 and the age dependency ratio was 44.5% (2005).[10] Life expectancy at birth in 2004 was 76.2 (women) and 69 (men), thus showing large gaps with the EU benchmarks. Infant mortality is (11.6 in 2004) above the 2004 EU average of 4.5 but shows a significant decrease from 27.3 in 1970. Perinatal mortality is also high, at 12.21 in 2004.

2. Overall strategic approach

The National Report on Social Protection and Social Inclusion adopts the key challenges identified in the Joint Inclusion Memorandum (JIM). Providing equal opportunities for all to use the benefits of economic growth is the key principle driving the overall strategic approach. The opportunities of disabled persons, children, young people and of the elderly are highlighted, as is the multidimensional nature of social inclusion challenges. Gender equality underpins the overall approach, together with the establishment of sustainable and efficient social protection and inclusion systems. It is acknowledged that social protection and policies for economic growth and more and better jobs guide the formulation of policies and programmes, as well as steering budgets. The National Strategic Report is an important step towards setting up strategic priorities for social protection and inclusion policies. Efforts, however, should continue to improve coordination of the sequencing, financing and monitoring arrangements under each policy priority. The Bulgarian Government shows its awareness of the importance of effective links between the Lisbon objectives and its social protection and social inclusion policies, but further efforts are needed to illustrate mutually reinforcing actions more effectively. Although the overall strategic approach does not specifically refer to the Roma population, subsequent sections of the report and other strategic documents indicate awareness and commitment to the inclusion challenges of ethnic minorities. In terms of governance, priority is given to consultation and early involvement of stakeholders. Consultation, however, needs to be meaningfully used as an instrument for reaching out to civil society and generating public ownership and adherence to policies. While acknowledging the added value of the JIM and the support granted by PHARE, additional efforts are needed to further develop the strategy for the use of ESF.

[10] National Statistical Institute available at : http://www.nsi.bg/Population/Population.htm (September, 2006)

3. Social inclusion

3.1 Key trends

Despite falling overall unemployment, employment rates remain low. At the end of 2005, the employment rate (15-64) was 55.8%, with a gender gap of 8.3 percentage points. Intervention measures, such as the lowering of the pension contribution rate and the increased control of labour inspectorates, were effective in reducing unregistered labour and contributed to improvements in the employment rate. Long-term duration is a distinctive feature of unemployment in Bulgaria: unemployed persons with no job for more than a year accounted for 59.8% of all unemployed in 2005. Over the two years 2004-2005, the percentage of early school-leavers (total) slightly improved (21.4% - 20% respectively), against 15.1% in the EU (2005). In terms of living conditions, GDP per capita (in PPP) rose from 26.5% (2000) to 31.8% (2004) of the EU-25 average. In 2004, the at-risk of poverty rate[11] stood at 15%. In 2005, the poverty line moved upwards and reached €936 annually, or €78 per month. Women account for 17% (2004) of persons with disposable income below the at-risk-of-poverty rate. Their share increases to 23% in persons aged 65+. The at-risk-of-poverty rate among people 65+ increased to 16% (2004) while it was 14.1% (2003). At the end of 2005, there were 2.3 million persons living on pensions. A higher poverty incidence is also found in the Roma community.

Thus, the percentage of those at-risk-of-poverty remains stable despite increased economic opportunities. Seen in this light, social transfers play an important role in reducing both relative and absolute poverty. Even though the average pension was increased from €41 (2000) to €69 (2005), pensions continue to have a low nominal value and yet contribute to poverty reduction: national data show that the poverty rate of 39.1% (2005, before social transfers) is reduced to 17.2% when pensions are included, and to 14.2% after inclusion of all other transfers. The income quintile share ratio for 2004 is 4. According to the National Strategic Report, social security and social assistance expenditure make up 13.4% of GDP (national figure 2005).[12] Particularly vulnerable to poverty and exclusion are: a) children (particularly those from ethnic minorities and those living in single parent family households); b) persons employed on low wages and unemployed (low wage workers and unemployed account for 55% of people living in poverty); and c) elderly persons, particularly those above 75 years of age.

3.2 Key challenges and priorities

Four main policy objectives are identified for the period 2006-2008: i) equal labour market participation of groups at-risk-of-poverty and social exclusion; ii) ensuring equal access to services designed to prevent social exclusion and its consequences; iii) social inclusion of vulnerable ethnic minorities; iv) poverty reduction among groups beyond working age, particularly among children and elderly persons. These policy objectives are linked to twelve key targets set for 2008 that can be grouped as follows:

Employment: i) activity rate (age group 15-64) of 65.6%; ii) unemployment rate below 9%; iii) increase of employment rate (age group 15-64) up to 59.2%; iv) increase of number of

[11]Data for all income based indicators ((at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) is based on the national household budget survey that is adjusted ex-post to the EU harmonised SILC methodology but is not fully compatible the SILC detailed definition income.

[12]Ministry of Finance, Consolidated budget

persons from vulnerable groups included in vocational training by 20%. Education: v) decrease of 10% in the number of children of mandatory school age dropping out of school compared to the 2005 rate; vi) increase by 15% in the number of children with special educational needs integrated in mainstream and professional schools; vii) increase in the number of Roma schoolchildren taken out of segregated schools by 10%. Social protection: viii) decrease in the number of persons on social assistance by 5%; ix) decrease in the number of persons in specialised institutions by 10%; x) increase in the number of persons from vulnerable groups using social and health services within the community by 20%. Overarching: xi) at least a 15% increase in total household income; xii) nominal growth of income from pensions of more than 5% per annum.

These targets correspond to key trends and challenges and are linked to a wide range of strategic documents in the areas of social protection and inclusion. They complement the strategic approach and mirror the seven key inclusion policy priorities. While these targets build on the JIM, their quantitative expression is innovative. Although target (x) contains a health dimension, the overall health challenges of Bulgaria require better policy coordination between the OMC strands. Access to health care services remains a critical issue for persons who have not paid their health insurance contributions. Particular attention needs to be paid to access to health care services and to the removal of financial and other barriers impeding access, particularly for people living in rural areas and for those outside the scope of social assistance programmes.

3.3 Policy measures

For each of the four policy objectives above, detailed policy measures are envisaged together with a set of indicators for further follow-up. The gender perspective appears as a horizontal issue, as a draft Law on equal opportunities has to be voted on by Parliament. The policy objective of *equal labour market participation of the groups at-risk-of-poverty and social exclusion* will be achieved by combining existing measures with new policy measures such as encouraging active behaviour on the labour market of the long-term unemployed through the payment of a "bonus" for getting a job, promoting employment tailored to the needs of vulnerable groups and promoting social economy. *Ensuring equal access to services designed to prevent social exclusion and its consequences* relies on measures aimed at securing respect of social rights and on new policy measures (streamlining of cooperation with local districts and civil society organisations, increasing financing for community-based services, development of social services aiming at deinstitutionalisation, reduction of drop-out rates and support for mainstream education of children with special educational needs). The policy objective of *social inclusion of vulnerable ethnic minorities,* in addition to current measures, entails measures such as improving of the capacity of Roma representatives for full-scale involvement, setting up a database for the Roma integration process, improving of the multi-ethnic cultural environment, and introducing measures to reduce the infant and maternal mortality rate among Roma. The policy objective of *poverty reduction among groups beyond working age* combines measures focusing on two particular groups: children and the elderly. These measures include normative approval of an official poverty line, the development and expansion of social services for both target groups, and the establishment of a monitoring mechanism for child poverty. In total, for the period 2006-2008 some 60 new measures will target the four key policy objectives. The state budget is the main financial source for these measures, together with the municipal budgets. The ESF and state guaranteed loan from the World Bank will complement the financing. However, there are no precise resource allocations per group of measures to evidence their budgetary feasibility and overall commitment to them. A limited number of more focused and adequately funded priorities

with precise monitoring arrangements, including intermediate targets and an impact assessment, would be preferable to a large range of actions whose implementation could go beyond available administrative capacity, particularly at local level.

3.4 Governance

The Ministry of labour and social policy is the main coordinating body at central level. The national legislation provides for consultation of stakeholders. This is achieved through a network of consultative bodies, such as the National Council for Tripartite Cooperation, the National Council for Integration of People with Disabilities, the National Council for Coordination of Policies and Programmes aimed at the Reduction of Poverty and Social Exclusion, the National Council for Cooperation on Ethnic and Demographic Issues, the National Association of Municipalities, and other consultative bodies. In the field of protection against discrimination, the Commission for protection against discrimination was established in 2005 following the entry into force of the Law on protection against discrimination. Transparency in decision-making and the involvement of all stakeholders are presented as key factors for better governance. It is therefore necessary to further improve the policy and inter-institutional coordination and the measures for active involvement of stakeholders. As regards the social inclusion of ethnic minorities, it is vital to continue and increase the involvement of civil society organisations representing their concerns. Sustained efforts are also needed to fight against informal payments in health and education

4. Pensions

As outlined in section 3.1, Bulgaria has made progress in pensioner poverty alleviation. However, 23% of women over the age of 65 are at-risk-of-poverty compared to only 5% of their male counterparts. Projections for Bulgaria's future old-age dependency ratio are significantly higher than the EU average (60.9% compared to the EU average of 53.2% in 2050), which will have a significant impact on the long-term sustainability of pensions. Replacement rate projections made in 2005 show that the average net replacement rate for pensions from the solidarity pay as you go (p-a-y-g) pillar will amount to 44% in 2030 and about 42% in 2050. Supplementary pension schemes are expected to have a positive impact on pensioners' incomes, increasing the total net replacement rate to 52% in 2030 and 57% in 2050. Long-term projections on public pension expenditure illustrate that the actuarial balance of public p-a-y-g funds will remain negative (4% in 2030 and 9% in 2050). However, public pension expenditures are projected to be about 7.3% of GDP in 2050.

Bulgaria made significant changes to its pension system in 2000, introducing a funded component to its first pillar system and reforming its pay as you go scheme. A rise in the retirement age, currently being debated, will have an impact on long-term sustainability. Concerns remain as regards the adequacy of pensions for persons who have not made sufficient contributions, and those on low earnings. The decision to link pension indexation to a mix of wages and prices will help future sustainability, but may result in poorer pensioners the further from retirement they are. The development of a funded tier of the first pillar and the promotion of other voluntary saving should provide good incentives for work and for working longer. However, it will be important to develop suitable mechanisms for the payment of pensions from these systems that are sustainable and contribute to improvements in replacement rates. Furthermore, extending working lives through incentives, or by linking contributions more closely to benefits, needs to go hand in hand with improved employment opportunities for older workers. Increases in employment and in particular in employment rates of older workers are steps forward, as are improvements in revenue collection and

adequacy of pensions. In addition, individuals are able to save via the two funded components of the system. However, improvements in employment rates still have a long way to go to reach the EU average and provide a solid, sustainable base.

5. Health and long-term care

5.1 Health care

Description of the system. Overall health indicators in Bulgaria show significant gaps vis-à-vis the EU averages. Following the introduction of mandatory health insurance (Health Insurance Act, 1998), the National Health Insurance Fund (NHIF) collects health insurance contributions from employers and employees set at 6% of wages. It contracts general practitioners, specialists in outpatient services and hospitals. General practitioners are paid by the NHIF on a capitation basis for the services provided, with regional compensation to offset geographical disparities. Outpatient care specialists are paid on a fee for service basis. Contributions for the unemployed, the poor, pensioners, students and other vulnerable groups are covered by the state and municipal budgets. The Ministry of Health is in charge of the overall health policy and management of the health care system. It is responsible for emergency care, vaccination and immunisation, psychiatric care, state sanitary and food control and health promotion. Hospital care is provided by acute care hospitals, specialised and long-term care establishments which can be jointly owned by the Ministry of Health and the municipalities, only by the municipalities or only by the state. Hospital treatment is covered by the NHIF on the basis of clinical paths for diagnosis. Reimbursement of pharmaceuticals varies. Life-saving drugs and the treatment of certain diseases such as cancer, diabetes and genetic diseases are free of charge. Hospital stay and treatments without prior referral require payment under fixed and uniform tariffs. Additional revenue for practitioners and hospitals is provided by patients' mandatory fees for visits (1% of the minimum wage) and for hospital stay per day (2% of the minimum wage). There are exemptions from payment of such fees for a large group of patients.The share of voluntary health insurance in health care purchase and provision is limited.

Accessibility. The state provides free, universal access to emergency health care and to all services paid for by the state budget. Access is impeded due to various reasons: geographical distribution of practices, transport problems, non-registration with a GP and non-payment of health insurance contributions of registered patients. Despite the reforms, a small percentage of the population are still not registered with a GP. This could impact negatively on their access to health care services. Although vulnerable groups' contributions are paid for by the state, limited access to health care services remains a problem due to a lack of information on patients' rights and responsibilities, exemptions and regulatory procedures. The state budget also provides a specific health benefit for hospital admission of vulnerable groups. A remaining problem is the fragmented access to primary health care services of some ethnic minorities, particularly in rural areas, resulting from non-registration and non-contribution with the health insurance fund. The level of reimbursement for certain pharmaceuticals and medical devices effectively hinders access to health care services. Similarly, co-payments (fees for non-referred services for the insured and those entitled to free care) and persistent informal payments negatively impact on access.

Quality. In recent years, 25 medical standards have been introduced in various medical specialities. The accreditation mechanism for health establishments has been expanded to include not only hospitals but also outpatient units. Rules for good medical practice are to be prepared and introduced. Establishing effective quality control and evaluation mechanisms of

the health care services remains a challenge for the authorities. Although preventive policies and immunisation campaigns are well established, their quality and quantity vary. Even though patients enjoy free choice of GP, the referral process to specialised care is hindered by the low quality and availability of these services (geographical disparities and transport issues). The authorities recognise that the introduction of accreditation and quality management systems, together with rules for medical practice, will help to increase the quality of medical services and equity in health. The authorities agree that further action designed to improve the quality of care and services is needed.

Long-term sustainability. In 2004, total health care expenditure amounted to 7.7% of GDP. The share of public health expenditure was 55.8% of total health care expenditure, with official out-of-pocket payments standing at 43.5% of total health expenditure. The authorities recognise the need to increase public funding for health care and improve the mandatory health insurance scheme. Since 2006, the NHIF share in hospital financing has increased and gradually replaced the share of state and municipal funding. In addressing the financial sustainability of the system, the authorities state that the funds specifically allocated for vulnerable groups' medical care will remain in place.

5.2. Long-term care

Description of the system. Long-term care is provided in both an institutional and a community setting. The authorities recognise the need to expand social services to offset demographic developments. This is in line with the overall tendency towards deinstitutionalisation and prioritised development of community-based care. The management of social services is the responsibility of municipalities, with both state and municipal budgets used to finance the social services provided. To guarantee financial sustainability and to support the municipalities in their new responsibilities in social services development, the state provides funding for a number of social services (day care centres, protected homes, centres for social rehabilitation and integration, specialised institutions, etc.). Social services can also be financed by private entities. Private providers have to be registered with the Social Assistance Agency. Social services are provided in return for fee payments or by way of agreements between the users and providers. Some groups are subsidised through the state budget (children under 16, persons with no income or savings, shelters residents). Social services use is voluntary and there is a free choice of provision. Institutional care is provided when community-based care is unavailable. The authorities plan to develop LTC services through complete implementation of the new legislation and the encouragement of public-private partnerships (2003 social services legislative reform).

Accessibility. For persons requiring mental care, the aim is to provide deinstitutionalised care with the appropriate integration mechanisms for their return into the community. For the elderly, however, there are plans to increase and expand social services, especially services provided in a community setting. Fees are low and do not impede access to LTC services. Measures are in place to guarantee free access to social services for vulnerable groups.

Quality. Despite the existence of legal norms regarding the obligations of LTC providers, including the possibility to close down institutions, improving physical conditions of accommodation continues to be a serious challenge. Besides state control, the social services are also subject to civil control (public councils, trustees, etc.). The authorities recognise the need to expand the range of services provided and improve the quality of existing services.

Long-term sustainability. The ageing of the population will require increased resources to be allocated to LTC for the elderly in particular. Although the recognised strategy of increased deinstitutionalisation will curb some of the financial burden on the state budget, adequate community-based care alternatives are needed and will incur additional costs, particularly for vulnerable groups without means.

6. Challenges ahead

To combat long-term unemployment and poverty, particularly in areas of multiple deprivations, through an active approach linking decisive actions on health and education in order to enhance individual capacities for labour market integration.

To break the intergenerational transmission of poverty and improve the chances of young people, in particular those from vulnerable groups and in underdeveloped regions and cities, by addressing the mismatch between skills and labour market requirements, reducing early school-leaving and providing social services and social housing.

To amplify efforts on the inclusion of vulnerable groups and ethnic minorities, focusing on the need for public anti-discrimination policies and awareness-raising actions.

To ensure that sufficient resources are available to provide access to health care and adequate social protection benefits for all (notably pensions) and to improve the poverty reduction effectiveness of the social protection system. To increase employment rates, in particular among older workers, and to improve contribution collection in order to ensure the sustainable financing of social protection and health care services.

To accelerate the implementation of the LTC reform through increased provision of social services, continued deinstitutionalisation and the expansion of adequate community-based care, without however neglecting the need for quality improvements in existing care institutions.

BULGARIA data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.4	26.5	**2000**	50.4	54.7	46.3	19.7	20.8	**2000**	16.4	16.7	16.2	33.7
2002	4.9	28.3	**2002**	50.6	53.7	47.5	19.4	27.0	**2002**	18.1	18.9	17.3	37,0
2004	5.6	31.8	**2004**	54.2	57.9	50.6	21.5	32.5	**2004**	12.0	12.5	11.5	25.8
2006	6.0f	34.2f	**2005**	55.8	60.0	51.7	21.6	34.7	**2005**	10.1	10.3	9.8	22.3

*** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	67.1	74.6	12.5	15.2	na	na	14.8	**1995**			-		
2000	68.4	75.1	12.8	15.4	na	na	13.3	**2000**	6.2	59.2	40.4		
2004	69.0sp	76.2sp	13.2sp	16.2sp	na	na	11.6	**2004**	7.7	55.8	43.5		

** Total health expenditure* ** Private health insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	na	na	na	na	na	na	na
2000	na	na	na	na	na	na	na
2004	na	na	na	na	na	na	na

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio	expenditure (% of GDP) level in **2004** and changes since 2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	na	na	na	na	na
2010	na	na	na	na	na
2030	na	na	na	na	na
2050	na	na			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
HBS income 2004	Total	Children 0-15	16+	16-64	65+	Total	Children 0-15	16+	16-64	65+		S80/S20
Total	15	22	14	14	16	19	24	18	20	13	**Total**	4
Male	13	-	12	13	5	20	-	20	21	8	**Male**	-
femal	17	-	17	14	23	18	-	17	20	14	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	na	na	na	**1999**	na	na	na	**1999**	na	na	na
2004	15.6	13.7	13.2	14.2	**2004**	7.2	7.3	7.0	**2004**	21.4	22.1	20.7
2006	14.5	11.6	11.1	12.0	**2005**	6.0	6.0	6.0	**2005**	20.0	19.5	20.6

** excluding students*

HBS income 2004	Total	Male	Female	HBS income 2004	Total	Male	Female
Relative income of 65+	na	na	na	***Aggregate replacement ratio***	na	na	na

Change in theoretical replacement rates (2005-2050)

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Current estimate (2002)	Assumption
na	na	na	na	na	na	na	na	na	na	na	na

**(DB / NDC/ DC); ** (DB / DC)*

2.3. CZECH REPUBLIC

1. Situation and key trends

Economic growth has been robust in recent years, accelerating to 6% in 2006, and GDP per capita has increased to 76.1% of the EU-25 average. Employment rates have started to increase after slight decreases in the previous years. In 2005, the total employment rate (64.8%) stayed above the EU-25 average, along with the employment rate of older workers (55-64), which increased significantly (44.5% against 42.7% in 2004). The employment rate among women (56.3%) was equal to the EU-25 average. On the other hand, the employment rate in the 15-24 age group continued to decrease (27.5%). There have been slight decreases in unemployment rates (7.9% overall, 9.8% for women). Youth unemployment has fallen more significantly (19.2%). In 2005, long-term unemployment remained at 4.2%. The at-risk-of-poverty rate[13] is one of the lowest in the EU-25 (10% in 2004). The population is ageing and the fertility rate of 1.2 is one of the lowest in the world. The Czech Republic is projected to face rapid ageing in the coming decades: the old-age dependency ratio was 19.8 in 2005 and is projected exceed 50% by 2050. Life expectancy at birth (72.6 for males and 79.2 for females in 2004) is somewhat below the EU-25 average[14], but has consistently increased over the last decade. Healthy life expectancy (62.8 and 63.3 in 2002) is not far below the EU-15 average. The infant mortality rate (3.7 in 2004) is one of the lowest in the EU and has seen a consistent decrease since 1960 (20). The perinatal mortality rate (4.3 in 2003) is also low by EU standards. Social protection expenditure is steadily increasing, reaching 19.6% of GDP in 2004 (EU-25 – 27.3%). Expenditure on pensions was 8.5% of GDP in 2005) and is projected to rise to 14% in 2050; total health expenditure was 7.2% of GDP in 2004.

2. Overall strategic approach

The main challenges presented in the Report are "achieving a sustainable standard of social protection", "sustaining adequate pensions and a decent living standard for pensioners", "preventing and tackling inter-generational social exclusion", and "increasing the participation of people at risk of social exclusion in the labour market". The Czech social protection system has been successful in decreasing poverty and preventing social exclusion, but needs to be adapted to ensure its sustainability and to tackle social benefit dependency. Social cohesion will therefore be pursued in particular through measures aimed at enhancing the degree of economic and social self-sufficiency of the population, while maintaining the basic standard of living of the population. The intention is also to prevent the intergenerational transmission of deprivation by focusing on the protection of families and children, ensuring equal access to education and vocational training. However, the Report does not present enough synergies between social inclusion and labour market participation and does not mention the issue of 'flexicurity'. Regarding pensions, the emphasis will be on postponing retirement and supporting complementary pension systems. Health and long-term

[13] Following the implementation of EU-SILC in 2005, the values of all income based indicators for 2004 (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition from ECHP to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national micro-census survey that was not fully compatible with the SILC methodology based on detailed income data.

[14] EU-25 average of 75.8 and 81.9 for males and females in 2004

care policy should contribute to social cohesion by focusing on the prevention of illnesses, raising public awareness of the need to avoid overuse of health services to ensure their sustainability, and increasing the quality and accessibility of health and long-term care. The Report refers to the Lisbon National Reform Programme (NRP) and its priorities and highlights the need to ensure the long-term sustainability of social protection systems in order to guarantee economic growth and competitiveness.

As regards governance, this is addressed differently in the three strands. The Committee on Social Inclusion created by the Ministry of Labour and Social Affairs (MPSV) has been coordinating the social inclusion strategy and also worked on the health and long-term care part of the Report (a special sub-group was created). A special team of experts was established by agreement of the political parties to work on the proposals for pension reform, while in the field of health and long-term care standard structures such as expert and working committees and doctor and patient organisations already exist. Regarding implementation, the emphasis is on mainstreaming social inclusion but this is still not applied as a general principle.

As an example of mutual strengthening, the educational measures for Roma children were singled out: these aim to overcome their disadvantages due to low education through preparatory classes, teacher's assistants, and support programmes for secondary education. Relevant statistics are not yet available, but it may be presumed that these measures are helping these children finish basic education and enter secondary school. This will also have a positive effect on their entry into the labour market. However, gender mainstreaming is not evident within the Report. The structural funds and especially the European Social Fund are viewed as important tools for implementing the social inclusion strategy in particular.

3. Social inclusion

3.1 Key trends

The Czech Republic has one of the lowest at-risk-of-poverty rate in EU-25 (10% in 2004). The role of social transfers in decreasing poverty is significant: without them, 39% of the population would fall under the poverty line. Pensions reduce the percentage from 39% to 21% and other social transfers to 10%. There is a very low proportion of poor pensioners due to the regular adjustment of pensions. Women (11%) are more at risk of poverty than men (10%), and the difference increases with age (in the 65+ age group, W= 7%, M=2%). The groups most at risk of poverty are the unemployed (51%), single-parent families with at least one child (41%) and households with three or more children (25%). The net income of social assistance recipients was 66.6% of the at-risk-of-poverty threshold for single persons, 89.1% for lone parents with 2 children and 85.9% for married couples with 2 children[15].

Child poverty is lower than the EU-25 average but is still quite high (18%). The youth unemployment rate is high (19.2% in 2005) but is starting to decrease. Educational attainment amongst 22-year-olds is one of the highest in EU-25, with 90.3% having completed secondary school in 2005 (M = 90.8%, F = 89.8%), though this represents a slight decrease (91.8% in 1999). The number of early school-leavers is very low (6.4% in 2005), although increasing

[15] Figures on the net income are not based on the EU-SILC but on the previous 2002 Microcensus survey.

(5.5% in 2002) and lower for men (M = 6.2%, F = 6.6%). The percentage of people living in jobless households (8.2% for children aged 0-17 and 7.3% in the 18-59 age group) is lower than the EU-25 average. The rate of in-work poverty (3% in the 18+age group) is significantly lower than the EU-25 average (8% for the 18+ age group).

The Czech social protection system is successful in protecting people from falling below the poverty line. On the other hand, it does not sufficiently motivate some population groups to enter the labour market. The unemployment trap was 78% for a one-earner + 2 children family in 2004. Recently, new measures have been implemented or approved to support making work pay, together with a comprehensive reform of the social benefits system to encourage higher activation. The reform aims to motivate people to enter the labour market by financially benefiting those actively trying to solve their situation and penalising persons refusing to cooperate with the labour and social affairs offices. To supplement the current minimum subsistence amount, which is the criterion for social benefit entitlement, a new concept, the existence minimum amount, will be introduced to ensure a basic living standard for the population. This will be accompanied by reform of the social services.

3.2 Key challenges and priorities

The Czech Republic chose to limit its previous multi-dimensional approach to social inclusion to a targeted approach focused on the most disadvantaged groups and families. The objectives are in line with the main features of the country's situation, in particular the fact that the rate of poverty is very low and concentrated among some population groups. An effort to involve regional and local levels in the strategy will aim to overcome the hitherto rather administrative and formal approach to implementing and mainstreaming social inclusion and will also endeavour to tackle regional disparities. In comparison to the last NAP/incl., which stressed employment as the most important way out of poverty, the current strategy focuses more on social services development and considers employment only in relation to the NRP 2005. The synergies between social policies and employment are thus less evident. This is particularly regrettable given the high unemployment rate among young people, which exposes them to the risk of poverty. A coherent approach in line with the European Youth Pact is needed.

The 2006 Joint Report identified two challenges for the Czech Republic regarding social inclusion: to support the implementation of social inclusion policies at regional and local level and to improve the situation of vulnerable groups (for example the Roma) and disadvantaged regions. Concerning the most vulnerable groups, progress is particularly evident as regards the Roma. The Concept of Roma integration has been amended and the Czech Republic has joined the Decade of Roma Inclusion 2005-2015. To eliminate the disadvantages in access to education, the numbers of preparatory classes and teacher's assistants have increased. A successful programme of outreach work in excluded Roma communities is being implemented and strengthened, and the complex 'Analysis of the Socially Excluded Roma Communities' has been produced. Progress has also been achieved with homeless people. The Report listed as one example of best practice a project financed by the ESF aiming to ensure systematic delivery of high-quality social services to the homeless. If more capacity were available for housing and individualised help, this could be successful in promoting social inclusion. To improve the situation of the most disadvantaged regions with over 14% unemployment, an additional investment incentive programme, which also finances training, was introduced in June 2004.

3.3 Policy measures

The first priority, which is to strengthen the integration of socially excluded persons or persons at risk of social exclusion and eliminate the barriers to entry and retention on the labour market for such persons, strongly builds on the previous NAP/Incl. and on the findings of the implementation report. It is to be pursued in particular by the social services in line with the new Act on Social Services to come into force in January 2007. The Act aims at facilitating access to social services and increasing their quality and will introduce personal benefits and a set of compulsory quality standards. The first priority covers most disadvantaged groups, including the long-term unemployed, people with disabilities, older people, excluded Roma communities, the homeless, immigrants, victims of domestic violence, ex-prisoners, persons leaving institutions, etc. Social inclusion is also to be enhanced by support for the social economy and social field work. There are many useful measures proposed, such as: introducing a uniform and complex approach to dealing with the problems of socially excluded Roma communities; creating a complex system of preschool education and supporting special programmes for the transition to secondary school and courses for early school-leavers. Regarding children with disabilities, the stress is on eliminating the regional differences in educational and counselling offer and transforming the special schools into integrated support centres. Significant attention is paid to the prevention of social pathological phenomena both in socially excluded communities and in weak families in order to protect children. Also positive is the increased attention paid to young persons leaving institutions: plans for their development are to be prepared before they leave their institutions and there will be programmes to support their independent living. On the other hand, several issues require more attention: the need to increase employment, the prevention of housing loss (according to the Strategy, a concept and system will be developed for social housing, but more clarification would be useful), and the situation of older persons.

The second priority, which is to strengthen the cohesion of the family and awareness of its importance, the awareness of intergenerational solidarity and the rights of the child, will be promoted by supporting the existing social services and developing the new services in cooperation with the NGOs. To tackle regional differences in the accessibility of services, their availability and quality will be surveyed. Special attention will be paid to families at risk of poverty and to supporting intergenerational cohesion. Also stressed is the prevention of pathological phenomena in families. A concept of caring for at risk children and children living outside their own families was to be produced in 2006. Attention will be paid to the rights of children and to foster care (including complex social services for families). The second priority will cover all families with a special focus on the disadvantaged, which indicates the increased importance given to family policy.

The third priority is intended to support decision-making processes at local and regional level and the development of partnership in social inclusion policy. In fact, however, it focuses mostly on the system and delivery of social services. The stress on quality is evident, and particular attention is paid to the education and training of social workers and service providers. The MPSV is to support the regions and towns in preparing their medium-term plans for the development of social services and motivate them to use a community planning method. Further, they are to be given support to modernise and humanise residential facilities, especially in developing alternative non-residential and field social services. Two measures with a broader social inclusion aspect were mentioned: developing tools to assess the status and efficiency of activities implemented at local, regional and national levels, and raising

awareness of active social policies to motivate municipalities to adopt a more sensitive approach to prevent social exclusion and support the integration of Roma communities.

No targets are set, but national policy-related input and output indicators are used, such as the volume of funds spent, the number of supported persons/entities/families, the number of programmes/plans in place, the number of newly provided services, the number of users, the number of children placed in foster care and institutional care, the number of persons who have completed an educational program, the number of municipalities involved in community planning, etc. While the Czech Republic is performing well on most of the EU-agreed outcome indicators, little use is made of them in monitoring policies. The gender perspective is not sufficiently taken into account. As regards the budget, the scale of resources allocated to the priorities is unclear, as no figures are given. In general, the aim is to finance implementation from the state budget and the structural funds. The role of the ESF in promoting social inclusion has been growing (it is making an important contribution to specific groups and the disadvantaged regions). In the next programming period, it should help create mechanisms to solve the problems of the excluded communities by the systemic way.

3.4 Governance

The social inclusion part of the Report was prepared by MPSV together with the Committee on Social Inclusion (CSI), which was created in 2003 to draft the Joint Inclusion Memorandum. It consists of representatives of ministries, governmental, regional/local authorities, social partners, NGOs, and experts. Preparation started in autumn 2005 at two regional conferences where the main social exclusion issues were discussed. The social inclusion part also builds on some of the new research reports. Coordination is primarily at national level and is not fully developed at regional and local levels. Nevertheless, work began in 2005 on the methodology for creating regional and local plans (by August 2007). In addition to the CSI, the "Stop Social Exclusion" project serves as an information tool for the social inclusion strategy. One of its targets to involve people experiencing poverty has not been fully achieved so far (however, they are included in decision-making on social services in regions and municipalities that implement community planning). Implementation will be monitored by the MPSV in conjunction with the CSI. The MPSV will prepare the implementation report each year in October and submit it to the CSI. The report will then be published on the internet. The intention is to produce the Final Implementation Report as well. Indicators for monitoring progress are included in all priorities.

4. Pensions

In 2004, older people had a relative standard of living quite close to that of the general population (83%), while the poverty risk among older people (5%) is estimated to be lower than for the population below the age of 65.

The Czech Republic is facing rapidly growing budgetary pressures of a significantly higher magnitude than in most Member States, and the 2006 Sustainability Report assessed the Czech Republic as a high-risk Member State as regards the sustainability of public finances. According to the AWG projections of 2005, spending on public pensions is expected to increase from 8.5% of GDP in 2004 to 14.0% of GDP in 2050 (a rise of 5.6 p.p.). According

to ISG projections, theoretical replacement rates for a worker retiring at 65 after 40 years of employment on the average wage are projected to decline by about 10 p.p. by 2050 (both gross and net), reaching 70% net (53% gross) in 2050.

The 2006 Joint Report noted that while the Czech Republic has managed to ensure the adequacy of pensions over the last decade, the pension system is facing growing pressures. The Report stressed the need for continuous reforms, in particular to improve the employment situation of older workers. While the Czech Republic currently has a low rate of poverty among older people, replacement rates are projected to decline and future adequacy needs to be carefully addressed. In spite of recent improvements, further increases in the employment rate of older workers are needed. Incentives to work longer need to be strengthened and the creation and take-up of jobs for older workers should be further encouraged so as to help balance financial sustainability and pension adequacy.

Further measures were suggested by an expert team (changing the calculation of benefits, further increasing the retirement age to 65, creating a reserve fund and increasing state support for private pensions, especially for annuities instead of lump-sums), though no agreement on reform has yet been reached at this time. There is a need for the new government to move on with further steps in reform in order to help strengthen the sustainability of pensions while securing adequacy.

5. Health and long-term care

5.1. Health care

Description of the system: Compulsory universal health insurance provides comprehensive health care coverage for all permanent residents. The General Health Insurance Agency (VZP) has a leading role among health insurance funds covering 70% of the population. There is a clear separation between financing and provision. Provision is decentralised and comprises a public-private mix. Service providers are independent and operate on the basis of contracts negotiated with insurance funds while the Ministry of Health regulates price ceilings. Primary health care (PHC) is organised by municipalities and delivered in municipal health centres, polyclinics or the private premises of general practitioners (GPs), dentists and gynaecologists. About 95% of PHC is private. A GP referral gives access to specialists, polyclinics and hospitals (outpatient and inpatient departments). 75% of specialist outpatient facilities are private whereas hospitals are public. GPs are paid on a capitation basis in the public sector and on a fee-for-service basis in the private sector. Specialists are paid a salary in hospitals and a fee-for-service in the private sector. Compulsory health insurance is financed primarily through an earmarked payroll tax on employees, employers and self-employed and by state budget contributions. Co-payments apply to certain services but are limited. Voluntary private insurance is negligible. In the light of health inequalities and barriers to access for some socio-economic groups, the government is aiming to improve the quality of healthcare services, to improve general health and reduce health inequalities, to ensure homogeneous geographic availability and to provide more easily accessible and equitable services that are better organised and integrated with social services, while maintaining the principles of solidarity, equality and availability of the system and current coverage. In addition, the government is also focusing on increasing the number of health workers and emphasising promotion and prevention as a means to improve long-term health.

Accessibility: The package of services available within the public system is very broad and only a limited number of services are excluded from coverage. The level of out-of-pocket payments is considered low (8.6% of total health expenditure in 2004) with the exception of dental care. Full payment for at least one medicine in each of the basic therapeutic groups is legally guaranteed. The report does not perceive regional inequalities in access to health care services. Nevertheless, unequal access is an important issue for some socio-economic groups (i.e. the homeless and people with disabilities). The report underlines that a stronger PHC, better coordination and the restructuring of the network of health care facilities is needed in order to improve access for patients to different types of care.

Quality: Authorities emphasise the need to develop a national quality assurance system based on international standards and plan to introduce a state-guaranteed accreditation programme for providers. At present, an independent accreditation agency is responsible for the external evaluation of the quality of healthcare in hospitals according to standards accredited by an international society. The report pinpoints the importance of a good information system (e.g. on activity and performance) to ensure quality and financial sustainability. The establishment of a national register to provide information on projects supporting security and quality in healthcare facilities is planned by the government. Patients in the Czech Republic have the right to choose their own health insurance company, doctor and healthcare facility. The establishment of a national agency for patients is envisaged by the government.

Long-term sustainability: Total health care expenditure (7.2% of GDP and 1333 per capita PPP$ in 2004) is below the EU-25 average in GDP terms[16] but noticeably higher than in the other new Member States. It has been constant over the decade in GDP terms. The annual growth rate of per capita expenditure is one of the highest within the EU (9.1% in 2002/2003). Public expenditure as a share of total health expenditure (90.7% in 2004) is the EU highest. Ageing (according to the 2006 EPC/EU projections public health care expenditure is projected to increase by 2 percentage points of GDP by 2050 due to population ageing) and technological developments are emphasised in the report as the main long-term challenges. Expenditure on pharmaceuticals is particularly high (27.5% of total health expenditure in 2004). The government is attempting to stabilise and then reduce these costs through new legislation and via changes in the mechanism of payment for pharmaceuticals to manufacturers and suppliers. The report highlights the overuse of specialist and hospital care (the number of acute hospital beds is still one of highest in the EU). To improve efficiency the authorities are planning to reinforce PHC, concentrate highly specialised healthcare providers in a few centres throughout the country and shorten the average hospital stay (very high by Western Europe standards). It should be noted that the general conditions for improving the equity of financing and the financial sustainability of funds may not be fully met. Improving risk-adjustment across funds by basing resource allocation not just on age but also on other elements may reduce the financial difficulties of some insurance companies, especially of the VZP. The report highlights some imbalances in the structure of human resources. The government also emphasises the need for stronger promotion and prevention to address risk factors and specific diseases and ensure health-supporting environments that facilitate healthy choices. On promotion and prevention, several programmes have been launched in recent years (e.g. the Long-term Programme for Improving the Health of the Czech Population - Health for All in the 21st Century) under the auspices of the WHO.

[16] 8.87% and 2376.33 per capita PPP$ in 2004.

5.2 Long-term care

Description of the system: Long-term care facilities vary in nature and financing, and involve primary, home and day care services (nursing activities, hygiene, shopping, meals-on-wheels, washing, leisure activities, and rehabilitation), assisted housing, residential services (pensioners homes and boarding houses for pensioners) and sheltered housing. The regional authorities and municipalities are responsible for organising the provision of long-term social care financed from the state budget (only long-term medical care is paid by health insurance). Clients and their families also contribute to the costs of institutional care. Some services (particularly out-patient) are provided through NGOs, financed mostly by public grants. As a result of ageing and societal changes, the government's strategy is to increase the provision of home care services and shift from institutional to primary and home care. A multi-source financing of social services is the recently declared central principle. Monitoring the impacts of the new Act on Social Services is also a priority for the authorities.

Accessibility: The report highlights that the current supply is insufficient, waiting times for placement in public long-term care facilities (e.g. pensioners' homes) varies from several months up to several years and regional inequalities (availability, waiting times, financial costs) are high. Moreover, due to co-payment obligations, a financial barrier to access exists. The strategies to tackle these issues differ from region to region depending on local government performance. Some municipalities are introducing new care paths to replace institution-based care with home-care, while others are extending nursing care or modernising facilities. However, the health and social care sectors are not fully integrated. The report underlines that the capacity of hospices has increased in recent years but is still insufficient. The government intends to encourage cooperation between stakeholders to tackle social exclusion and create a network of geriatric outpatient and community gerontology centres. The provision of adequate long-term care is a key priority in the coming decade.

Quality: A new Social Services Act defines the conditions for the registration of social service providers and is expected to improve the current fragmented framework. Social Services quality standards set basic levels for personnel training and procedural and operational aspects regarding the provision of social services. The importance of improving coordination between health and social care is emphasised in the report.

Long-term sustainability: Stronger coordination between the health and long-term care sectors is planned by the government through the introduction of a joint-financial (multi-source) model for the "institute of the social – health-care bed". Within this new system healthcare facilities will be able to integrate nursing care units with medical facilities or transform acute care beds into aftercare beds. The government considers the development of and access to long-term care to be their main priority in terms of ageing and socio-economic policy. According to the 2006 EPC projections, expenditure is projected to increase by 5.6 percentage points of GDP by 2050 due to population ageing.

6. Challenges ahead:

To support the implementation of social inclusion policies at regional and local level;

To improve the situation of vulnerable groups (for example the Roma) and support disadvantaged regions;

To address pension reform and encourage the creation and take-up of jobs for older workers so as to help balance financial sustainability and pension adequacy;

Improve efficiency and reduce waste through a more rational use of resources (notably through a stronger focus on PHC while reducing the high dependency on specialist and hospital inpatient care) and by adjusting staff numbers;

To improve risk-adjustment across funds to improve equity of financing and the financial sustainability of funds;

To enhance coordination between health and social care and between different stakeholders and to improve access to long-term care services.

Czech Republic: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,6	64,7	**2000**	65,0	73,2	56,9	36,4	36,3	**2000**	8,7	7,3	10,3	17,8
2002	1,9	67,7	**2002**	65,4	73,9	57,0	32,2	40,8	**2002**	7,3	5,9	9,0	16,9
2004	4,2	72,1	**2004**	64,2	72,3	56,0	27,8	42,7	**2004**	8,3	7,1	9,9	21,0
2006	6.0f	76.1f	**2005**	64,8	73,3	56,3	27,5	44,5	**2005**	7,9	6,5	9,8	19,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth*		Infant mortality rate	WHO	Total Health exp %GDP	Public Health Exp % of THE**	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI*** % of pop
	male	female	male	female	male	female							
1995	69.7	76.6	12.7	16,0	na	na	7.7	**1995**	6.9	92.7	-		
2000	71.6	78.4	13.7	17.1	na	na	4.1	**2000**	6.6	91.4	8.6	100	negligible
2004	72.6sp	79.2sp	14.3sp	17.7sp	62.8p	63.3p	3,7	**2004**	7,2	90,7	8,6		

**data for 2002* ***THE: Total Health Expenditures* ****PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	17,4	39,7	37,2	2.3	11,9	1.3	7,6
2000	19,5	43,3	33,7	3,5	8,4	3,3	7,8
2004	19,6	41,1	35,3	3,9	8,4	3,4	7,9

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old age dependency ratio	expenditure (% of GDP) level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health Care	Long Term care
2005	19.8	19.3	8.5	6.4	0.3
2010	21.9	-0,5			
2030	37.1	1.7	1.1	1.4	0.2
2050	54.8	7.1	5.6	2	0.4

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	10b	18b	9b	9b	5b	18b	18b	18b	19b	8b	**Total**	3.7b
male	10b	-	8b	9b	2b	19b	-	19b	19b	25b	**male**	-
femal	11b	-	10b	10b	7b	18b	-	17b	19b	6b	**female**	-

	People living in jobless households				Long Term Unemployment rate			Early school leavers			
	Children	% of people aged 18-59*			% of people aged 15-64			% of people aged 18-24			
	Total	Total	male	female		Total	male	female		Total	male	female
1999	7.2	7.2	5.6	8.8	**1999**	3.2	2.4	4.2	**1999**	na	na	na
2004	9,0	8,0	6.4	9.6	**2004**	4.2	3.4	5.3	**2004**	6,1	5,8	6,5
2006	8,2	7,3	5.8	8,8	**2005**	4.2	3.4	5.3	**2005**	6.4	6,2	6,6

** excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0,828b	0,854b	0,808b	***Aggregate replacement ratio***	0,506b	0,485b	0,576b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Estimate of current (2002)	Assumption
-9	-7	-7	DB	…	…	100		…	28	…	…

**:(DB / NDC/ DC); ** (DB / DC)*

2.4. DENMARK

1. Situation and key trends

The Danish economy has been characterised by strong activity in recent years with GDP growth estimated to reach 3.0% in 2006. Denmark continues to record employment rates well above the EU targets (75.9% in 2005), particularly for women (71.9%) and older workers (59.53%). Unemployment has decreased significantly and is expected to reach a historical low of 3.9% in 2006. Long-term unemployment (1.1%) and unemployment among young people are decreasing and are among the lowest in the EU. Denmark performs well as regards the risk of financial poverty (12% in 2004 – 10% including imputed rent). Immigrants, students and the unemployed are overrepresented in the lower income brackets. The social protection system is based on the principle of universality with all citizen guaranteed fundamental protection against social risks such as unemployment, sickness or dependency. There is a strong involvement of social partners, local authorities and other stakeholders. Danish expenditure on social protection ranks as one of the highest in the EU (30.7% of GDP in 2004). The ratio of persons aged 65 and above to 15-64 year olds will increase from the present 22.6% (2005) to 37.1% in 2030 and 40% in 2050 (significantly below the EU-25 average of 52% in 2050). Male life expectancy is average (75.4 years in 2004) but is below average for women (80.1 years). Infant mortality (4.4 in 2004) is near the EU average. Perinatal mortality is also about average (4.4 in 2001) and has constantly declined since 1960 (26.2).

2. Overall strategic approach

The overall strategic approach to social protection and social inclusion is to develop an inclusive labour market by increasing the labour market participation of vulnerable groups. Key challenges are 1) to increase the employment rate of vulnerable groups, 2) to ensure that all citizens have equal access to a high- quality, efficient health care system and 3) to establish the budgetary conditions for maintaining the present universal pension system. Denmark has addressed all three overarching objectives of the Open Method of Coordination.

On social cohesion, Denmark has recently taken steps to safeguard its social protection system in the long term through a newly adopted welfare agreement, which is expected to address a large part of the long-term welfare challenges caused by ageing. The long-term focus of the social inclusion strategy is on breaking the vicious circle of deprivation. The short-term focus of the social inclusion strategy is on vulnerable, disadvantaged and already socially excluded groups. The weakness of the social inclusion strategy is that, so far, it has lacked an analysis of the background for the various initiatives and particularly the social situation of certain target groups. Together with relatively few targets and indicators to help monitor the activities, there is a risk of limited evaluability, fragmented management and blurred accountability. The Government has recently taken steps to develop analysis, evaluations and indicators within its social inclusion strategy, notably in the framework of the new action programme "Our Collective responsibility II". .

There is an effective and mutual interaction between the strategy on social inclusion and the Lisbon Strategy. Both the National Strategy Report on social inclusion and social protection and the National Reform Programme are drawn up in close cooperation with all the ministries involved . Social inclusion policies are presented as an integral part of the Danish Lisbon strategy, and the measures are seen as key elements in pursuing the targets of this strategy.

Examples are the employability of vulnerable groups and improving the flexibility of employees.

On governance there has been extensive involvement of key stakeholders in the preparation of the social inclusion strategy, including social partners, civil society, evaluators, regional authorities and relevant ministries. Denmark has a very long tradition of cooperation between NGOs and the public sector in implementing social policy..

3. Social inclusion

3.1 Key trends

Denmark has one of the lowest levels of income inequalities in the EU, despite a slight widening in the late 1990s. However, the share of people living in jobless households decreased from 8.5% in 2004 to estimated 7.7% in 2006 for adults and from 6.0% to 5.7% for children.

According to ESSPROS data, Denmark spends 30.7% of its GDP on social protection, compared to the EU15 average of 28% (2004 data). Measured as expenditure per capita in Purchasing Power Standards (PPS), the Danish expenditure on social protection, at 8 115 PPS, is one of the highest in the EU. According to the 2003 EU-SILC data, 12% of the Danish population lived on an income of less than 60% of the median income (10% when including imputed rent). This rate is one of the lowest in the EU, largely reflecting a relatively even income distribution.

Immigrants, students and the unemployed are over-represented in the lower income brackets. The employment rate of people with ethnic minority background remains significantly below the average of the population.

3.2 Key challenges and priorities

The overall strategic approach for social inclusion policies in Denmark is the assumption that a strong and competitive society requires social cohesion without too many social and economic differences. The key priority for Denmark for obtaining an inclusive society is therefore through intensive involvement of and dialogue with social partners and key stakeholders to ensure that vulnerable and marginal groups also have sufficient access to the labour market. This strategic approach can be seen as bridging well the three strand objectives for social inclusion.

In the 2006 Joint Report, two challenges were identified for Denmark. As regards "safeguarding the current high level of protection while satisfying increasing demands for health and welfare services in view of the ageing population", Denmark has made good progress. The far-reaching welfare agreement reached in June 2006 is expected to address a large part of the long-term welfare challenges caused by ageing. Concerning the second challenge of "developing labour market tools designed to improve integration of ethnic minorities within the labour market", participation rates have improved only moderately over the past year. More substantial effect from new measures adopted by the welfare agreement has to be seen.

A major challenge of the social inclusion strategy is to establish analysis of the impact of policy initiatives on the situation of vulnerable groups.In particular, the social situation of

certain immigrants especially affected by reduced social allowances in recent years - has been highlighted regularly by key stakeholders, such as the Government's independent "Council of Socially Marginalised People". Within the action programme *Our collective responsibility II*" the Government has now taken first steps to address this.

The ESF is contributing to Denmark's social inclusion policies through the Objective 3 programme, but the funding is negligible in comparison to the total expenditure on social inclusion in Denmark.

3.3 Policy measures

In order to pursue its key priorities for vulnerable groups, the government has launched in August 2006 a new phase in its action programme *"Our Collective Responsibility II"* with an estimated budget of €83 million . The main focus of this phase is 1) to strengthen outreach and support services, 2) to create more openings to the labour market, and 3) to improve social administration.

In 2006, the Government launched a new strategy to break the vicious circle of deprivation. A new reform aims at strengthening early preventive activities for disadvantaged children and young people and their families, while also improving casework in local authorities. The reform also puts greater emphasis on the school attendance of children and young people in care, thus helping to break the vicious circle of deprivation. Another crucial element is the existence of day-care facilities, for which €268 million has been allocated over a four-year period mainly to help support children. The newly adopted welfare agreement contains ambitious targets for increasing the share of pupils with upper-secondary education to 95% in 2015. Special efforts are being made to address the challenges faced by immigrants, including pilot projects for "whole-day-schools" to provide additional support.

The new welfare agreement contains concrete measures to strengthen the adult and vocational training system in Denmark. This is the result of the work of the Tripartite Committee for Lifelong Upgrading of Skills and Education, which concluded that while activities are already extensive when compared internationally, too many adults still have problems with basic school-level skills. This group also participates relatively little in vocational training. Some of the main measures will be to increase the number of participants in Preparatory Adult Education (basic skills in literacy and innumeracy) to a yearly number of 40.000. An additional 2.000 adult apprenticeships will be established, and there is also a strong emphasis on enhancing the motivation for lifelong learning

A number of activities have been launched to boost employment among vulnerable groups. About €67 million has been allocated to activate the long-term unemployed with a target of doubling the participation rate within 2 years. In the National report several activities for people on the fringes of the labour market are mentioned: the *pool for social activation* with about 7.2 million, a *special mentor scheme* with around €5.3 million and a *temporary working scheme* with about €2.7 million. Finally, an annually €3.3 million has been allocated for the period 2005-2008 to a debt remission pilot project targeting socially disadvantaged groups. A 2005-2009 action plan for people with disabilities with a budget of €11 million has been launched with the aim of increasing their employment yearly by 2000 and the share of enterprises employing the disabled by 1 percentage point. Finally, about €43 million has been allocated to help mentally ill people enter the labour market.

On housing, anti-Ghetto measures will be continued with the aim of stopping the flow of vulnerable groups into these areas and retaining the more well-off residents. New rules will permit the municipalities in 25 special areas to reject house seekers receiving social assistance but at the same time will oblige them to offer replacement housing within six months. The anti-Ghetto measures also allow for businesses to be set up in buildings that were assigned to social housing. In 2006-2008, an additional €5 million has been allocated to establish protected houses for the homeless and socially vulnerable. Finally, about €32 million is allocated yearly to housing renovation and €7 million to urban renewal.

On integration, the newly adopted welfare agreement contains a number of new measures for immigrants. Apart from a tightening of rights and obligations for activation, these new measures also contain yet to be tested initiatives, including the creation of partnerships with large enterprises and the introduction of wage subsidies. About €40 million has been allocated over a four-year period to a special counselling scheme aiming to assist immigrants in their job search and job applications. Finally, a new quadripartite agreement has been reached in order to introduce special access packages etc.

Special attention is still being given to trafficking in women and to address the growing need for informing ethnic minority women about their rights in Denmark. It is estimated that there are about 4000-5000 prostitutes in Denmark of which almost half are foreigners. Many of them are believed to be the victims of trafficking. Increased cooperation with the Baltic countries is being envisaged to prevent recruitment for trafficking. An action plan aims at improving outreach work, and a protected shelter/hostel has been established to help women out of their situation. Finally, a €135.000 information campaign has been launched to raise awareness of trafficking and have cases reported to a special "hotline".

3.4 Governance

The involvement of stakeholders has been extensive during the preparation of the National Strategic Report. A national conference took place in April 2006 with the participation of a large spectrum of key stakeholders, including social partners, civil society, evaluators, regional authorities and relevant ministries. Based on contributions from various ministries, a first draft of the National Strategic Report was then submitted to a hearing procedure for all participants at the initial national conference. The policies for social inclusion and social protection are presented as an integral part of the Danish Lisbon strategy, and the measures are seen as key elements in pursuing the targets of this strategy. Denmark has a very long tradition of cooperation between NGOs and the public sector in social matters. This is one of the strongest points in the Danish policy on social inclusion, and makes an important contribution to Denmark's successful and inclusive society.

The Danish Government has recently taken steps to improve the monitoring and evaluation of the social policies. .

4. Pensions

The income of people aged 65+ relative to the 0-64 age group stands at 71%, which is lower than in most other member states, while the risk of poverty for the elderly population remains at a moderate level (17%), but higher than for the 0-64 age group (10%).[17]

The 2006 Sustainability report assessed Denmark as a low risk Member States as regards the sustainability of public finances. According to AWG projections, public pension spending will grow between 2004 and 2050 from 9.5% to 12.8% of GDP[18]. A major increase is also expected in expenditure on occupational pensions, as these schemes will mature and contribute significantly to future pensions. According to ISG projections, total gross theoretical replacement rates for a worker retiring at 65 after 40 years on the average wage is expected to increase from 49% in 2005 to 64% in 2050 (from 71% to 76% in net terms), despite a decrease in the gross replacement rate for the first pillar (including ATP) from 45% to 39%, reflecting the expected increase in occupational pensions from 4% to 25% (current coverage of those schemes is close to 80%), assuming contribution rates of 12.7%).

The 2006 Joint Report underlined that the Danish strategy for ensuring the adequacy and sustainability of public pensions seems appropriate. It stressed that the maturation of occupational pensions should contribute to the future adequacy of pensions and would benefit from periodic reviewing. It also noted that despite good employment records, further measures to improve employment rates among older people would be required, in particular as regards early retirement schemes.

A budget policy leading to quick debt reduction has already been sustained for some years, and should result into substantially lower levels of public debt by 2010. With the development of occupational pension schemes, replacement rates are expected to rise significantly and reduce the current relative income gap between people aged 65 and over and people below the age of 65. The first pillar will nevertheless continue to play a dominant role in pension provision.

Under the welfare agreement of June 2006, retirement ages will increase from 60 to 62 for early retirement schemes (from 2019 to 2022) and from 65 to 67 for old age pensions (from 2024 to 2027), while from 2025 they will be indexed to life expectancy at 60. Though the phasing in of these measures appears to be particularly long, they should make a substantial contribution to long-term future adequacy and sustainability.

[17] Accumulated wealth, which is higher for older people, should also be considered when comparing living standards across generations, but due to data limitations this is unfortunately not possible for all countries. These figures do not include as income negative capital income and imputed rent from private housing, or in kind benefits or services (such as as home-help or health care), and possibly some specific in cash benefits (such as heating benefits), which gives an incomplete picture of the income situation, in particular for older people. When taking into account this more comprehensive definition of income, the risk of poverty in Denmark for elderly people is fairly the same as in the rest of the population (8.7% for people aged more than 65 and 10.6% for people aged more then 75, compared to 9.8% for 0-64 aged people).

[18] Excluding the effects of the Welfare Agreement reached in June 2006

5. Health and long-term care

5.1 Health Care

Description of the System: Denmark has a tax-based, decentralised health care system that provides universal coverage for all Danish citizens. Primary care and hospital care are free at the point of use. Health care has to day been primarily funded and provided by the counties. However, The Local Government Reform of 1 January 2007 introduces five new, larger regions to replace the counties, which will now be mainly responsible for hospitals and psychiatric treatment. The new regions can no longer levy taxes, but will be financed from the tax-based state (around 80%) and the local authority budgets. The ninety-eight new local authorities will assume a wider responsibility and a reinforced role in the health area, especially for prevention and rehabilitation but specialised outpatient rehabilitation will still be provided in hospitals. The reform aims to ensure cohesive patient treatment across administrative borders especially for disadvantaged persons and simplified access to prevention, examination, treatment and care. It allows local authorities to develop new organisational solutions to improve quality, interdisciplinary activities and staff recruitment.

Accessibility: All citizens in Denmark are entitled to free and equal access to health care and rehabilitation as well as to prevention and health promotion services. Citizens have a free choice of public hospitals in the country, and in July 2002 the Government guaranteed all citizens the right to opt for publicly financed treatment at a private or foreign hospital if waiting times for public hospitals are more than two months (from 2007 the limit is one month).From July 2002 to July 2006 nearly X% of the patients have used this guarantee, almost entirely in the form of treatments at private domestic hospitals. Hospital treatment for non-emergency cases requires referral from a doctor, usually the patient's general practitioner. Private out-of-pocket payments accounted for 16% of total health expenditure in 2004, in the form of as co-payments for e.g. physiotherapy, dental care, spectacles and pharmaceuticals as well as contributions to voluntary health insurance schemes. About 30% of the population purchase such insurance to cover statutory co-payments.[19] From 2002 to 2006, average waiting times for 18 selected treatments fell by 22%, from 27 weeks to 21 weeks. Almost 96.000 (approx. 20%) more operations were performed in 2005 than in 2001. Waiting times are considered to reflect the organisational quality of the hospitals.

Quality: The Danish quality model, which aims to promote and improve the quality and delivery of treatment, will be developed over a period of time. The initial aim is to accredit all public hospitals under the model by the end of 2008. Subsequently this will be gradually expanded to cover the entire health sector. The quality model must be based on standards with measurable indicators for clinical quality (e.g. treatment of lung cancer) and on standards for organisational quality (e.g. hygiene and patient information). A Danish quality institute was set up in 2005 with the task of ensuring the implementation of the Danish quality model.. In recent years a number of initiatives have been launched with the primary aim of increasing quality in cancer treatment. To help reducing the total waiting times the Government has recently announced further measures to help guiding patients. The Government is ensuring more openness and transparency in hospital treatment, for instance by introducing a website in October 2006 to publish comparable information on quality and service at individual hospitals.

[19] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005

Long-term Sustainability: Total healthcare expenditure (9.0% of GDP and PPP$2763 per capita in 2003) was just above the EU average as a percentage of GDP (8.8% and PPP$2266 in 2003). The share of GDP was 9% in 1980-1983, declining to 8.2% in 1997 before rising again to the current level. The share of public healthcare expenditure[20] decreased from 88% in 1980 to 83% in 2002. Public healthcare expenditure grew from 6.9% of GDP 1998 to 7.4% in 2004. According to the 2006 EPC/EC projections public health care expenditure will increase by 0.8 percentage points of GDP by 2050 due to population ageing, whereas a national projection show a 1.1% increase. Increased free choice for patients have led to increased transparency in the use of resources. Local government reform is expected to promote better coordination of competences and responsibilities at different levels thereby ensuring more efficient use of resources. The local government reform will also mean that prevention at local level will have a higher priority, and should help ensure greater coherence between care actions at different organisational levels. The five new regions should provide a stronger basis for centralising more treatments, taking better advantage of specialisation and ensuring optimum resource utilisation.

5.2 Long-Term Care

Description of the system: Legislation defines the overall rights to receive long-term care. The local authorities (local council) are responsible for providing the various forms of long-term care services. The costs are financed through local taxes and grants from the state and the local authority always decides on the assistance to be granted, irrespective of whether it is provided within the public or private sector. Local authorities are obliged to ensure assistance with the necessary personal care and practical tasks in the homes of individuals unable to take care of themselves on their own. Assistance is granted following an individual assessment of the recipient's functional abilities and needs, and is planned in cooperation with the recipient on the local council's adopted service level. Assistance aims at activation, by enabling the recipient to perform as many tasks as possible by themselves. Almost half of all older people over 80 receive permanent home-help services. A basic principle of this policy is that the type of home should not dictate what care services are offered, but that the needs of older individuals should steer such decisions. Since 1987, Denmark has only built special housing for older people with living quarters separated from where care is provided. Local authorities continue to convert old care homes into such 'close-care accommodations'

Accessibility: Danish care for the elderly rests on the basic principle that all residents of Denmark have free and equal access to various services, where temporary or permanent physical or mental impairment prevents them from handling such tasks on their own. In principle, permanent personal care and practical help is free. Some fees are charged for temporary help, except for citizens on the lowest incomes. For permanent help, local councils may charge payment for non-staff expenses. Fees may be charged for meal schemes. However, such fees account for only a small part of total care expenditure on older people. Residents in social housing for the elderly pay monthly rent corresponding to the costs of running the housing area, and may have access to general housing benefits depending on income. Residents of conventional care homes pay rent related to the costs of running the care home, with possible deductions based on the resident's financial situation.

Quality: Legislation directs local authorities to establish quality standards containing a description of the service level determined by the local council and to prepare quality

[20] As a percentage of total health care expenditure

standards for personal and practical help. As of 2001, local authorities are obliged to prepare quality standards for rehabilitation that must state what help citizens are entitled to. The content, scope and performance of services must be precisely described and quality targets set. Local authorities must adopt quality standards once a year and follow them up regularly. An initiative has been taken recently to create more openness regarding care home quality by enabling user information to be compared within and across local authority borders. The local council must offer respite care (outside the home) or relief (in the home) for family carers. For several years, activities have been undertaken to train, educate and upgrade the qualifications of staff and managers in the care sector. It is felt that the recruitment of nurses may become increasingly problematic as the profession is associated with low salary levels, a heavy workload and poor working conditions.[21]

Long-term Sustainability: The Government attaches great importance to offering citizens free choice as part of its strategy towards older people. Healthy competition can improve quality and efficiency, and encourages suppliers to better meet recipients' expectations. All persons deemed eligible for special housing are entitled to choose such housing freely within the local authority as well as across local authority borders. Moreover, elderly and disabled people are entitled to choose between various home-help suppliers. In 2005, 160.000 persons receiving home help were entitled to choose between suppliers of that service. Of these, some 15% used this option to choose a private supplier. The Government wants to provide further options for free choice. A new bill will thus be introduced to provide a framework for ensuring greater freedom of choice for citizens, allowing the private sector to establish and operate free retirement housing in competition with retirement housing run by local authorities. According to the 2006 EPC/EC projections, public long-term care expenditure will increase by 1.1 percentage points of GDP by 2050 due to population ageing (from 1.1% of GDP in 2004), which corresponds to the national growth projection.

6. Challenges ahead

– To safeguard the current high level of protection, while satisfying increasing demands for health and welfare services in view of the ageing population.

– To further develop labour market tools to improve the integration of ethnic minorities within the labour market.

– To encourage more people with disabilities and older workers to stay on the labour market.

To take the necessary steps to further improve the quality, effectiveness and efficiency of the Danish health care system, including measures to improve the organisation and performance of cancer treatments.

To take more actions to recruit people to work in the care professions and improve the working conditions.

[21] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005

DENMARK

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.5	126,0	**2000**	76.3	80.8	71.6	66,0	55.7	**2000**	4.3	3.9	4.8	6.2
2002	0.5	121.4	**2002**	75.9	80,0	71.7	63.5	57.9	**2002**	4.6	4.3	5,0	7.4
2004	2.2	120.1	**2004**	75.7	79.7	71.6	62.3	60.3	**2004**	5.5	5.1	6,0	8.2
2006	3.0f	122.6f	**2005**	75.9	79.8	71.9	62.3	59.5	**2005**	4.8	4.4	5.3	8.6

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65 (2003 instead of 2004)		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	72.7	77.8	14.1	17.5	61.6	60.7	5.1	**1995**	8.2	82.5			
2000	74.3	79.0	15.2	18.3	62.9	61.9	5.3	**2000**	8.4	82.4	16	100	28
2004	75.4sp	80.1sp	15.9sp	18.9sp	63.0e	60.9e	4.4	**2004**	9	82.6	16.1	100	

*s: Eurostat estimate; p: provisional; e: Estimate; *THE: Total Health Expenditures **PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old-age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	31.9	37.7	17.8	14.8	12.4	6.8	10.6
2000	28.9	38.1	20.2	10.5	13.1	6.1	12
2004	30.7	37.2	20.6	9.5	13	5.8	13.9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
2005	22.6	26.8			
2010	24.8	0.2			
2030	37.1	4			
2050	40	4.8			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate***					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12	10	12	11	18	16	18	16	22	8	**Total**	3.5
Male	12	-	12	11	17	16	-	14	22	7	**Male**	-
Female	12	-	13	11	18	16	-	16	22	9	**Female**	-

*** Without imputed rent

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	na	na	na	**1999**	1.1	1.0	1.3	**1999**	11.5	14.2	9.1
2004	6,0	8.5	8.3	8.8	**2004**	1.2	1.1	1.3	**2004**	8.5	10.4	6.7
2006	5.7p	7.7p	7.7p	7.8p	**2005**	1.1	1.1	1.2	**2005**	8.5	9.4	7.5

**: excluding students; p:provisional*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.7	0.718	0.695	***Aggregate replacement ratio***	0.353	0.325	0.388

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates			
								pensions	pensions		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Current estimate (2002)		Assumption
5	15	-6	DB	21	DC	100	78	0.9	19:12		12.7

**:(DB / NDC/ DC); ** (DB / DC)*

2.5. GERMANY

1. Situation and key trends

Against the background of increasing GDP growth (estimated at 2.5% in 2006 as against 0,9% in 2005), the total employment rate started picking up in 2006 after a long period of stagnation but remains well below the Lisbon target (65.4% in 2005). The unemployment rate started decreasing after reaching a peak of 9.5% in 2005. The youth unemployment rate has been rising over the past years and stabilised at 14,8% in 2005. Following a steady trend since 2001, the employment rate among older workers rose to 45.4% in 2005, but remains below the Lisbon target of 50%. A steady rise in long-term unemployment can be observed, the rate reaching 5% in 2005. The at-risk-of-poverty rate stood at 13% in 2004[22].

Total social expenditure as a percentage of GDP in 2004 was 29,5% above the EU average (28%). Total expenditure on families and children, at 10.5% of GDP, is one of the highest in the EU and contrasts with a very low birth rate and an at-risk-of-poverty rate of 14% for children in 2004.

Demographic trends will result in a significant increase in the old-age dependency ratio, from 27,8% in 2005 to 52%[23] in 2050, and total age-related public social expenditure is projected to rise from 23.7% in 2005 to 26.4% in 2050. Pension expenditure amounted to 12.4% of GDP in 2004. Life expectancy at birth (76.5 and 81.9 years for males and females in 2004) is slightly above the EU average for men[24]. It has risen about 2 years over the last decade (from 73.3 and 79.7 in 1995). Infant mortality (4.1 in 2004) is low, the EU value being 4.5. Perinatal mortality is also low (5.8 in 2003) and has constantly declined since 1960 (34.9).

2. Overall strategic approach

Enhancing the sustainable functioning of the pension, accident insurance, health care and long-term care system is identified as a priority. Improving the labour market prospects of young people, older people, immigrants and people with disabilities also remains a political priority.

In relation to social inclusion, the report highlights the situation of children and families, the position of immigrants and access to the labour market for women. Concerning pensions, Germany is consolidating the first pillar and supporting the second and third pillars of the pension system through attractive incentives. As in health and long-term care, the main objective is to secure the efficiency and quality of the system in view of the demographic challenges.

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[22] Following the implementation of EU-SILC in 2005, the values of all income based indicators for income year 2004 (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years. Due to 2002 and 2005 break in time series the large year to year differences that can be noted are therefore not significant. During the transition from ECHP to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the German Socio-Economic Panel that was not fully compatible with the SILC methodology based on detailed income data.

[23] Calculated on the basis of the ad hoc scenario.

[24] The EU average was 75.8 and 81.9 years for males and females in 2004.

The gender dimension is more visible in the policy process than in previous reports, especially as regards raising the participation rate of women, broadening their occupational choice, tackling the gender pay gap, and increasing their self-employment and career opportunities through an increase in child care facilities and the introduction of a new parental allowance.

The report notes that improving general labour market participation and sustaining the social protection system directly contribute to the Lisbon objectives of economic growth and greater social cohesion. The report also identifies economic growth and more employment as essential conditions for achieving an adequate level of social protection and equal opportunities. Adequate governance of social policies is ensured through regular and institutionalised consultation of all relevant stakeholders. Hearings are regularly held in the process of adopting social protection laws. This broad participation of relevant stakeholders is also ensured in the preparation of reports, such as the national strategy report and the report on poverty and wealth, a comprehensive reporting tool.

While the report encompasses many important and relevant policy fields, the three strands of the strategy remain however largely disconnected from one another.

3. Social inclusion

3.1 Key trends

Long-term unemployment stood at 5% in 2005, compared to 3.9% in the EU-25. National data show that from September 2005 to September 2006, the number of long-term unemployed increased by 5.3%, to 1.6 million people. Long-term unemployment is a major poverty risk and could have longer-term implications when the people concerned enter pension age.

The strong correlation between parental socio-economic status and the educational attainment of children has been confirmed by recent studies. Children from a higher socio-economic background are 3.1 times more likely to enter secondary education than children from lower strata of the population. An OECD study of May 2006 shows in particular that the educational attainment prospects of children of immigrant background (i.e. second- and third-generation) are only 50% of those of comparable native children. In 2005, the early school-leaving rate was 13.8%, lower than the EU-25 rate of 15.1.

The overall at-risk-of-poverty rate stood at 13% in 2004. According to national data, there is a strong disparity between East (17.3%) and West (12%). Certain groups were more exposed, for example single parents with dependent children (30%). In July 2006, 2.1 million children (0-17) were living on the social allowance level. The unemployed had an at-risk-of-poverty rate of 42% (EU-25 40%) in 2004. For immigrants, the rate was 24% (2003), thus significantly higher than for German citizens. In-work poverty stood at 5%. The at-risk-of-poverty rate for the 65+ age group stood at 15% in 2004, but with a strong gender disparity (18% for women and 12.0% for men).

3.2 Key challenges and priorities

The 2006 joint report identified as the main challenges for social inclusion the need to ensure that the labour market reform does not adversely affect the social and economic integration of groups at risk, and to ensure the sustainable integration of immigrants.

This report responds to these challenges while taking a broader approach. It identifies seven political priorities for 2006-2008, namely enhancing labour market participation, reducing disadvantages in education and vocational training, modernising child and family policies to eradicate child poverty, improving the integration of immigrants, fighting discrimination against disabled people, strengthening the role of social services and civil society and improving governance.

With these priorities, the proposed strategy should help improve access to resources, rights and services for all, which constitutes one of the Common Objectives for social inclusion. In the field of education and training, for example, the report describes numerous initiatives at different government levels to improve access.

The continued emphasis on labour market participation will also contribute to the second Common Objective for social inclusion. Concerning the coordination of social policies at all levels — the third Common Objective — the report demonstrates good progress in comparison with former National Action Plans. It draws a clear picture of the division of tasks in the field of social inclusion between the Federal government, *Länder* and the local authorities.

Based on the 2006 National Strategic Reference Framework, the ESF will shift its focus from the integration of disadvantaged groups within the labour market to adaptability and human capital. While social inclusion is not identified as a separate priority within the forthcoming ESF programmes, a number of relevant actions will be supported, in particular for young people, such as improvements in the education and training system and the integration of immigrants into the labour market.

The general approach of the inclusion strand consists in providing equal opportunities for all and ensuring a fair balance between solidarity and individual responsibility. While the choice of priorities in the report seems fully justified, targets for inclusion are seldom defined.

3.3 Policy measures

In order to enhance the labour market participation of low-qualified workers, immigrants, older workers and young people, a number of measures are planned or already partially implemented. In 62 regions, for example, the employment of older workers is to be boosted through the programme "Perspektive 50 plus". This aims at raising the effective labour market exit age, which stood at 61.3 in 2005. This is in line with the policy of raising the pension age to 67 by 2029. However, the 2005 Hartz IV reform package is not yet fully implemented. The new administrative structures responsible for supporting the long-term unemployed (ARGEs) have not been delivering a satisfactory level of service, as a recent report by the Federal Court of Auditors has revealed. In reaction to the report, the Federal Labour Ministry in cooperation with the Federal Employment Office has issued new guidelines to improve the functioning and level of services provided by the ARGEs. Additional training for case managers and recommendations for better integration services have been provided. Financial and administrative incentives for the low-qualified to enter the labour market, on the one hand, and the availability of job opportunities for this group, on the other, merit further attention. The Government is planning an initiative to improve labour market prospects for the low-qualified.

Improving equal opportunities in education for all strata of the population by supporting children from disadvantaged families at a very early stage is pursued by a package of

measures in cooperation with the *Länder*. The programme "FörMig" aims to improve the reading and writing skills of children. For the transition from school to the labour market, the recently introduced Federal programme, EQJ, helps disadvantaged young people to qualify for an apprenticeship. As this tool has proved to be successful, the number of available places has been significantly increased for 2006 and 2007.

To ease the situation of families, a package of financial and support measures has been put in place. Here, the emphasis is on support measures — rather than increased financial transfers — for families in need, such as the expansion of care services and comprehensive counselling services. However, the effectiveness of these measures will depend on the resources of the local authorities, which carry the main responsibility for financing measures for children and families.

The language courses for newly arrived immigrants will be continued in the reporting period and given an added value by revising the system of immigrant counselling agencies. Individual migrants have access to these services for the first three years after arrival in Germany.

The four European Antidiscrimination Directives were transposed into German law in 2006. This should improve the opportunities for people with disabilities to participate in social and working life. The compulsory implementation of a personal budget in 2008 for each person in rehabilitation empowers disabled persons to organise their personal pathways back into society through appropriate measures. The success of this new approach has been confirmed recently by the published results of pilot projects.

As regards the last priority, strengthening the role of social services, the report is somewhat limited but does announce an improvement in the tax regime for NGOs, which should help with their activities.

3.4 Governance

From the first NAP/Incl. in 2001, the cooperation between federal government, *Länder* and NGOs has continuously improved. This improvement is largely attributable to the parallel process for producing the Federal Poverty and Wealth Report. A "Permanent Advisory Workgroup on Social Inclusion", representing 35 important stakeholders, has been established. This workgroup was also consulted on the National Strategy Report. A stakeholder hearing on the first draft of the report took place in May 2006. In order to report on the social inclusion process in a more detailed way, some *Länder* produce their own social situation reports. With a view to improving the circulation of best-practice information within Germany, the Government has launched the project "Info-exchange: Participation and social integration". It will produce a structured web-based database on projects in the field of social inclusion.

4. Pensions

Older people have a standard of living close to that of the general population (92%). The poverty risk among older people (15% in 2004)[25] is slightly higher than that of the population below the age of 65.

Despite recent increases, the employment rate among older workers, standing at 45.4% in 2005, remains below the Lisbon target of 50%. Despite the current weak budgetary situation, the 2006 Sustainability Report assessed Germany as a medium-risk Member State as regards the sustainability of public finances, notably on account of the effects of the pension reforms enacted. According to the 2005 AWG projections, public spending on pensions will increase from 2004 to 2050 by 1.7 p.p. of GDP. According to ISG projections, the gross replacement rate of statutory pensions for a worker working for 40 years on the average wage and retiring at 65 will decrease from 43% in 2005 to 34% in 2050. The overall gross replacement rate is projected to increase from 43% to 48% by 2050 (63% to 67% net), with the decline in statutory pensions of 9 p.p. being offset by an increase of up to 15 p.p. in the private pension replacement rate (these schemes currently cover around 70% of the employed, with contributions assumed to be 4% of wages).

The 2006 Joint Report underlined the key importance of further improvements in the employment situation of older workers and improved coverage of private pensions to ensure future adequacy. In 2006, the new Government decided to increase the retirement age gradually from 65 to 67 (from 2012 until 2029 by one month a year and then two months a year, the first generation to be affected being those born in 1947). People with more than 45 validated insurance years (including validated periods of child care) will still be allowed to retire at 65 without reductions. Germany is terminating early retirement paths within a fairly short transition period and is focusing on improving employment among older workers with the programme "Initiative 50plus".

As people take advantage of the opportunities for supplementary provision, it is expected that the replacement rate can be kept more or less constant for a given age and that the increase in the employment of older workers will enable them to accrue higher pensions. In order to help ensure future adequacy, voluntary private provision, either through occupational or personal pension schemes, is strongly subsidised through tax allowances and direct public grants, especially for low-income groups and for people raising children. For the latter, further increases in incentives are to be introduced from 2008, while a general information campaign will be launched in early 2007. The future adequacy of overall pension provision will depend on the take-up rates of these new opportunities and on the improvement in the employment of older workers. The Federal Government will report every four years on trends in the adequacy and sustainability of the pension system as well as the employment of older employees.

5. Health and long-term care

5.1 Health Care

[25] These income figures do not include negative capital income, imputed rent from private housing, or in-kind benefits or services, and possibly ignore some specific in-cash benefits, which gives an incomplete picture of the income situation, in particular for older people. Accumulated wealth, which is higher for older people, should also be considered when comparing living standards across generations, but due to data limitations this is not possible for all countries. As from 2008, EU-SILC is expected to include imputed rents in the definition of income.

Description of the System: The health care system is decentralised, characterised by federalism and delegation to self-administered non-governmental bodies, which are the main actors in the social health insurance system: The sickness funds and their associations on the purchaser side, and the physicians' and dentists' associations on the provider side. Hospitals are on the other hand represented by organizations based on private law. These actors are organised at both federal and regional (*Land*) level. The 253 health funds (2006) collect contributions for the statutory health care and long-term care insurances, and negotiate contracts with the health or long-term care providers. The Ministry of Health proposes health legislation that, when passed by parliament, defines the legislative framework for the social health insurance system. It also supervises the non-governmental bodies and, with the assistance of subordinate authorities, undertakes various licensing and supervisory functions, scientific work and information services. The range of services available under statutory health insurance is laid down by the legislator and further defined by the self-administration of the health insurance providers and service providers in the Joint Federal Committee. The catalogue of services is largely uniform and applies across all types of insurance providers. Services are not divided into basic and optional services. However, individual options are offered by health insurance providers for separately defined areas of services. Since 1996, almost all insured persons have had the right to choose a health fund freely, while funds are obliged to accept any applicant.

Accessibility: The 2006 National Strategy Report states that 74% of German citizens have mandatory health insurance. Another 15% are voluntarily insured with a statutory health insurance provider. The spouses and children of people with statutory health insurance are also insured without having to pay contributions under certain conditions. Some 10% of the population have private health insurance, of whom approximately half are civil servants who have only a proportion of their sickness costs covered by private insurance. However, a small but growing number of citizens have been found to be outside the insurance systems and have problems to (re)enter them. The currently proposed new law aims to ensure that all citizens are covered by health insurance. A need for action has been seen with respect to the nation-wide distribution of physicians[26], especially general practitioners. Thus the law governing the contractual relationships between physicians and the statutory health insurance has been liberalised in order to give incentives for a better distribution of physicians, especially in the new *Länder* and rural areas.

Quality: There is a legal requirement making quality assurance obligatory for all service providers in out-patient and in-patient provision, which expressly gives them responsibility for the quality and efficiency of their services, including regularly certified further training for doctors. The law requires statutory doctors, hospitals and out-patient and in-patient preventive and rehabilitation facilities to set up internal quality management systems. This internal quality assurance is coupled with external quality and effectiveness assurance, so that quality can also be assessed in comparison with others and any quality deficits can be recognised and remedied. Hospitals are required by law to write a structured quality report every two years, enabling interested parties to ascertain the type and number of services provided in the hospital and the quality improvement measures carried out. An agency (DIMDI) has set up and operates a database information system to evaluate the efficiency and effectiveness of health technologies. Integrated care is promoted by GP networks, health centres, the opening of hospitals for out-patient care as well as bonus programmes for health-conscious behaviour. An electronic patient card will be introduced gradually.

[26] National Reform Program Germany 2005 – 2008, Implementation and progress report 2006.

Long-term sustainability: Total healthcare expenditure in 2004 was 10,6 % of GDP and 3043 PPP$ per capita, above the EU average (8.87% and 2376) and the highest in EU as a % of GDP.[27] The share of GDP was 8.5% in 1990 and 10,3 % in 2000. The share of public healthcare expenditure as a percentage of total health care expenditure decreased from 81,5 % in 1992, after reunification, to 76,9 % in 2004. According to the 2006 EPC/EC projections public health care expenditure is projected to increase by 1.2 percentage points of GDP by 2050 due to population ageing. The 2006 National Strategy Report notes that Germany has a high ratio of health expenditure to GDP, which is seen as an expression of comprehensive health care provision, but - on the other hand – raise questions as to the efficiency of the health system. The poor development of wages combined with continuing high unemployment has led to reduced contribution payments to statutory health insurance in recent years and contributes to a structural income weakness in statutory health insurance. The 2006 implementation and progress report on Germany's National Reform Programme 2005 – 2008 reports on the reform concept for the sustainable financing of statutory health insurance and for further quality and efficiency improvements. With some of the social tasks of statutory health insurance being financed from the federal budget, the resources of statutory health insurance will be placed on a more stable, more equitable and employment-promoting basis in the long run. A grant of €2.5 billion will be made available from the 2007 budget, and is to be increased in the following years. The financial reforms to be initiated this year will also be linked with the reform of health care structures in order to ensure that the funds available will be used more efficiently and more effectively in the future. On 25 October 2006, the federal government adopted a proposal for an extensive law to strengthen competition in statutory health insurance (GKV-WSG), which will now be debated in the Bundestag with the aim of having it come into force on 1 April 2007.

5.2 Long-term care

Description of the system: The public long-term care insurance scheme, introduced in 1995 as the fifth pillar of the social security system, covers the risk of needing permanent, extensive care. Insurance is mandatory in line with the principle that long-term care insurance follows health insurance. Consequently, almost the entire population is insured against the risk of needing (non-medical) long-term care. All insured in a statutory health insurance scheme are members of the related long-term care insurance scheme. All persons with private health insurance, or in a special system, are members of a private long-term care insurance scheme. The benefits are fixed by law and identical in both systems. They depend on the extent of the need for care, but are granted as a lump sum irrespective of age, income or wealth. Long-term care benefits are separate from other insurance entitlements that are related purely to illness and thus come under health insurance (e.g. entitlement to a home help or a district nurse in the event of illness or to prevent a hospital stay). In addition, supplementary general care services are often available to those in need of care and to their family members. These are mainly provided by local authorities and charities.

Accessibility: Access to the services of long-term care insurance is possible for all insured people in the Federal Republic of Germany if the requirements under insurance law are met. This means that almost the whole population is included in the protection of social long-term care insurance and private long-term care insurance. While this ensures universal coverage,

[27] WHO Regional Office for Europe, European health for all database (HFA-DB), updated June 2006. (The OECD Health Data 2006, updated 10 Oct, reports for Germany in 2004: 10.6% of GDP and 3043 PPP$).

there is debate in Germany on how to ensure access in future, including the specific contributions that the long-term care insurance can or should make towards the total cost of care, notably in cases of intensive care needs.

Quality: Because of demographic developments, the number of people needing care is expected to increase. Against this background, ensuring the provision of high-quality care in future requires that (1) an appropriate number of adequately trained personnel, (2) internal measures in the care institutions to ensure and develop quality and (3) appropriate contractual agreements with insurance funds to enable the care institutions to meet their responsibilities. Well trained, skilled specialist staff is essential to ensure appropriate care quality. The new professional regulations in the Act on the Care of the Elderly and the Nursing Act therefore aim to improve training in the care professions and increase their attractiveness. The development of modules for culture-sensitive care for the elderly and in nursing, and including them in training, will help to improve the quality of care for immigrants, as will training for people from immigrant backgrounds in the care professions. These new provisions are a response to the debate on the quality of care and the questions raised in a number of cases regarding respect for the rights of those receiving care.

Long-term Sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is projected to increase from 1.0 % of GDP in 2004 to 2 % of GDP by 2050 due to population ageing, if benefits rise in line with GDP per worker. According to an alternative scenario, expenditure will stay constant at 1.0 % of GDP assuming that benefits rise in line with the general inflation rate[28]. A legislative proposal for sustainable and fair financing will also be presented for long-term care insurance, in 2007. Among other things, it should take account of the need to supplement the system with capital-covered elements such as a demographic reserve and to harmonise the different risk structures of social and private long-term care insurance schemes. The proposal will also depend on the final form of the new legislation for the health insurance system.

6. Challenges ahead

To ensure that the continued implementation and revision of the 2005 labour market reforms effectively supports the long-term unemployed and people furthest away from the labour market.

To promote the sustainable and active social inclusion of immigrants and persons of immigrant background (second and third generation) into society, in particular through adequate access to education and vocational training and measures to support their integration on the labour market.

To break the intergenerational transmission of poverty by increasing educational opportunities at all levels for disadvantaged groups and securing early intervention services for disadvantaged families.

[28] This scenario has been developed by the EPC to better reflect the German system of long term care with nominally fixed benefits that have not been amended since the introduction of long term care insurance in 1995. A future dynamic sampling of the benefits in line with the general inflation rate is discussed as an element of the forthcoming reform.

To ensure the adequacy and the long-term sustainability of pensions, notably by further promoting longer working life and increased participation in supplementary pension provision.

To finalise a sustainable reform for the health care system, improving financing and efficiency while maintaining high quality standards, and implement this reform in 2007, and to finalise in 2007 a similar reform for the long-term care insurance system.

To improve the geographical distribution of physicians, especially outpatient general practitioners in the new *Länder* and some rural areas, e.g. by successful implementation of the amended law that governs the contractual relationship between physicians and the statutory health insurance.

Germany : data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,2	111,7	**2000**	65,6	72,9	58,1	47,2	37,6	**2000**	7,2	6,0	8,7	10,6
2002	0.0	108.5	**2002**	65.4	71.8	58.9	45.7	38.9	**2002**	8.2	7.1	9.4	14.2
2004	1.2	111.1	**2004**	65.0	70.8	59.2	41.9	41.8	**2004**	9.5	8.7	10.5	15.0
2006	2.5	110.1	**2005**	65.4b	71.2b	59.6b	42.0b	45.4b	**2005**	9.5	8.8	10.3	14.8

** Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); b: break in data series*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	73.3	79.7	14.7	18.5	60.0	64.3	5.3	**1995**	10.6	80.5	-		
2000	75.0	81.0	15.7	19.4	63.2e	64.6e	4.4	**2000**	10.6	78.6	10.6	90.9	18.2
2004	76.5sp	81.9sp	16.7sp	20.1sp	65.0e	64.7e	4.1	**2004**	10.9	78.1	10.5		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	28.2	42.7	31	9	7.5	2.9	6.8
2000	29.2	42.4	28.3	8.4	10.6	2.6	7.8
2004	29.5	43.5	27.2	8.6	10.5	2.5	7.7

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio**	expenditure (% of GDP) Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long term care ***
2005	27.8	23.7	11.4	6.0	1
2010	30.7	-1.2	- 0.9	0.3	0
2030	44	-1	0.9	0.9	0.4
2050	52	2.7	1.7	1.4	1

** including administrative costs* *** based on the ad hoc scenario*
****Under the assumption that benefits are dynamised in line with general inflation, the expenditure level stays unchanged in 2030 and 2050.*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13b	14b	13b	12b	15b	20b	18b	21b	22b	18b	**Total**	4.1b
male	12b	-	11b	11b	12b	21b	-	22b	23b	19b	**male**	-
femal	14b	-	15b	14b	18b	20b	-	20b	22b	17b	**female**	-

	People living in jobless households				Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female	Total	male	female		Total	male	female
1999	9.5	10.5	9.5	11.4	4.1	3.2	5.2	**1999**	14.9	14.2	15.6
2004	10.9	11.1	10.8	11.4	5.4	4.8	6.1	**2004**	12.1	12.2	11.9
2006	10.5	10.6	10.4	10.9	5.0b	4.7b	5.4b	**2005**	13.8	13.5	14.1

**: excluding students; b: break in data series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0.92b	0.93b	0.90b	***Aggregate replacement ratio***	0.45b	0.44b	0.48b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Estimate of current (2002)	Assumption
4	5	-9	DB	15	DC	Nd	70		19.5	Nd	4

** (DB / NDC/ DC); ** (DB / DC)*

2.6. ESTONIA

1. Situation and key trends

Estonia is expected to achieve a 10.9% growth in total output in 2006 (2005: 9.8%, EU25 1.6%). GDP per capita rose to 57.3% of the EU average in 2005 and is predicted to reach 65% in 2007. The relative poverty rate was 18% in 2004 (EU-25 16%). Both real wages and productivity have increased rapidly, the former more than the latter. The inflation rate of 4.1% exceeded the EU average of 2.2% in 2005. Employment growth in 2006 is projected to be strong at 3.2% (2005: 2.0%, employment rate 64.4%, activity rate 70.1%), but is expected to slow down to 1.8% in 2007. In 2005, the employment rate for females was 62.1% (EU-25 56.3%), among 55 to 64-year-olds it was 56.1% (EU-25 42.5%) and for 15 to 24-year-olds 29.1% (EU-25 36.8%). The unemployment rate, which decreased from 9.7% in 2004 to 7.9% in 2005 (8.8% for males), is projected to fall further to 6.8% in 2006 and to 6% in 2007. Youth unemployment fell down from 21.4% in 2004 to 15.9% in 2005. Long-term unemployment has decreased, but was still higher (4.2%) than the EU-average (3.9%) in 2005.

The share of GDP spent on social protection was 17.1% in 2004. 39% of the total was for pensions (6.7% of GDP in 2004, projected to fall to 4.8% by 2030) and 32% for health care (5.4% of GDP in 2004, projected to rise to 6.2% by 2030). Life expectancy (66.5 and 77.9 years for males and females in 2004) is the second lowest in the EU. For men, it is 9 years less than the EU average[29]. It has increased about 4 years for men and 2.5 for women in the last decade (61.9 and 74.5 in 1995), a considerable improvement following the 1989-1994 decrease. Healthy life expectancy is low at 52.5 years for women and 49.2 years for men in 2004. Low fertility rates and increases in life expectancy will increase the old-age dependency ratio from its present 24% to 31% by 2025 and to 43% by 2050. The infant mortality rate (6.3 in 2004) is one of the highest in the EU[30] though it has seen a substantial decrease since 1960 (31.1) and in the last decade (14.9 in 1995). Perinatal mortality is high at 8, but has been consistently decreasing since 1960 (22.5).

2. Overall strategic approach

The NRS for 2006-2008 aims to support the strategic objective of achieving rapid, socially and regionally balanced and sustainable economic development. In this context, social protection systems should secure the ability of an individual to cope where social risks emerge. The strategy emphasises the primacy of work and equal opportunities for all in the prevention of poverty and social exclusion. Gender mainstreaming remains declarative.

Promoting social cohesion: The main priorities for 2006-2008 are preventing and reducing long-term unemployment and inactivity, alleviating the social exclusion of families with children, ensuring an adequate level of pensions, maintaining the financial stability of the health care services and health insurance system by widening the tax base, promoting healthy lifestyles and improving public health services, and improving life-long learning systems.

Relationship with the Lisbon Strategy. As with the NRP, the NRS is based on the State Budget Strategy and was prepared in co-operation with all the relevant Ministries, social

[29] EU average of 75.8 and 81.9 years for males and females in 2004.
[30] EU average of 4.5 in 2004.

partners and civil society. The NRS refers to the NRP 2005-2007 and notes that it has a more in-depth analysis of how social protection policies support growth and jobs and vice versa. The NRP underlines e.g. the importance of policies aimed at bringing the at-risk groups into employment with a view to reducing the pressure on the state budget resulting from the high level of social benefit payments.

Governance: The main stakeholders participated in a steering group for the preparation of the NRS. In addition, civil society in a wider sense had the opportunity to provide input. More partners are gradually becoming involved, but many still lack the competence and knowledge to take part in the process. The NRS notes the aim is to increase administrative capacities in order to support the integrated design and implementation of policies in different fields. The NRS also calls for the establishment of a permanent forum involving the steering group and NGOs to improve coordination and monitoring of the implementation of the NRS. In order to promote the more effective participation of the social partners and NGOs in this forum, it could be useful to make competence development measures available for them as well.

3. Social inclusion

3.1 Key trends

Relative poverty was 18% in 2004, the threshold value being the third lowest in the EU after LT and LV (2869 PPS in 2004). As a result of the growth in Estonians´ real income, the share of the population living in absolute poverty (the line is defined at national level in terms of minimum consumption and adjusted annually in accordance with the consumer price index) has decreased considerably in recent years (national data: adults from 32.8% in 1998 to 17% in 2004; children from 40.4% in 1998 to 25.3% in 2004).

Unemployment, in particular long-term unemployment, and economic inactivity, remain major causes for exclusion and are often connected with other risk factors. In 2004, the relative poverty rate among the unemployed was 60% and among the inactive 31%. A major part of unemployment is structural in nature, relating to skills mismatches. Long-term unemployment is more common among the over-50 and young people. The at-risk groups with difficulties in integrating within the labour market include: those with only a basic education and/or skills that do not match market needs; ethnic minorities; young people; disabled persons; and the inactive wanting to have work (7% of the working age population in 2005).

The at-risk-of-poverty rate was also higher than average among one-person households (36%) and single parents (40%) in 2003. In-work poverty at 7% was slightly lower than the EU average (8%) in 2004, and their share of the population below the relative poverty line was 28% (EU 27%). Households with dependent children accounted for 55% of the at-risk-of-poverty population and their relative poverty rate of 18% in 2004 was the same as the national average. 8.2% of all children lived in jobless households in 2006 and children comprised one fifth of the at-risk-of-poverty population in 2004. Children's at-risk-of-poverty rate was 31% before and 21% after social transfers in 2004. Social transfers excluding pensions also reduce the overall risk-of-poverty rate by six percentage points compared to the EU average of ten points.

Youth educational attainment declined from 82.3% in 2004 to 80.9% in 2005 (EU benchmark: min. 85% in 2010). The share of early school-leavers increased slightly in 2005 to 14% (EU

benchmark: max. 10% in 2010). The adult participation rate in life-long learning was 5.9%, half the EU-average in 2005.

3.2 Key challenges and priorities

The key policy challenges highlighted in the NRS are increasing labour market participation and eliminating child poverty, which reflect the challenges identified in the 2006 Joint Report for Estonia. The priority objectives for 2006-2008 for increasing social inclusion are the prevention and reduction of long-term unemployment and exclusion from the labour market; and the prevention and alleviation of poverty and social exclusion among families with children. Estonia provides a reasonably multi-dimensional synthesis of the situation and main trends to justify focussing on reducing structural unemployment and supporting children in the context of the family, although the experience of implementing the 2004 NAP/inclusion is not reported. The approach chosen is nevertheless quite compatible with the common objectives under the social inclusion strand.

Estonia has not only made extensive use of indicators to support their selection of main priorities, but has also set clear and quantified interim targets for the period covered by the plan. A multi-faceted set of measures has been outlined to achieve both strategic objectives. The budgetary impact or equivalent as well as the responsible authorities have normally been specified for the measures. The contribution of the Structural Funds, especially the ESF, to supporting the NRS objectives will be significant, in particular for active labour market measures, where the majority of funding will come from the ESF.

3.3 Policy measures

The priority objective of increasing labour market participation is supported with the following measures and targets:

Existing measures include the Strategy for Labour Market Measures approved in 2004 and the Labour Market Services and Benefits Act adopted to implement the principles of the strategy. The Act came into force on 1 January 2006. It provides for: an internship system, identifying young people and the long-term unemployed as focus groups; work practice and services for disabled people; improved access to active measures; the introduction of case management; and the principle that the unemployed must under certain conditions accept suitable work. The NRS reports that 0.12% of GDP was spent on the implementation of labour market policy in 2005, of which 74% or 0.09% of GDP was spent on active measures (Eurostat: ALMP expenditure in EE was 0.04% of GDP and the number of participants in LMP measures was 0.6 per 100 persons wanting to work in 2004).

New measures include the increase in the level of passive measures (e.g. the monthly unemployment allowance will rise to €69 in 2007 from the present €25) to motivate and support the unemployed in seeking work. The planned increase in the State budget is 90% in 2006 and 23% in 2007. A system of in-service retraining and a single system of professional and career counselling will be created; employment services will be extended to working people; and a service to respond to collective redundancies will be tested as part of an ESF project. The planned amount for ALMP in 2006 is €20.5m (115% increase) of which €12.1m from ESF. In 2007, the amount will be €17.2m (16% decrease), of which €9.1m will be from the ESF. In addition to labour market measures, the intention is to encourage flexible forms of work (only 16.5% of employees were in non-standard employment or self-employed, compared with the EU average of 39.6% in 2005), to encourage a more employee-friendly

working environment, to develop welfare and other public services supporting employment, and to utilise opportunities provided by information and communication technology.

Targets for 2008 are: an employment rate of 69% (2005: 64.4%); an activity rate of 73.1% (2005: 70.1%); a long-term unemployment rate of 2.7% (2005: 4.2%); and the number of long-term unemployed cut to 18 500 (national data 2005: 27 900)

Best practices include two ESF projects: The 'Pilot Project of Home Care Workers' targeted to 100 unemployed persons from ethnic minorities with the aim of training them to return to the labour market as home care workers. 88 passed the training and the objective is to have 60 home care workers employed by local authorities. The other project 'Training Unemployed Persons as Call Center Operators' involved 390 persons, and 95% of them are now employed.

The priority objective of eliminating child poverty is supported with the following measures and targets:

Existing measures are based on the Child Welfare Strategy adopted in 2004. In 2006, the duration of parental benefit was extended to 455 days (100% of average monthly pay during the previous year); the quarterly benefit for families with three children was increased to €19 and with four or more children to €29; the childbirth allowance and adoption allowance were raised to €320. In addition to the financial support there are a number of measures that have an important role in addressing social inclusion risks: rehabilitation plans for disabled children and delinquent children; an agreed method for calculating maintenance costs; support persons; free phone line; and training to develop networks around an abused child. An increase in the ratio of child protection officials in local authorities is also planned.

New measures comprise: upgrading child benefit from €19 to €57; improving counselling services; training in social and parenting skills; strengthening of co-operation networks; enhancing the housing conditions of families with children; creation of equal opportunities to obtain good education; improving development opportunities for children belonging to specific risk groups; and addressing children's special needs e.g. intervention strategies for school violence and improving leisure opportunities.

Targets for 2008 comprise: reducing the number of children living below the relative poverty line by 2% compared to 2005 (2004: 21%); the difference between the absolute poverty rate among children (0-15 years) and that of total population being 7.9% (national data 2004: 8.3%); increasing the number of child protection officials to one per 1000 children (baseline not given); and increasing the participation of children with special development needs in kindergartens or pre-school classes (not quantified). A further target is to increase the ratio of child care staff per child to 1:6.

3.4 Governance

A steering committee involving the ministries and social partners and a representative of the NGOs was convened to ensure the inclusion of stakeholders in the preparation of the NRS. In addition, an informal umbrella organisation was established to allow the third sector to participate in a more meaningful way. For better coordination and monitoring of the implementation of the NRS, the Ministry of Social Affairs will call upon a permanent round table consisting of the steering committee and NGOs. This will be a useful contribution to strengthening the monitoring of the process, although the NRS could also have outlined the

extent to which independent evaluation will be used to feed into the process. All in all the governance arrangements nevertheless appear slightly stronger than before.

4. Pensions

Older people have a standard of living relatively close to that of the general population (73% in 2003), while the poverty rate among the elderly is currently 20% (gender differences are high: 10% for men and 26% for women), slightly higher than for the 0-64 population.

The 2006 Sustainability Report assessed Estonia as a low-risk Member State as regards the sustainability of public finances. According to the AWG 2005 projections, Estonia will see a noticeable fall in spending on public pensions (from 6.7% of GDP in 2004 to 4.2% in 2050), linked to the diversion of part of the social security pension contributions into privately funded schemes (for the mandatory funded system, pension expenditure will stay stable from 6.7% in 2004 to 6.6% in 2050). According to ISG calculations, the theoretical net replacement rate was 41% in 2005 (gross replacement rate 33%) and is projected to remain roughly constant until 2050. This reflects a steady decrease in the replacement rate provided by the first tier of the first pillar (from a 33% gross replacement rate in 2005 to 15% in 2050), while the contribution of the funded tier is projected to reach a gross replacement of 13% in 2030 and 21% in 2050. These replacement rates are predicated on a worker contributing for 40 years, but with the higher reliance on funded provision inherent in the reformed system, those with interrupted work patterns are less likely to achieve these levels.

The Joint Report of 2006 highlighted the financial sustainability of the overall Estonian pension system, and the success in achieving high employment rates for both women and older people. However, the challenges facing the system were the adequacy of current pensions and the possibility of further declines in the future. The report also noted the availability of early retirement schemes. On this last point, the updated report mentions the possibility of reducing access to such schemes, though it gives no indication of how or when this will be achieved.

The reform of the Estonian public pension scheme introduced a strong link between pensions and individual contributions as well as mandatory and voluntary funded tiers. Transition costs are estimated to be moderate, requiring additional public subsidies only during the period from 2007 to 2012. The implementation of the mandatory funded scheme has also had a positive impact on the coverage of voluntary funded schemes. While poverty rates among the elderly are moderate at present, the main challenge is the future adequacy of pensions, as current replacement rates are already rather low and projected to decline even further. Although the employment rate among older workers is in line with the Lisbon target, attention should be paid to special retirement schemes where retirement ages remain considerably lower than in the public PAYG old-age pension scheme. Moreover, the mandatory funded component of the system still requires further legislation to define the arrangements for paying out benefits from 2009 onwards.

5. Health and long-term care

5.1. Health care

Description of the system: The Estonian Health Insurance Fund (EHIF) purchases and reimburses care for about 94% of the population based on residence and group membership (e.g. the unemployed, children, pensioners, full-time carers). Provision is decentralised and

mostly public, though private provision is increasing. Residents register with primary health care (PHC) doctor, who provide general medical care and health promotion and prevention services and play a gate-keeping role for specialist and hospital care. Ambulatory specialist care is provided in health centres, hospital outpatient departments and specialists' own practices. Inpatient care is provided in regional, central and local hospitals (mostly owned by municipalities or the state). Outpatient and inpatient care providers (either private or public) enter into contracts with the EHIF. The EHIF pays family doctors on a capitation basis plus fees for home visits. Other staff are salaried. The system is financed primarily through an earmarked payroll tax on employees (in practice employers) and the self-employed and through taxation (that pays for ambulance and emergency care and promotion and prevention). Co-payments apply to home and outpatient visits, hospital stay and drugs. Adult dental care is not covered by EHIF. Out-of-pocket payments are paid to any non-EHIF contracted provider. Recognising as challenges the low health status of the population, access barriers and the clear need for resources, the authorities are aiming to improve population health through more promotion and prevention activities, to ensure an homogeneous geographic availability of services, to extend population coverage, to implement a well-functioning PHC sector and to allocate additional resources to the sector, while maintaining the sustainability of the system in both financial and human resources terms.

Accessibility: The report states that though population coverage is high, 6% of the population is not insured. The authorities, who have already extended coverage to those on unemployment benefits, are considering ways (e.g. local government insurance) to extend coverage to other groups now only covered for emergency care. The authorities argue that PHC accessibility is good with 99.8% of patients able to see a family doctor within the prescribed 3 days (the number of GPs per 100 000 inhabitant is one of the highest in the EU: 95.1). To tackle geographic disparities in access (e.g. the uneven distribution of important specialities), the authorities are planning a PHC network with services close to the patient's place of residence. A free 24-hour phone line has also been set up. They also want to ensure that everyone can reach special medical care within an hour. The report indicates that to better organise waiting lists hospitals are providing information to the NHIF, which publishes it on line (and which is to also allow patients greater hospital choice in future). It also notes that to tackle long waits there are national/ central waiting lists for certain services and extra funding has been allocated to the specialties with the longest lists. Data show that private spending is high (out-of-pocket payments were 21.3% of total health expenditure in 2004) due to increasing co-payments and an increasing number of treatments being excluded (e.g. dental care) from the benefits package. This may place a financial burden on more vulnerable groups and indeed there are socio-economic (income) differences in the use of health services. The authorities wish to improve access with the planned increase in the sector's funding.

Quality: According to the report, to the improve quality of care specific requirements for providers are being set up, whereby the Health Care Board (HCB) licenses and controls the providers, clinical guidelines (best practice) are being implemented and the EHIF together with the WHO have started to develop a system of hospital quality indicators. The authorities see the greater use of ICT and eHealth solutions as a means to improve access by filling service gaps in certain areas, but also and importantly as a way to improve standardised data gathering for monitoring and planning, to offer better information for providers on standards and guidelines and to improve coordination between providers and services. They also emphasise patient choice and involvement as a quality dimension. Hence, patients can choose and change their family doctors at any time and can choose any specialist within a region and, in the future, in any region. Patient complaints are dealt with by the HCB, patient associations

are now included in some national disease strategies and in certain committees, and satisfaction surveys were launched. The government expects digital patient information to reduce complications and lead to better diagnosis and treatment. Cooperation networks (i.e. family doctors, nurses and some specialists) are seen as a way to improve the offer of integrated care. Guidelines and multidisciplinary teams are envisaged in the rehabilitation field.

Long-term sustainability: Total health expenditure (5.5% of GDP and 776 per capita PPP$ in 2004) is the EU lowest and well below the EU average[31]. It has decreased in GDP terms in the last decade though it has increased in per capita terms. GDP growth may partly explain this trend. The share of public expenditure in total expenditure (76% in 2004) has decreased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 1.1 percentage points of GDP by 2050. Hence, it may be feasible to increase state expenditure notably to enhance effective promotion and prevention, to increase coverage and to reduce financial barriers to access. The authorities are planning to widen the (earmarked payroll) tax base (increasing the rate of tax and extending the population base) to add resources to the sector. To enhance efficiency they want to continue reducing the number of beds (which stills exceeds targets) and average hospital stay while increasing the proportion of outpatient and day-case care and PHC (ensuring an effective referral system). These measures are to be coupled with cost-based prices and DRG-based payment for inpatient care. The authorities see maintaining sufficient human resources as a serious challenge due to the migration of qualified staff to Western Europe (staff numbers dropped by 24% during the 1990s) and shortages of nursing personnel. A voluntary re-registration system and an additional fee-for service payment for GPs for preventive care services are seen as means to motivate personnel. They also highlight the need for stronger promotion and prevention to address risk factors (tobacco, alcohol, drugs, diet, exercise, environment) and specific diseases and to ensure health-supporting environments that facilitate healthy choices. Specific strategies include: Heart and Physical Activities, School Health Care, HIV/AIDS and tuberculosis. Cooperation is sought with the private and social sector. Strong emphasis is placed on extending the coverage of occupational health and the availability of related services (e.g. medical buses in rural areas).

5.2. Long-term care

Description of the system: The health care system provides medical care, nursing care in institutions or hospitals, geriatric assessment, home PHC and home nursing care. These services are paid by the EHIF. The welfare system provides care in institutions, day care centres, home care, housing services (e.g. house adjustment, cleaning, food) and other social services. The municipalities are responsible for providing these services or purchasing them from state and local agencies and the private sector. Caregivers receive an allowance to reimburse care costs or alleviate their care burden. A social worker together with the family doctor or a geriatric team considers and chooses between forms of care based on the person's needs and financial situation. The authorities put emphasis on: developing home-based care that helps people remain in their homes for as long as possible, developing institutional care for when necessary, developing human resources and promoting healthy ageing.

Accessibility: Institutional and community services have been increasing. Acute hospital capacity is to be transformed into nursing care beds. Local authorities should pay for the full

[31] EU average of 8.87% and 2376.33 in 2004.

costs of institutional care for those on low incomes. The authorities want to concentrate on enhancing home-based services to improve access (and reduce costs) through additional sector funding. Home care is still not provided by 30% of local authorities. The reduced availability of services forces people to use institutional care (also more expensive for the state). It also makes it easier for richer vis-à-vis poorer households to find private solutions which can impose an excessive financial burden on poorer households.

Quality: County governors monitor the quality of social services and deal with patient complaints. To enhance quality, the authorities plan a set of uniform minimum standards to replace the current very general standards that resulted in different geographic service quality. This is to be coupled with workers registration and the licensing of provision. Recognising that the separation between health and welfare services does not always ensure the quality of services and patient flows across services, the authorities are defining levels of care under an integrated care structure with multifunctional institutions and a multidisciplinary team assessment.

Long-term sustainability: The joint municipal provision of services and cooperation between local authorities and different stakeholders are seen by the government as ways to reduce costs or provide extra care in an efficient manner. They regard the number of nursing personnel and therapists as insufficient to ensure care provision. Estonia is also focusing on healthy and active life-styles and equal opportunities for the elderly.

6. Challenges ahead

To continue increasing labour market participation of at-risk groups, through a combination of properly financed active labour market policies and effective monitoring of the increased participation of disadvantaged groups, as well as by promoting flexible forms of work.

To reduce the high risk of poverty among families with children by focusing on the income, housing, educational and social needs of disadvantaged families.

To ensure that sufficient resources are available to guarantee overall adequacy of pensions and to organise the conversion of pension savings into safe annuities;

To improve the population and geographical coverage of care, reduce patient's financial burden of care, to tackle long waiting times and enhance the provision of home and community-based long-term care services.

To allocate additional and needed resources to the sector in view of the low health status of the population and existing access barriers while improving the efficiency and coordination of services and improving health status through promotion and prevention strategies.

Estonia: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	10.8	42.1	**2000**	60.4	64.3	56.9	28.3	46.3	**2000**	12.8	13.8	11.8	23.9
2002	8.0	46.8	**2002**	62.0	66.5	57.9	28.2	51.6	**2002**	10.3	10.8	9.7	17.6
2004	8.1	53.4	**2004**	63.0	66.4	60.0	27.2	52.4	**2004**	9.7	10.4	8.9	21.7
2006	10.9f	65.0f	**2005**	64.4	67.0	62.1	29.1	56.1	**2005**	7.9	8.8	7.1	15.9

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate		Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	61.9	74.5	12.0	16.1	n/a	n/a	14.9	**1995**	5.9		-		
2000	65.6	76.4	12.7	16.9	n/a	n/a	8.4	**2000**	5.5	77.5	19.9		
2004	66.5sp	77.9sp	13.0sp	17.8sp	n/a	n/a	6.3	**2004**	5.5	76.0	21.3		

s: Eurostat estimate; p: provisional ** Total Health Expenditure* ** Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	14.0	45.3	32.1	1.3	11.9	2.7	6.6
2004	13.4	43.7	31.5	1.6	12.7	1.5	9.1

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	24.1	17.1	6.7	5.4	
2010	24.7	-0.6			
2030	33.4	-2.3	-1.9	0.8	
2050	43.1	-2.7	-2.5	1.1	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	18	21	18	17	20	24	30	22	29	11	**Total**	5.9
Male	17	-	16	17	10	29	-	29	31	13	**Male**	-
femal	19	-	19	17	26	21	-	19	28	11	**Female**	-

	People living in jobless households				Long-term unemployment rate			Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64			% of people aged 18-24		
	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female
1999	10.2	10.4	10.5	10.4	5.0	5.5	4.5	14.0	19.0	9.2
2004	9.6	9.5	10.2	8.7	5.0	5.6	4.4	13.7	20.5	na
2006	8.2	6.0	6.1	5.8	4.2	4.2	4.2	14.0	17.4u	10.7u

** excluding students* *u: unreliable*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.728	0.757	0.698	***Aggregate replacement ratio***	0.467	0.402	0.54

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or social security)	pensions: Current estimate (2002)	pensions: Assumption
2	3	3	DB / DC			100		22		

**(DB / NDC/ DC); ** (DB / DC)*

2.7. IRELAND

1. Situation and key trends

GDP growth of 4.7% in 2005 ensured that the economy continues to grow appreciably above average EU rates (1.6%). Forecasts for 2006 estimate an increase in GDP growth of 5.3%, although there are concerns that there is an over-reliance on the construction sector. Employment rates continue to grow and, if current trends are sustained, IE is likely to achieve all quantitative Lisbon targets on employment. The overall employment rate in 2005 stood at 67.6 %, the male employment rate was 76.9% and female employment 58.3%.Employment amongst those aged 15-24 (48.7%) and employment amongst those aged 55-64 (51.6%) are both above EU averages.

IE unemployment remains low and stable at 4.4% (2005).Whileoverall activity rates (70.8%) now exceed the EU averages (70.2% in 2005), there are continuing constraints, notably in relation to care services, which limit the capacity of some categories – e.g. families with children (particularly lone parents) - to participate in the labour market.

At 20% in 2004, the at-risk-of-poverty rate remained substantially above the EU average (16% in 2004). At-risk-of-poverty rates are particularly high amongst older people living alone and lone parents, though more recent national data from 2005 indicate that at-risk-of-poverty rates for these categories have been significantly reduced, reflecting the impact and focus of the Irish social security system on people on the lowest incomes.

Life expectancy at birth (75.8 and 80.7 for males and females in 2003) is about the EU average. It has increased by about three years for men and two years for women over the last decade (72.9 and 78.4 in 1995). It has risen consistently since 1970 (68.54 and 73.19). Healthy life expectancy (63.4 for males and 65.4 for females) is slightly below the EU15 average (64.5 and 66 respectively) but it has not changed much for men since 1995 and it shows a small reduction for women (67.6 in 1999). The infant mortality rate (4.9 in 2004) is about the EU average and shows a large reduction since 1960 (29.3) though it decreased more slowly in the last decade (6.4 in 1995). Perinatal mortality is however rather high (9.2 in 2001).

The current old-age dependency ratio (16.5 in 2005) is considerably below the EU average, but is projected to increase significantly to reach 45.3 by 2050.

Gross social protection expenditure amounted to some 17% of GDP in 2004, which is substantially below the EU average (27.3%). The very significant growth in GDP, however, means that the very significant real increases in benefit rates and child income support introduced in recent years is somewhat masked. Further explanatory factors for the lower levels of social protection expenditure in IE include the lower proportion of pensioners and the reliance on private pension provision to supplement flat-rate State pensions; and lower spending on unemployment benefits in the light of sustained low unemployment figures.

2. Overall strategic approach

The Irish National Strategy Report can generally be said to contain a coherent strategic approach which builds upon the achievements of the earlier National Anti-Poverty Strategy and the National Plan against Poverty and Social Exclusion 2003-05. Mirroring the outcome

of the negotiations on a new Social Partnership Agreement, *Towards 2016*, it adopts a lifecycle approach which makes for a cogent analysis of the issues being addressed in tackling social exclusion.

The four priorities identified - child poverty, access to quality employment, integration of immigrants, and access to quality services – are appropriate and consistent with EU priorities and in most cases clear, ambitious but achievable targets are included, again drawing to a considerable extent from *Towards 2016*. A notable weakness, however, is the absence of any explicit targets in relation to poverty reduction. It is important to note that IE will shortly complete a separate new National Action Plan for Social Inclusion in parallel with, and complementary to, the forthcoming National Development Plan 2007-13. While a certain caution towards the setting of poverty reduction targets (even in relation to the national consistent poverty measure) can be discerned in the Strategy Report, it is expected that this new Plan will clearly address this issue. At a wider level, the streamlining of Action Plans on Poverty and the NDP must be viewed as a positive step, since it should facilitate greater coherence in policy development and more effective mainstreaming of poverty and social exclusion issues across all policy domains.

The linkages with the National Reform Programme will be addressed within the context of the Steering Group, chaired by the Secretary-General of the Department of the Taoiseach (Prime Minister) and representing the Government and the Social Partners, charged with overseeing the implementation of *Towards 2016*. This Group will periodically review progress in implementing key strategies including the NSSPI, the NAP/Inclusion 2006-08, the National Development Programme 2007-13 and the National Reform Programme.

3. Social inclusion

3.1 Key trends

The economic background in Ireland remains positive with strong GDP growth and a vibrant labour market predicted to continue over the coming years. There are concerns however that growth is excessively linked to domestic consumption and notably to the construction sector, and there is some concern too at the relatively high levels of inflation currently being experienced. Of particular significance is the net migration experienced in recent years with population growth, largely fuelled by immigration, of 8.1% being recorded between 2002 and 2006. This presents a new set of challenges to be faced in terms of integration and service provision.

While the latest figures for the national 'consistent poverty' measure show positive results, down from 8.8% (2003) to 6.8% in 2004, it is not possible to measure trends over the longer term owing to methodological issues associated with the change from the ECHP to the EU-SILC.

IE argues that the high levels of people at risk of poverty (20% in 2004) is attributable primarily to an increase in the median income driven by a significant shift from one to two income households (itself a consequence of increased female workforce participation). While the impact of rapid economic growth and associated household structural changes over the past decade does tend to mask the very significant investment in welfare benefits over the same period, the underlying high proportion at risk of poverty also reflects the structure of the Irish welfare system (based on flat-rate benefits) and points to a continued level of inequality in Irish society which must be a matter for concern. Expenditure on public social expenditure

in Ireland (15.5% in 2004) is considerably below the EU average (23.4%). Families with children (particularly lone parents), older people living alone and people with disabilities are particularly vulnerable to being at risk of poverty. It is notable also that there is an increasing prevalence of people in employment who are at risk of poverty, reflecting primarily those who are engaged in low-paid and/or part-time work.

3.2 Key challenges and priorities

The strategic approach can be viewed as a further development of the strategy followed in Ireland to date in the National Anti-Poverty Strategy and the previous NAP/inclusion and sets out the intention to continue reform of the social welfare system, to address access to the labour market, enhance employability and improve access to better quality education, health and other services. The strategic framework adopted mirrors that contained in the recently concluded social partnership agreement – *Towards 2016. T*he major innovation in *Towards 2016* in relation to social policy is its adoption of a life cycle approach. This divides up the population into three groups: children, people of working age and older people, (although it continues to identify people with disabilities as a separate category) and includes a set of policy goals in relation to each group, together with priority actions.

IE places a strong emphasis on the provision of enhanced services and reiterates commitments to continued investment in welfare provision.

As regards active social inclusion, the Strategy again reflects the tenor of *Towards 2016* which seeks to be more explicit than in the past in identifying the complementary relationship between social policy and economic policy. This can be seen as reflecting also the greater visibility of flexicurity as a policy driver insofar as the Strategy identifies the importance of effective interaction between social protection and growth and employment. (The creation of the new Office of the Minister for Children is also a significant development in terms of structures designed to facilitate effective implementation of the lifecycle approach.) Overcoming educational disadvantage is also taken up as one of the challenges ahead for Ireland.

As regards policy co-ordination and the involvement of all actors, there are further welcome developments in the IE approach. *Towards 2016* provides for instance that a 'streamlined national social inclusion report' will be prepared annually by the Office for Social Inclusion, with the purpose of monitoring and reviewing progress at each stage of the life cycle. This development is welcomed and should help to ensure that social inclusion issues receive due weight in policy development and implementation.

The challenges identified in the 2006 Joint Report related firstly to the need to sustain investment in service provision, notably in relation to childcare and elder care; and IE can be regarded as having responded positively in this area (e.g. through the Childcare Investment Programme). The second area related to the need to address the high proportion at risk of poverty and the high level of income inequalities. While significant investment in income supports has been sustained in recent Budgets, including the 2006 Budget, the absence of an explicit commitment to setting poverty reduction targets gives some cause for concern. As noted earlier, the finalisation of a new NAP/inclusion will provide a clearer picture of IE's intentions in this regard.

3.3 Policy measures

The following four priority areas are selected: child poverty; access to quality work and learning opportunities (activation measures); integration of immigrants; and access to quality services. While by definition, identifying priority areas means that some other worthy issues are overlooked, it is perhaps regrettable that the approach adopted has the perceived effect of diminishing the priority accorded to vulnerable groups, such as Travellers, in earlier NAPs/inclusion. In general, however, the areas identified are all in need of significant attention and fit well with EU priorities.

Notwithstanding the absence of explicit child poverty reduction targets, the Report identifies a wide range of targets that will impact on child poverty in the areas of income support, childcare, tackling early school leaving, addressing educational disadvantage (notably through the implementation of the 'Delivering Equality of Opportunity in Schools' programme), and improving health outcomes. A review of child income supports is to be completed within a year. This is a critical area, given the emphasis on improving access to employment opportunities, since there is evidence to suggest that disincentives to employment within the welfare system have re-emerged as a serious issue. The key targets identified are by and large quantitative, time-limited and demonstrate an integrated approach to addressing child poverty.

The second objective focuses on increasing employment participation and access to education among marginalised groups, notably lone parents, people with disabilities, older workers and the unemployed through the removal of barriers to employment on one hand and the implementation of a new case active management service for all social welfare customers on the other. If it is to succeed, this approach will demand a more flexible response in the area of training and education provision if the needs of the target groups are to be adequately addressed (e.g. in terms of affordable and accessible childcare and the removal of rigidities in the scheduling of training). The targets set relate primarily to literacy, employment rates and investment in the Back to Education Initiative and are relatively clear and time-limited. No targets are included however in respect of the adoption of a case management approach for all social welfare customers. In 2006, substantial investments were made in employment and training supports for the unemployed and the economically inactive and programmes aimed at facilitating access to learning opportunities for low skilled disadvantaged workers

The third objective – integration of immigrants – is clearly an area of increasing relevance in IE, given the scale of inward migration in recent years. The approach outlined is wide-ranging covering service provision, active integration and anti-racist initiatives, but there is an absence of clear targets (other than to increase the number of language support teachers in schools) with continuing data shortages being advanced as the key explanatory factor. While the NSSPI does indicate that this issue is being addressed as part of the data strategy of the Office for Social Inclusion, it is important that data deficits are not allowed to become a barrier in themselves to effective early actions to address the needs of migrants and to ensure their integration into society.

The final objective relates to access to quality services and the approach outlined represents a substantial development on earlier Plans. An impressive range of policy domains - income support, health, long term care services, transport, accessible ICT, housing and accommodation, improving local environments, and investing in local infrastructure – is covered and clear targets relating to housing, health and transport are included

The approach taken to gender issues is mixed. A gender perspective is systematically included within the discussion of each policy objective, an approach which demonstrates an increased awareness of the particular issues facing men and women. This does not however translate

into gender-specific targets. The adoption of the life cycle approach, mirroring that set out in the *Towards 2016* Agreement can be characterised as 'gender-blind' with the result that the visibility of gender mainstreaming is diminished considerably.

While budgetary allocations are provided in respect of some specific actions (e.g. the National Childcare Investment Programme), and current (2006) expenditure levels are broadly outlined, the Report indicates that future proposed resource allocations will be contingent on the completion of the National Development Plan 2007-13 and on the annual budgetary process. No reference is made in the report on the possible future role of the ESF in supporting actions planned under the Strategy.

3.4 Governance

IE continues to demonstrate a clear commitment to wide-ranging consultation in the preparation of its inclusion strategy. An extensive consultation process was undertaken, including a public call for submissions, regional public consultations, a meeting of the Social Inclusion Forum and consultation with the local authorities. (There is a commitment now to establish Social Exclusion Units in half of all local authorities by end-2008, a welcome – albeit limited – development which will help to embed social exclusion-related activities more concretely within local communities.) Other seminars were run by the Combat Poverty Agency and by various community and voluntary organisations. The direct involvement of stakeholders is more limited in the areas of implementation, monitoring and evaluation although the social partners will have an oversight role through their participation in the Steering Group for the Social Partnership Agreement.

The Strategy envisages a more streamlined approach in the future to the monitoring and evaluation of social inclusion issues. The role of the Office for Social Inclusion has been enhanced under *Towards 2016* and the Office is now charged with monitoring progress on the implementation of the NSSPI, the forthcoming NAP/Inclusion and the social inclusion elements of the new National Development Plan. A single annual Social Inclusion Report will be published, commencing in June 2007. Given that a key message emerging from the consultation process centred on the need to address the 'implementation gap' in existing legislation, policy programmes and task force recommendations, it is to be hoped that the more streamlined monitoring process will in turn underpin a more rigorous implementation of commitments and the achievement of targets. In this regard, also, the recent overhaul of the poverty proofing process, now known as Poverty Impact Assessment, is a positive step.

4. Pensions

Pensioner incomes in Ireland are among the lowest in the EU-25, relative to the overall population (65% of those aged 0-64), and persons aged 65+ are more at risk of being in poverty than those aged 0-64 . In 2004, 33% were at risk of poverty (men 30%, women 36%), meaning that poverty rates of older people in Ireland remain amongst the highest in EU-25, in spite of the fact that State pensions have been increasing at a faster rate than either prices and earnings.

The 2006 Sustainability Report assessed Ireland as a medium-risk Member State as regards the sustainability of public finances, notably due to the high cost of ageing and despite the current strong budgetary position. According to the AWG 2005 projections, public spending on first-pillar pensions (including public service pensions) is set to rise from 4.6% of GDP in 2004 to 11.1% in 2050. The rise is relatively continuous and stable over the whole period.

Theoretical pension replacement rates are expected to stay stable until 2050 (78% total net and 67% total gross – of which 31% from public pensions; currently only about 50% of the employed population is covered by occupational schemes).

Ireland has made progress in making provision for increasing the adequacy of pensions, and further steps have been announced recently by the Government which will have a particular impact on the poorest older pensioners, the majority of whom are women. Nevertheless, as set out in the 2006 Joint Report, extended coverage of supplementary pension provisions is important to ensure the effectiveness of the income replacement function of pension systems. Evidence suggests that despite Government initiatives, levels of supplementary pension coverage are at best static. Although Ireland has made good progress in increasing its older workforce, early retirement is still common, in particular for reasons of illness or disability. Further strengthening of incentives to work longer would contribute to ensuring future adequacy and sustainability. The Irish Government's commitment to allow a pension to be drawn, whilst continuing to work, could help improve flexibility in retirement.

The Irish Government is committed to accumulating a considerable reserve fund in order to partially pay for future liabilities, and thus make a significant contribution to financial sustainability, in the face of significant projected pensions expenditures in the future. Recent returns of the reserve fund (19.5% in 2005) are impressive and have taken the value of the fund to 11% of GDP. The commitment to monitoring the adequacy of contribution rates through regular actuarial reviews should help to react to any signs of adjustments being needed, and thus help to keep the system on a sustainable footing. A pensions green paper is expected in early 2007 setting out further possible steps for pension reform. A consultation process will follow the publication of the green paper and the Government will respond to these consultations by producing a framework for long-term pensions policy.

5. Health and long-term care

5.1. Health care

Description of the system: A National Health Service (NHS) provides care to all residents some of whom (medical card holders) are entitled to free care (primary, secondary, dental, ophthalmic, aural, maternal and infant care, medicines) based on income and age (70+). Non-medical card holders are subject to charges for consultations, inpatient, outpatient and emergency care and are not covered for dental, ophthalmic and aural care. The NHS is a mix of public and private provision. Primary health care (PHC) is delivered in health centres on the one hand, and in the private premises of general practitioners (GPs), pharmacists, dentists and optometrists, on the other. A GP referral gives access to specialist and hospital care which are available in hospitals' outpatient and inpatient departments. Public sector specialists also conduct private practice for outpatients. Most hospitals are publicly owned but private care can be provided in public hospitals. GPs are paid on a capitation basis for medical card patients and a fee-for-service for all others, whereas specialists' pay is salary based in hospitals and fee-for-service in the private sector. The NHS is mainly financed through general taxation. Private health insurance (duplicate, complementary and supplementary), mostly community-rated and run by the Voluntary Health Insurance Board (80% of market), covers 43.8% of the population. Highlighting health inequalities and barriers to access as serious challenges, authorities have goals to improve general health and reduce health inequalities through health promotion and to provide more easily accessible and equitable services that are better organised and integrated with social services, whilst enhancing system responsiveness and performance.

Accessibility: Data show that individual financial costs of care are rather high (private health care expenditure was 21.5% of total health care expenditure in 2004). To tackle this (over and above medical cards and an annual cap on hospital charges for all), authorities are extending free GP services to those around a threshold income. Moreover, they are introducing new legislation changing income guidelines and bringing further funding into the sector to increase the numbers of medical and free GP visit card holders. However, data show that GP numbers (3.1 per 100 000 inhabitants in 2004) are well below all other EU countries (e.g. 80.8 in England), which is clearly an obstacle to achieving appropriate and accessible PHC. The Irish authorities' response to this is the planned training of more GPs and expanding GP geographical coverage (including GP out-of-hours cooperatives), with 300 PHC teams expected by 2008. To address acute care shortages authorities are allocating funding to open new acute hospital beds and to contract with private facilities. The report highlights that appropriate long-term care outside the acute care setting can free additional beds. Emergency, renal and organ transplantation services will also receive additional funding. To reduce waiting times, the Irish authorities have set up the National Treatment Purchase Fund that collects data and pays for those waiting too long to be treated in private hospitals. A strong concern expressed in the report relates to substantial health inequalities: mortality was 3.5 higher in the lowest occupational class, chronic physical illness 2.5 times higher among the poor, infant mortality 3 times higher in poorer families, and travellers live 10-12 years less than the general population. Indicators are being defined for vulnerable groups and by socio-economic status (see further).

Quality: To improve quality the authorities are implementing quality standards together with a regulation and inspection regime. Legislation will establish the Health Information and Quality Authority (HIQA) and, to provide quality assurance, authorities will run a continuous accreditation system conducted by the Accreditation Board and a staff registration system. A national health information strategy is currently being implemented to develop standardised data sets and comparable indicators (on health status, health determinants, sector activity and financing) which authorities hope will support the planning and evaluation of services. In order to support the information system more emphasis will be placed on ICT. Authorities have allocated additional funding to the health research board to pursue research and evidence-based decision making. The HIQA will evaluate health technology. A customer charter and a complaints framework are planned, patients will be offered a choice of provider wherever possible, and an electronic health care record is planned. According to the report various fora (e.g. national consultative forum, regional health forums) are to provide opportunities for users, providers and staff to give feedback and be involved in decision making. To improve coordination between services and reduce fragmentation of management and delivery of care, the Health Service Executive was created, merging 11 previously separate and specialised agencies. ICT will support the links between services.

Long-term sustainability: Total health expenditure (7.2% of GDP and 2619 per capita PPP$ in 2004) is slightly below the EU average in GDP terms. It varied little throughout the decade, probably due to high GDP growth. Per capita expenditure increased rapidly between 1998-2002 (showing real rates of growth of between 9.8 and 11.2%). The share of public expenditure (78.5% of total expenditure in 2004) is around the EU average having increased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 2.0 percentage points of GDP by 2050. In this context, extra resources can be used to improve access and increase promotion and prevention activities whilst still achieving efficiency gains. The Irish authorities emphasise the need to enhance the use of PHC and daycase surgery while improving DRGs definition and DRG payment as a means of

controlling costs and enhancing efficiency. They expect that the new organisational structure and various plans will improve governance and accountability. Public-private partnerships are seen as opportunities to bring extra funding (capital investment) into the sector. With regards to health workers, a skills' monitoring report was published which authorities hope will help in the the long-term planning of the work force. Further developments have been the introduction of a health care-assistant training programme and an increase in the numbers of trained therapists, paramedics and nurses. New midwifery and children's nursing places are also planned to open. Highlighting the need to improve general health and reduce health inequalities, the authorities are implementing various promotion strategies addressing risk factors and specific diseases (e.g. smoking, alcohol, diet, exercise, cancer, drugs, aids, obesity, breastfeeding, suicide, mental health). Health promotion is to be implemented in a comprehensive manner using health impact assessment in all sectors, legislation, environment, education, health sector (e.g. access, immunisation, screening), inclusion/ anti-poverty, income, employment, and supply side (drinking and food industry) policies. It is to be conducted in different settings (e.g. schools, workplace).

5.2. Long-term care

Description of the system: Services include, alongside PHC and hospital care: home nursing, home help and care attendants, day centres, grants to adapt homes, meals-on-wheels, nutrition advice, therapy and rehabilitation, day hospitals, public residential care and private nursing homes. Services are provided in partnership with users, families and carers and a range of statutory, non-statutory, voluntary and community groups. Access is based on needs. Care in public facilities is free or almost free while a means-tested subvention is given to patients to pay for private nursing home care. There are some financial schemes for carers such as the carer's allowance for low income carers and the respite care grant. Care in the community is considered the preferred option by authorities both for the individual and on economic grounds. The goal is to maintain people in dignity and independence at home in accordance with their wishes; to support family, neighbours and voluntary bodies; and to provide hospital and residential care once this is no longer appropriate. Healthy ageing (promotion and prevention at older ages) is also a stated aim.

Accessibility: The report argues that public supply may be insufficient and private care may impose large financial burdens on patients and their families. Hence, to ensure equal access, authorities want to run a national standardised needs assessment with appropriate levels of co-payments and provide additional funding to expand the home care package and contract private services. Home care grants have been piloted as an alternative to residential care.

Quality: To ensure quality the report suggests that the HIQA will set national quality and safety standards for public services and a regulatory framework will define the standards in private nursing homes. Inspections are to be carried out, nurses will have full training and attendants will receive informal training. The report indicates that the National Council on Ageing and Older People advises on issues relating to older people with particularly regards to health care. The report also describes a number of databases and indicators related to disability and those at particular risk such as the 65+ and 75+ (influenza vaccination rates, waiting lists for certain procedures, and rates of residential care and home care use) A survey and report on long-stay care is conducted annually. Authorities expect that multidisciplinary teams will ensure integrated care.

Long-term sustainability: The 2006 EPC/EC age-related projections show an increase in public expenditure of 0.6 percentage points of GDP by 2050. Several reports have been

looking at ways of financing long-term care. A combined system of taxation, co-payments and social insurance or pre-funding mechanisms is one possibility.

6. Challenges ahead

To ensure that the investment in services is sustained, delivered in an integrated manner along with welfare reforms and that it leads increasingly to more accessible and more flexible delivery attuned to the needs of those groups at greatest risk of poverty and exclusion, in particular to break the cycle of deprivation.

To continue to promote active inclusion to ensure that the range of issues, including the necessary adaptation of services, associated with the significant ongoing levels of migration are effectively addressed

To ensure the ongoing adequacy of income support for pensioners, in order to avoid their exclusion in a context of rapidly rising general living standards and to achieve a significantly wider coverage of supplementary private schemes, while taking due account of the long-term sustainability of public finances;

To implement the set of measures that tackle major barriers to access (e.g. financial burden of care and long waiting times) and ensure more equitable access notably through enhancing nationwide availability of PHC, acute care, emergency and long-term care services; improve care coordination and integrated care,

To achieve efficiency gains in service delivery whilst improving the health of population and reduce substantial health inequalities.

<<IRELAND>>: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	9.4	126.1	**2000**	65.2	76.3	53.9	50.4	45.3	**2000**	4.2	4.3	4.2	6.8
2002	6.0	132.3	**2002**	65.5	75.4	55.4	47.6	48,0	**2002**	4.5	4.7	4.1	8.5
2004	4.3	135.7	**2004**	66.3	75.9	56.5	47.7	49.5	**2004**	4.5	4.9	4.1	8.9
2006	5.3f	139.2f	**2005**	67.6	76.9	58.3	48.7	51.6	**2005**	4.4	4.6	4.1	8.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality	WHO	Total health exp %GDP	Public health exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	72.9	78.4	13.6	17.3	63.2	na	6.4	**1995**	6.8	71.6	-		
2000	73..9	79.1	14.6	17.8	63.3	66.9	6.2	**2000**	6.2	73.9	13.6	100	43.8
2003	75.8	80.7	15.7	18.9	63.4e	65.4e	4.9	**2004**	7.2	78.5	13.6		

e: estimate **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure* (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004			
										Total social expend.	Public pensions	Health Care	Long-term care
1995	18.8	26.5	36.2	15.3	12	5.2	4.8	**2005**	16.5	15.5	4.7	5.3	0.6
2000	14.1	25.1	41	9.5	13.6	5.6	5.2	**2010**	17.5	-0.1			
2004	17	23.3	42.1	8.3	15.5	5.5	5.3	**2030**	28.3	3.3	3.1	1.2	0.1
								2050	45.3	7.8	6.4	2	0.6

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate						Poverty risk gap					Income inequalities	
SILC income 2005	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	23	19	16	33	20	23	18	22	10	**Total**	5,0
Male	19	-	17	15	30	21	-	19	22	12	**Male**	-
femal	21	-	20	17	36	19	-	17	22	10	**Female**	-

	People living in jobless households				Long-Term Unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female	Total	Male	Female		Total	Male	Female
1999	11.7	9.8	8.5	11.1	2.4	3,0	1.6	**1999**	na	na	na
2004	11.8	8.6	7.2	10.1	1.6	2.0	1	**2004**	12.9p	16.1p	9.7p
2006	11.3	7.9	6.5	9.3	1.5	1.9	0.8	**2005**	12.3p	14.9p	9.6p

** excluding students* p: provisional

SILC income 2005	Total	Male	Female	SILC income 2005	Total	Male	Female
Relative income of 65+	0.654	0.663	0.647	***Aggregate replacement ratio***	0.426	0.382	0.506

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or social security)	pensions Current Estimate (2002)	pensions Assumption
0	0	3	DB	-3	DB	100	52	9.5	10-15	20.7

**:(DB / NDC/ DC); ** (DB / DC)*

2.8. GREECE

1. Situation and key trends

Real GDP growth has remained at high levels in recent years, despite the slowdown in the world economy. Even though a decline in the annual real GDP growth has been observed (from 4.7% in 2004 to 3.7% in 2005), the real GDP growth rates outstrip, by far, the respective EU-25 averages (2.3% in 2004 and 1.7% in 2005). Moreover, the projections for 2006-2007 indicate that growth will remain high (3.5% and 3.4% Eurostat).

The strong domestic economic activity has not led, however, to the expected gains in employment. The total employment rate has shown a gradual increase over the last few years, but in 2005 it continued to lag behind the EU-25 average by 3.7 percentage points (60.1% against 63.8%). The gap is greater for young people's and women's employment rates (25% in 2005 against 36.8% and 46.1% against 56.3% respectively), while the older workers' employment rate, is near the EU-25 average. After reaching a peak of 12% in 1999, the unemployment rate fell to 9.8% in 2005 but remains higher than the EU-25 average. Moreover, unemployment continues to affect mainly young persons and women, whose unemployment rates remain significantly higher than the EU-25 averages. Similarly, despite its modest downward trend over recent years, the long-term unemployment rate remains higher than the EU-25 average.

Total social protection expenditure as a percentage of GDP reached the EU-25 average in 2001 and, though slightly decreasing since, remains close to the EU-25 average, at 26% against 27.3% in 2003. Nevertheless, in 2004, Greece posted an at-risk-of-poverty rate after social transfers of 20% against a 16% EU-25 average, while the disparity for the 65+ age group was even stronger (28% against 18%). Expenditure on pensions was slightly above the EU-25 average, at 12.9% of GDP in 2004, but is projected to increase sharply until 2050. Greece's old-age dependency rate will grow from a moderate 26.8% in 2005 to 58.8% in 2050, among the highest in the EU.

In 2004, life expectancy at birth in Greece was 76.6 years for males and 81.5 for females, among the highest in EU-25 and showing a significant increase since 1995. Healthy life expectancy was above the respective EU-25 averages, 66.7 years against 64.5 years for males and 68.4 against 66 years for females. Infant mortality was below the EU-25 average, at 3.9% against 4.5% in 2004. At the same time, total health expenditure, as a percentage of GDP, seems to have stabilised in recent years and in 2004 was above the EU-25 average, 9.8% against 8.87% (WHO-HFA database). On the other hand, per capita spending on health in purchasing power parity is below the EU-25 average, at 2,011 in 2003 against 2,266, while the high level op private health care expenditure – accounting for almost half of the total expenditure (48.3% in 2004 against 24.1% EU-25 average) – may signal inequities in access for vulnerable groups.

2. Overall strategic approach

Over recent years, there has been recognition of the need for social policy adjustments. Consequently efforts have been under way to improve the social protection system and specifically the ability to meet existing and emerging needs of all those citizens at risk of social exclusion and poverty. The strategy announced in the National Report on Strategies follows the rationale of the previous NAP inclusion, is based on specific national challenges

and takes into consideration the input of the reports on pensions and health and long-term care. Within this framework, three strategic priorities are identified, namely a) improving governance, b) promoting employment and fighting unemployment among vulnerable groups by upgrading their abilities and c) securing a dignified socioeconomic standard of living and ensuring high-quality social services for all, especially with regard to education, health and social security and protection systems. The strategic approach and the key challenges identified are steps in the right direction. However, the links between the strategic priorities and the proposed interventions are not always sufficient. Moreover, further efforts are needed towards the adoption and implementation of a strategy addressing fully and comprehensively all three overarching objectives of the Open Method of Coordination for social protection and social inclusion. The willingness to address the governance objective is noticeable; nevertheless the implementation of the presented interventions had already been announced in the previous NAP and seems to encounter delays. On the other hand, the National Report provides links with the Lisbon strategy and puts emphasis on improving the employability of socially vulnerable groups. Moreover, efforts are under way in order to better address the question of immigrants' integration. An integrated approach has for the first time been adopted, which, if rapidly and fully implemented is expected to contribute to smooth progress in immigrants integration. Furthermore, there is a notable attempt to link the National Report with the interventions presently carried out and co-financed by ESF. The role of this contribution to achieving the overarching objectives looks indisputable. Yet, the link with the National Strategic Reference Framework (NSFR) 2007-2013 could benefit from more clarity, because many of the envisaged interventions will solicit ESF co-financing.

3. Social Inclusion

3.1 Key trends

Recent strong economic growth has not led to the expected gains in employment, but sustained high growth combined with structural reforms is expected to make a positive contribution. The total employment rate increased gradually over recent years, but in 2005 it continues to lag behind the EU-25 average by 3.7p.p. The gap is much greater for women and young people. The total unemployment rate has been declining in recent years, but remains higher than the EU-25 average (9.8% in 2005 against 8.8%). In 2005, the youth unemployment rate was 26% against 18.6% EU-25 average, while the unemployment rate for women was 15.3% against 9.9%. Similarly, despite a modest decrease in recent years, the long-term unemployment rate remains higher than the EU-25 average (5.1% against 3.9% in 2005).

Regarding education and lifelong learning, in 2005, persons with low educational attainment were 23.1% among the 25-34 years old, against an EU-25 average of 22%, while the gap for older generations is much higher (83% against 66.1% for the 65+). The percentage of low-achieving 15-year-olds in reading literacy was one of the highest in EU, at 25.2% against 19.8% in 2003. On the other hand, the total early-school-leavers rate was lower than the EU average in 2005, 13.3% against 14.9%. Participation in lifelong learning is very low, 1.8% against 11% EU-25 average. Given that spending on education remains lower than the EU-25 average, investing in education, including a drive to boost participation in lifelong learning, seems a priority.

Over the last decade, efforts to improve and extend the social protection system, in terms of both quantity and quality, are evident and partly reflected in the increase in social protection expenditure as a percentage of GDP, which reached the EU-25 average in 2001. Despite a

moderate downturn since, it remains close to the EU-25 average, standing at 26% against 27.3% in 2003. Nevertheless, its impact on the relative reduction of the at-risk-of-poverty rate has been limited, only 3 p.p. against 9 p.p. EU-25 average. In 2004, the at-risk-of-poverty rate after social transfers was 20% against 16% EU-25 average, while the relative median at-risk-of-poverty gap was 25%. Greeks aged 65+ faced an at-risk-of-poverty rate after social transfers well above the EU-25 average, 28% in 2004 against 18%, while the rates for those at work and not at work were respectively 13% and 26%, against the 9% and 23% EU-25 averages. It should be noted that these percentages would probably be lower if the considerable level of owner-occupied housing among those at-risk-of poverty was taken into account. Greece exhibits one of the most unequal income distributions among the EU-25 (s80/s20 quintile share ration: 6.0 in 2004). Moreover, it should be noted that Greece has adopted neither an official poverty line, nor a universal minimum income scheme. The existent income support schemes target specific groups considered at greater risk.

3.2 Key challenges and priorities

The social inclusion strategy identifies four strategic priorities, namely a) strengthening employment, especially for women, young people, the long-term unemployed and vulnerable groups; b) tackling the disadvantaged position of persons and groups with regard to education and training; c) reinforcing the family and supporting the elderly; and d) promoting social inclusion of the disabled, immigrants, and persons and groups with cultural and religious particularities. Although the identified priorities point in the right direction, further efforts are needed towards the adoption of an integrated and streamlined strategic approach. The links between the strategic priorities and the proposed interventions are not always sufficient, while the social inclusion objective of Governance is only partly addressed. With the notable exception of three specific targets to be achieved by 2010 (employment rate of 64.1%, poverty gap rate at 20% and the rate of early school leavers below 10%), the plan lacks further concrete targets. Besides, it fails to refer to the availability of budgetary and human resources considered necessary for its successful implementation and does not provide any pre-assessment. Consequently, although the main challenges are well identified, the social inclusion part of the report could become more operational, if the spelled out priorities and measures were better associated with specific targets and concrete means. This would also have facilitated the ex-ante and ex-post evaluation of the strategy.

Referring to the challenges identified in 2006, the limited number of actions undertaken towards improving governance and mobilising all stakeholders has not yet had satisfactory results. The weaknesses in coordinating, monitoring and evaluating social policy interventions have so far rendered their effectiveness and efficiency rather limited. On the other hand, an increase in the number of structures providing social support and care services throughout the country has been observed. Moreover, some progress towards the integration of immigrants and the promotion of multiculturalism has been made through the adoption of a new law. Nonetheless, prompt and effective implementation is crucial if this is to succeed. Upgrading and extending the provision of services to the most vulnerable groups constitutes the prevailing concern. In this respect, increasing the efficiency of social protection expenditure is crucial. Some challenges, such as extending a “safety net” for all groups experiencing poverty and developing an integrated approach on child and in-work poverty remain to be adequately addressed. Finally, linkage with the intervention of the Structural Funds in the future period could benefit from more clarity, given that many of the envisaged interventions in the field of social inclusion will solicit ESF co-financing.

3.3 Policy measures

Over recent years, active employment measures for vulnerable social groups have been on the increase, while a number of integrated action plans for particular social groups are under way. Further restructuring of the public employment services by transforming them into one-stop shops, along with stronger active policies better geared to sectoral needs and the needs of vulnerable groups, receive a high priority. The creation of a Social Solidarity Fund to provide financial support and encouragement to the reintegration into the labour market of older unemployed persons, mainly victims of restructuring, is currently the subject of dialogue between the social partners. Moreover, the report expresses a willingness to promote policy planning focused on local needs and the particularities of regional labour markets.

In the wider framework of improving planning and implementation of educational and training policies, and making them better targeted and adapted to the needs of vulnerable groups, interventions such as “Supportive Classes” and "Intercultural Schools" will continue, and extra efforts will be dedicated to primary and secondary education. Adult’ education will be further promoted by the creation of at least one Second Chance School and one Adult’ Education Centre in each municipality.

Progress regarding support for the family and the elderly accelerated through the creation, at municipality level, of structures providing social care and accompanying services, especially to groups in need. The institutionalisation of specific schemes of social support, such as “Help at Home” and “Child Care”, along with the ESF co-financing, facilitated better provision of such services. Nonetheless, securing their financial sustainability remains a challenge. In relation to gender mainstreaming, certain priority criteria for women’s participation have increasingly been applied in recent years, though there is still room for progress. Furthermore, the report refers vaguely to the political will to implement interventions for households with no working members.

Over recent years, income support measures have been extended to cover more socially vulnerable groups, providing a categorical income support, which is gradually being improved. However, it continues to fall short of forming a "safety net" for everyone in need, while no national guaranteed minimum income scheme exists. Furthermore, bottom-up and user-oriented approaches, open procedures and social dialogue that would enhance the participation of stakeholders are still not being adequately developed in the context of poverty and social exclusion.

The selected intervention, aiming to promote health and social inclusion of Greek Roma, is indeed a good example of an integrated, and thus innovative, action plan. Yet, given the scarcity of evaluations of the impact of the implemented measures, and knowing that in reality a lot remains to be done to adequately address the issue of improving the situation of Greek Roma, to consider this specific intervention a good practice seems debatable.

Despite the positive steps, social policy adjustments carried out so far have failed to address effectively the multidimensional problems and needs in the area of poverty and social exclusion. The majority of undertaken measures appear to be fragmented as the appropriate institutional mechanisms to facilitate the adoption of an integrated approach are still at an early stage of development. The presented key policy measures go in the right direction and are well targeted. However, the report fails to set quantitative targets and lacks information on associated resources and their availability. Synergy and close interaction between the various measures, as well as coordination between the competent bodies, need to be further strengthened. The willingness to commit to and keep up the efforts for ensuring an efficient

and equitable social protection system is apparent in the plan which, if fully implemented, could contribute to alleviating poverty and social exclusion.

3.4 Governance

The National Report on Strategies was prepared under the coordination of the Minister of Employment and Social Protection, which had set as a priority the involvement of all relevant bodies. At the first stage of preparation of the report, survey questionnaires were sent to all relevant actors. Subsequently round tables with the Social Partners, NGOs and civil society were organised, before the draft report was presented by the Secretary General of the Ministry of Employment to the National Economic and Social Committee. Before its finalisation, the report should ideally have been discussed within the National Social Protection Committee, while the launch of broad social dialogue following the presentation of the draft would have been welcomed.

Identifying the need to improve governance, as an overall strategic priority, is a good starting point for developing an integrated social inclusion policy. Yet, delivery remains the core challenge. The creation of a National Council for Social Protection to formulate proposals on social protection policy planning issues, to monitor and evaluate the undertaken actions and to provide annual studies on the social situation, is a step in the right direction. However, concerns arise as its implementation seems to delay.

4. Pensions

Older people enjoy a living standard relatively close to that of the general population (79% in 2004), while according to SILC figures for 2004 (income year 2003), the poverty rate of people aged 65 or more stands at 28% (but with very low gender difference), about 10 p.p. higher than the poverty risk of people aged 0-64.

The 2006 Sustainability Report assessed Greece as a high-risk Member State regarding the sustainability of public finances, notably due to the high projected increase in age-related expenditure and a high level of debt. According to the budgetary projections made by the AWG in 2001, expenditure on pensions is projected to almost double, reaching a level of 24.8% of GDP in 2050. ISG projections for workers with a complete career record of 40 years of contributions show that the total net replacement at age 65 is projected to decline by 9 p.p. by 2050, from a net 115% (gross 105%) to 106%, still above 100%. If instead of 40 years of contributions, the current weighted average of 25 contribution years is taken into account, and instead of the 65 retirement age the current weighted average retirement age of 60 is considered, the replacement rate for the primary pension is 33%. In this case, a proportional fall is also computed for the auxiliary pension amount.

The 2006 Joint Report highlighted that implementing the 2002 reform is considered to be crucial for modernising the pension system and rebuilding confidence in it, as well as for laying the groundwork for further reform efforts, certain aspects of which are under way. In order to meet the significant financial challenge of ageing, the process of pension reform needs to continue and to be strengthened. Pending further reform, which is subject to the results of the recently launched social dialogue, the system's sustainability relies heavily on increasing employment rates and curbing contribution evasion. The unification of the fragmented pension system is also a challenge. Recent measures, such as the unification of different funds, point in the right direction. The latest update mentions the further development of occupational pension schemes, which could help improve adequacy and help

incentives for working longer. While most recent reforms have translated into strengthened incentives to work longer, further measures are needed to help raise employment rates, especially for women and older workers. Apart from this, the overall efforts with a view to ensuring viability should continue at a faster pace.

5. Health and long-term care

5.1 Health care

Description of the system: The Greek healthcare system is based on the coexistence of the National Health Service (NHS), a compulsory social health insurance and voluntary private health insurance schemes. Universal coverage of the population is provided by the NHS and a variety of social insurance funds (35). 8% of the population maintains complementary private voluntary health insurance coverage. The provision of health care consists of NHS units, insurance funds' units and private sector units contracted by the insurance funds. A legal reform resulting in NHS decentralisation along regional lines has been remodelled. The original Administrative Health Regions (PESYs) which were not given individual budgets have been replaced by Managerial Regional Health Units (DYPE). Primary Health Care (PHC) is delivered through PHC centres, hospital ambulatory (outpatient) services that belong to the NHS, and PHC units that belong to the largest social insurance fund (IKA). Secondary and tertiary care is provided in general and specialised hospitals. Health services are funded almost equally by public and private sources. Public expenditure is financed by taxes and compulsory social health insurance contributions. Voluntary payments by individuals or employers represent a high percentage of total health expenditure (48.3% in 2004). The NHS budget is set annually. Taxes provide approximately 70% of all hospital funding, and the remaining 30% is a public/private mixture combining social security and out-of-pocket payments. The national strategy aims at improving the efficiency and effectiveness of both healthcare and LTC systems by extending the scope of PHC. Both healthcare and LTC appear mutually dependent, with coordination problems in one system negatively affecting the other.

Accessibility: Universal access is guaranteed by law and the population coverage is high. Despite the legal provision of non-discrimination, access problems remain, due to geographical disparities and an uneven distribution of facilities and medical staff. Efforts to ameliorate patients' access include the modernisation-supplementation of medical-technological equipment, the creation of new specialised departments (intensive care and dialysis units) and efforts to improve the staffing of the healthcare system. Extra funding has been allocated to increase capacity and service distribution (including primary care centres and hospital care). This increased health expenditure, combined with the absorption of the allocated Structural Funds (3rd CSF), resulted in the creation of new hospitals and the addition of beds to the NHS. These measures aim at improving general access to health services whilst dealing with regional disparities, due to the geographical peculiarity of numerous islands. High and increasing private health care expenditure – almost half of the total – signals inequities in access for vulnerable groups. A legislative reform with an emphasis on PHC, the structural inclusion of family doctors and the inclusion of social insurance healthcare entities into the PHC system is ongoing.

Quality: The authorities acknowledge the need to institutionalise a comprehensive and uniform framework for quality control. Problems of poor effectiveness and efficiency concern mainly the hospital sector. One priority covers the generalised use of ICT, improved data gathering and exchange of information. To tackle the low level of computerisation, the setting up of a National Health Information System (ESPY) for data collection is receiving support.

A legislative proposal aimed at establishing quality control mechanisms, accreditation, inspection of facilities, the enforcement of patient rights (Ombudsman) and the promotion of preventive measures is to be adopted.

Long-term Sustainability: Total health expenditure as a percentage of GDP (9.8% in 2004) is above the EU average[32], whilst expenditure has stabilised in recent years. The public share of total health expenditure is 51.7% in 2004, originating from the state budget and social security. The remaining 48.3% of total health expenditure originates from private payments, with 46% of total health expenditure consisting of out-of-pocket payments. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.7 percentage points of GDP by 2050 due to population ageing. The mixed financing system (state, health insurance, private) operates with differentiated funding rates according to whether care is closed, open-ended and to the legal status of the care provider. Private expenditure appears very high for a mainly public healthcare system. The deficient and segmented PHC system is under review with the aim of fully integrating the role of the General Practitioner and bringing the insurance institutions into PHC. High private expenditure indicates access and service use inequities. Despite increased total health expenditure, health status indicators have not improved. Relatively low public expenditure raises concerns of severe under-financing of the system. There is no uniform price for acute bed use between public and insurance hospitals. Tax revenue is often used to fill the gap between the official funding level and the actual cost of hospital care. Despite the law on PHC centres (2004) assuring their financial and administrative autonomy, they are still financed through hospital budgets. Apart from high private expenditure, the system's financial sustainability is also undermined by excessive medicine and technology use and supply driven demand for health services. Modernisation efforts emphasise efficient ICT use, rational medicine and technology prescription, prevention-based policies and active ageing promotion.

5.2 Long-term care

Description of the system: The LTC system is mixed, including direct social services provisions, care needs coverage through insurance funds and tax exemptions for indirect care provision. LTC services for the elderly are provided by the State, private non-profit organisations and private for-profit organisations. These services have been supplemented by open care and home care services leading to a reduction in the use of hospital or institutional care. After the successful evaluation of the "Care at Home" Programme, there is planning for the development of day care centres for the elderly in order to allow working women with dependent family members to adequately cover their working hours. The National Direct Social Aid Centre (EKAB) is being reinforced.

Accessibility: The general aim is to favour care at home for the elderly. Service providers are concentrated in urban centres. Often the connective family network has to meet the needs of the elderly in semi-urban and rural areas. Focusing on home and close to home day care centres, supporting informal carers, will bring quality gains and more efficient use of resources. One priority is the development of more specialised, post-hospital support services (as well as infrastructure in particular for mental patients). The authorities plan to establish a National System of Social Solidarity based on a White Paper on Governance, pilot programmes aimed at combating social exclusion of particular groups, flexible and individualised needs-based LTC services and the modernisation of welfare institutions.

[32] EU average of 8.87% and PPP$ 2376.33 per capita in 2004

Quality: An independent Patients Rights Protection Agency covering LTC recipients' rights is in operation. Vocational Training Centres are in operation for the training of carers for the elderly. Evaluation is carried out by the Association of Inspectors of Health and Welfare Services. The authorities are aiming to achieve a uniform provision of LTC services. The legislative framework for the accreditation and evaluation of NGOs and voluntary organisations in the provision of LTC is in place. Implementation gaps and insufficient LTC health professionals (rural areas) are a challenge to uniform provision and to the level of quality of services.

Long-term sustainability: It is difficult to assess total LTC expenditure due to the multiplicity of providers and the forms of provision. A large part of LTC is informal, family provided and hence hard to assess in cost terms. The mixed financing system of formal long-term care is further complicated by differences in the financing rates, which vary according to the type of care and the provider's legal status. Cost-controlling mechanisms are weak and there is no comprehensive framework for cost evaluation.

6. Challenges ahead

To promote the active social inclusion of the most vulnerable social groups by upgrading and extending the provision of services and the financial "safety net" (minimum incomes) and by developing multidimensional policy approaches to the wider social inclusion of persons and groups with special characteristics and needs such as immigrants, disabled people, Roma and other vulnerable groups.

To improve governance and to promote the mobilisation and full participation of all relevant stakeholders, in order to strengthen implementation, monitoring and evaluation and also to increase the efficiency of social expenditure.

To increase efforts to ensure adequacy and long term sustainability of the pension system, notably by increasing employment and promoting longer working careers, so as to broaden the contribution base.

To enhance, better integrate and distribute PHC services to improve access, combat high costs, inequalities and tackle the high financial burden of care on vulnerable groups in order to curb the over-consumption and wastage of resources.

To modernise the management of the system through structural changes (in LTC the aim is to move away from a 'clinical' model and to adopt a 'social' model, mainly developed at the local level) and the development of a comprehensive framework for evaluating the quality of the services provided.

GREECE: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.5	72.7	**2000**	56.5	71.5	41.7	27.6	39,0	**2000**	11.2	7.4	17.1	29.1
2002	3.8	77.2	**2002**	57.5	72.2	42.9	26.5	39.2	**2002**	10.3	6.8	15.6	26.8
2004	4.7	81.4	**2004**	59.4	73.7	45.2	26.8	39.4	**2004**	10.5	6.6	16.2	26.9
2006	3.8f	84.9f	**2005**	60.1	74.2	46.1	25,0	41.6	**2005**	9.8	6.1	15.3	26,0

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total Health exp. %GDP	Public Health Exp. % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop.	Pop. Covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	75,0	80.3	16.1	18.4	65.8	69.2e	8.1	**1995**	9.6	52	-	:	:
2000	75.6	80.5	16.3	18.3	66.3	68.2	5.9	**2000**	9.9	52.6	44.9	100	
2004	76.6sp	81.5sp	16.9sp	19.1sp	66.7e	68.4e	3.9	**2004**	9.8	51.7	46	100	8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditure **PHI: Private health insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	22.3	52.1	26	4.5	8.8	3.8	4.8
2000	25.7	49.7	26.5	6.2	7.4	5.4	4.8
2004	26	50.9	26.5	5.9	6.9	4.7	5

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health Care	Long-Term Care
2005	26.8	8.9	5.1	5.1	:
2010	28	-0.2		5.4	:
2030	39.1	0.2	0.8	5.9	:
2050	58.8	1.3	1.7	6.8	:

*** total social expenditure for GR does not include pension expenditure. The Greek authorities have agreed to provide the pension projections in 2006.*

4. Social inclusion and pensions adequacy - Eurostat

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	20	19	17	28	24	23	24	24	24	**Total**	5.8
Male	18	-	18	16	25	24	-	24	24	22	**Male**	-
femal	21	-	21	18	30	24	-	24	24	25	**Female**	-

	People living in jobless households				Long-Term Unemployment rate			Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64			% of people aged 18-24		
	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female
1999	5.2	9.6	7.0	12.1	6.5	3.8	10.7	18.6	22.1	15.4
2004	4.5	8.5	6.2	10.7	5.6	3.0	9.4	14.9	18.3	11.6
2006	3.6	8.1	6.1	10.1	5.1	2.6	8.9	13.3	17.5	9.2

** excluding students*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.79	0.83	0.78	***Aggregate replacement ratio***	0.49	0.56	0.47

Change in theoretical replacement rates (2005-2050) - Source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions Estimate of current (2002)	pensions Assumption
-9	-11	-11	DB	:	:	Nd	:	20	:	:

** (DB / NDC/ DC); ** (DB / DC)*

2.9. SPAIN

1. Situation and key trends

Economic growth accelerated to 3.5 % in 2005, above the EU average (1.6%). The debt ratio is low (43.1%, 63.4% in the EU, 2005). Both activity and employment rates, although significantly increasing since 2001, continue to be somewhat below EU averages: the activity rate stood at 69.7% in 2005 (70.2% in the EU); the employment rate at 63.3% (EU: 63.8%). The unemployment rate declined to 9.2% in 2005 (8.7% in the EU). The increase in employment rates has mainly benefited women (+15.4 percentage points between 1998 and 2005), but there is a clear need for further effort (the total female employment rate in 2005 stood at 51.2%, in the EU: 56.3%). With the employment rate of people aged 55-64 standing at 43.1%, Spain is marginally above the EU average (42.5%). However, the rate of employment for women aged 55-64 is substantially lower than the EU average (27.4% in Spain, 33.7% in the EU). The labour market is highly segmented, with a fixed-term employment rate of 33.3% in the second quarter of 2005, affecting particularly women, young people and low-skilled workers. Low productivity growth and high inflation hamper competitiveness. The substantial growth in the Spanish economy and in employment in recent years has directly benefited the social security system. The age structure of the population has changed significantly (with the number of people aged 65+ projected to grow from 17% in 2005 to 33.5% in 2050). The population increase, as a result of migration flows (more than 3 million people between 1998 and 2005), will play an important role in the sustainability of the system in the short and medium term. It will also positively influence the old-age dependency ratio, which is expected to grow from 25% in 2004 (close to EU average) to 67.5% in 2050 (EU: 52%). The effective labour market exit age in 2005 was one of the highest in the EU: 62.2 years, 60.7 years EU average. Although economic growth has accelerated in recent years, there is no significant improvement in terms of the number of people at risk of poverty: 20% of the Spanish population was below the at-risk-of-poverty threshold in 2004 (16% in the EU). People aged 65+ are particularly at risk (29% in Spain, 19% in the EU). Spain continues to be significantly below the EU average regarding social expenditure as a percentage of GDP (20% compared to 27.3% in the EU in 2004) and has one of the highest rates of early school leavers in the EU (30.8% in 2005, more than twice the EU average), particularly among men (36.4%, while the rate is much lower among women: 25%). Life expectancy at birth (76.9 and 83.6 for males and females in 2003) is above the 2003 EU average[33] showing a 2-year increase in the last decade (74.3 and 81.5 in 1995). Healthy life expectancy (66.8 and 70.2) is also above the EU average[34]. The infant mortality rate (3.5 in 2004) is one of the EU's lowest[35], a decrease from 35.4 in 1960. Perinatal mortality (5.3) is average, having decreased from 42.8 in 1960.

2. Overall strategic approach

The Spanish report has improved its strategic character in relation to previous years. Its main aim is to combine and mutually reinforce economic convergence with employment, sustained growth and social welfare, taking into account the reduction of territorial disparities and the overall objective of preventing social exclusion. The report identifies several key challenges

[33] EU average of 75.1 for males and 81.2 for females in 2003
[34] EU average of 64.5 and 66 for males and females in 2003
[35] EU average of 4.5 in 2004

related to social protection and social inclusion issues, in the light of the two major objectives included in the National Reform Programme: full convergence in per capita income with the EU and a total employment rate of 66% in 2010. The strategy plan is fully consistent with the analysis and challenges identified by the NRP, such as halving the alarmingly high early school drop-out rates to 15% in 2010. The Agreement for the Improvement of Growth and Employment, signed this year by the Government and the social partners, introduces important measures to tackle the excessive segmentation of the labour market. It will certainly have positive effects in the short term, although diminishing the structural segmentation of the labour market will require sustained and comprehensive efforts. The report foresees the modernisation and consolidation of the Spanish social model. In relation to social protection, the Government and the social partners signed in July an Agreement on Social Security Measures. The Agreement aims to modernise the system, while ensuring financial sustainability, as well as addressing adequacy and the contributions/benefits balance. Very important measures pertaining to social security and inclusion objectives concern the increase in the minimum wage (to rise to € 600 / month in 2008) and in the lowest pensions (a 26% increase between 2004 and 2008). Regarding other social inclusion objectives, the report lists measures relating to the integration of immigrants (Draft Strategic Plan on Citizenship and Integration 2006-2009), to guarantee the provision of care services to dependent persons (Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency, which will be implemented in 2007-2015), and to enhance equitable treatment regarding education. The adoption of the draft Equality between Women and Men Act regarding employment should help reduce the gender pay gap and improve women's access to employment. In order to address the specific needs of vulnerable groups, the report lists a series of measures for the elderly, people with disabilities, young people, children, families, Roma, migrants and the homeless. The Quality Plan of the National Health System has among its objectives to ensure a more rational use of resources, and to guarantee access to the same range of services for all citizens.

The preparation of the report, coordinated by the Ministry of Labour and Social Affairs, involved all relevant ministries and non-governmental stakeholders. The intention is to maintain this involvement through the implementation and follow-up phases. The report mentions a number of coordination measures involving the national, regional and local administrations.

3. Social inclusion

3.1 Key trends

As a result of strong job creation, the employment rate has increased significantly (up to 63.3% in 2005), but remains below the Lisbon objectives, especially for women. The high rate of fixed-term contracts is one of the major problems of the Spanish labour market, especially for women (also facing a high rate of unwanted part-time contracts), young people and low-skilled workers. 20% of the Spanish population was at risk of poverty in 2004 (EU: 16%), with higher rates for some traditional risk groups such as the elderly (29% for persons aged 65+, rising to 47% if living alone), children aged 0-17 (24%), single parents (37%) and the unemployed (40%). Access to housing is difficult for new entrants; often it is only possible through a high level of indebtedness. Young people face difficulty in accessing stable employment and housing; immigrants face difficulties regarding an adequate integration in the school system, and have some housing-related problems, especially for the newly arrived, and the Roma, despite a general improvement in their living conditions, still face inequalities

in the fields of health, employment, housing and household income. Spain faces one of the highest rates of early school leavers of 18 to 24 years in the EU, 30.8% in 2005 (with differences among Autonomous Communities), though the educational level of the population and the schooling rate have improved (81% at the age of 17).

3.2 Key challenges and priorities

The report outlines five overall strategic objectives, connected to some extent with the challenges identified in the 2006 joint report. The overall strategic objectives have been translated into specific targets and actions designed for its achievement. All objectives are mutually reinforcing, linked to the Lisbon objectives and focus on combining economic growth with social welfare, while reducing inequalities and preventing social exclusion.

One objective refers to enhancing access to the labour market, focusing specifically on women and other vulnerable groups, such as people with disabilities, victims of gender-related violence or people facing social exclusion. Another objective refers to the need to guarantee minimum resources, with special emphasis on vulnerable groups, such as recipients of low wages and pensions. An important target group are immigrant female workers, most of them working in the informal labour market for very low wages.

The third objective is to ensure equal treatment and non-discrimination regarding education options. The report sets out a range of specific targets, such as increasing the rate of pupils who attend the class that corresponds to their age up to 95% by 2010 (in 2005, this rate oscillated between 84.3% for the 12-year olds and 58.4% for the 15-year olds), increasing the supply of places for 0-3 year-old children by 2% annually (rising to 27% by 2008), guaranteeing free schooling in the second cycle and 100% schooling of 3-6 year-old children by 2010, and further developing a specific plan to reduce school failure, so that it covers 2000 schools by 2010.

The large number of immigrants has highlighted the need for a sound and comprehensive integration policy. The fourth objective therefore concerns the integration of immigrants and provides for a comprehensive approach, including such core areas as education, employment, housing, social services and health, while taking into account the more specific needs of youth and women.

The fifth objective addresses the increasing potential demand for social support services and benefits by the dependent population, as a result of social and demographic trends. According to national statistics, the estimated number of dependent people (more than 1.1 million persons in 2005) will increase by 250 000 in 2015. Currently, the dependent person's relatives are the main providers of basic care and support. The total public spending allocated to dependent people, which amounts currently to 0.32% of GDP, will rise to 1% of GDP after the implementation of the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency.

The report highlights the significant contribution of the ESF to inclusion policies. It includes an annex on co-financed measures, and another one setting out best practices regarding social inclusion, such as the functioning of the Fund for Reception and Integration of Immigrants and their educational support, and the national OP "Fight against discrimination", co-funded by ERDF and ESF (€ 345 million).

3.3 Policy measures

The report lists a whole range of new measures, mainly related to the five overall objectives identified in the report. Many of these measures include quantified targets. Many of the actions from the previous plan have been extended and updated in the 2006-2008 NAP. In the context of the five overall strategic objectives identified in the report, two significant policy measures are those aimed at reducing fixed-term employment (Decree Law 5/2006) and increasing the female employment rate (draft Equality between Women and Men Act regarding employment, complemented by some specific actions to promote and support the reconciliation of work and personal life). A similar range of actions will be put in place for some other vulnerable groups (design of employment pathways for women with disabilities, immigrants, etc.). In order to facilitate access to training for the most disadvantaged groups, a new system of vocational training has been devised, unifying the two existing systems: training for the unemployed and training for people in employment.

The report provides for measures such as increasing the minimum wage up to € 600 / month in 2008 and the lowest pensions by 26% between 2004 and 2008 (thereby reducing the gap with the EU15 average).

A key tool for promoting equity in education is a recently approved Law, aiming to ensure an equitable education system for all students and a significant reduction in early school leaving. It sets out to establish specific programmes in schools located in areas where remedial schooling is considered necessary, and to guarantee grants and other educational assistance to needy students. Addressing the concentration of immigrant children in the public school system is also considered in the Law. The Law includes significant financial commitments, and concrete measures in relation to equity in education listed in the social inclusion strand of the report.

The draft Strategic Plan for Citizenship and Integration 2006-2009 (main objective: coordination of measures implemented by the various public administrations involved) and the Fund for Reception and Integration and educational support are the most important instruments for the integration of immigrants. The integration process will also be boosted by the funding of local innovative projects, and financial assistance to NGOs and bodies working in this area. Finally, the creation of a monitoring centre for equal treatment and non-discrimination based on race or ethnic origin should be also mentioned.

The needs of dependent people are addressed mainly by the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency (2007-2015), which sets out to prevent poverty and social exclusion for both the carer and the dependent person. The law will be implemented with the creation of the National Dependency System, aiming to provide support to dependent persons, mainly people aged 65+ and people with disabilities. The potential beneficiaries of the Autonomy and Dependency Care System will number some to 1.5 million by 2015. The financing of the system in 2007-2015 will amount to more than € 25 000 million. for all public administrations. The report also details other measures in the areas of health, social services, housing, justice and information society. Women's specific needs will be addressed by the implementation of the Law on Equal Opportunities between women and men. The NAP lists a series of measures for the elderly (Action Plan for the Elderly 2003-2007), people with disabilities (Action Plan for people with disabilities 2003-2007 and the National Plan on Accessibility 2004-2012), young people, children, families, Roma (constitution of the National Roma Council and creation of the Institute on the Roma culture).

3.4 Governance

The report was written with the participation of all relevant stakeholders, both public and private. The Ministry of Labour and Social Affairs coordinated the process of drawing up the national action plan. It is important to highlight the increasing importance of NGOs and social partners in drawing up, implementing and monitoring the plan. The explicit mention of a number of coordination measures among the national, regional and local administrations, which takes into account the decentralised structure of Spain, should also be noted.

4. Pensions

The income of people aged 65+ is relatively close to that of the 0-64 age group (75%), while the risk of poverty for the elderly population (29% in 2004) is significantly higher than that of the 0-64 year-olds. In spite of recent increases in the employment rate of older workers and a slightly higher rate than in the EU, further progress is needed to achieve the 50% Lisbon target for 2010.

Spain faces a major challenge with regard to financial sustainability due to demographic trends. Nevertheless, the 2006 Sustainability report assessed Spain as a medium-risk Member States as regards the sustainability of public finances, notably due to the high cost of population ageing and despite the current strong budgetary position. According to the 2005 AWG projections, public spending on pensions is set to increase from 8.6% to 15.7% of GDP, far more than the EU average. Due to Spain's relatively late ageing profile, nearly all the pension expenditure increase is projected to occur after 2015, and the reserve fund would enable deficits to be delayed until 2020. According to ISG projections, the theoretical replacement rate provided by the earnings-related scheme for average-earning workers retiring at 65 after 40 years should decrease by 6 p.p. by 2050, reaching a level of about 85% of gross replacement rate in 2050 (92% of net replacement rate).

The 2006 Joint Report underlined that the increase in employment rates and the reforms already enacted, in particular the strengthening of the link between contributions and benefits and the gradual implementation of the reform of minimum pensions, should translate into an improvement in the adequacy of pensions and a reduction of gender differences in living standards and poverty risks. It also stressed the importance of further reforms to secure both future adequacy and sustainability, in particular through a higher rate of participation in the labour market, especially for women and older people.

Thanks to sustained economic growth and fiscal discipline, Spain has made major efforts to achieve balance in public finances. Moreover, the national social security system has been showing surpluses since 1999 (1.1% of GDP in 2005, more than 1% GDP expected in 2006).

An Agreement between Government and Social Partners was signed in July 2006. Together with measures already adopted for increasing minimum pensions, it reaffirms the process of separating sources of financing for top-ups of minimum pensions, which will also be extended to include some pending specific categories of permanent invalidity pensions, and restructures widows' pensions. It also develops the rationalisation of the social security system, incorporating self-employed workers under the agricultural special schemes in the self-employed scheme, while salaried agricultural workers will be members of the general scheme. Furthermore, incentives to work longer are strengthened, notably for partial pensions (available from 61 instead of 60) and for deferment of retirement above the age of 65. This new agreement will improve future sustainability and adequacy, though it remains to be seen whether further measures will be needed to achieve sufficient increases in the employment rates for older workers.

5. Health and long-term care

5.1 Health care

Description of the system: A National Health System (NHS), defined as the mix of central government and regional government services, provides universal coverage. It is a decentralised system with 17 autonomous regions running the health care services for their populations, the Ministry of Health having a monitoring role and ensuring the equity of the system, and the Interterritorial Council of the NHS (ICNHS) having a coordination role. Primary health care (PHC) is publicly managed and delivered in health centres. Patients register with a general practitioner (GP). GPs refer patients to specialists, who refer them to hospital care. Outpatient ambulatory centres provide outpatient specialist care ,and inpatient care is provided in hospitals which are publicly owned. The NHS also contracts services from private non-profit providers. PHC staff are paid a salary with some capitation, and hospital doctors are paid a salary. It is a tax-based system, free at the point of access. Co-payments apply to pharmaceuticals. Private voluntary complementary insurance covers 10% of the population. Civil servants can opt for one of the three publicly funded mutual funds (70% state funding and 30% contributions) and can choose between public and private provision. Authorities identify as goals the need to ensure countrywide equitable access to high quality care (notably by ensuring specific protection for disadvantaged groups) and the need to improve population health and reduce premature mortality and the burden of disease.

Accessibility: Though care is free at point of access except for pharmaceuticals, data show that private, notably out-of-pocket expenditure is high (23.3% of total expenditure in 2004), which may denote a financial burden for more vulnerable groups. Authorities highlight that whilst decentralisation can ensure more adaptability to local needs it has resulted in regional differences in provision. To prevent such differences they have established a portfolio of common standardised services for the NHS countrywide and will use social cohesion funds to compensate some regions. Another concern which has been voiced relates to the length of the waiting lists (partly due to having one of lowest number of beds – 358 per 100 000 inhabitants – in the EU and still a strong use of hospital care vis-à-vis PHC as GP numbers are low in EU terms). Thus, the Ministry of Health has established criteria indicators and minimum basic and (countrywide) common requirements for waiting lists for specialists, diagnostic and therapeutic trials and surgery.

Quality: A quality plan for the NHS has been drawn up to guarantee maximum levels of quality in healthcare in all regions on an equal basis. It involves developing strategies with all stakeholders (e.g. staff and patients) to ensure clinical excellence, for example. Strategies include greater use of ICT. Authorities are devising a plan to gather and monitor data on effectiveness. Patients can choose their GP within their area of residence.

Long-term sustainability: Total healthcare expenditure (7.8% of GDP and 1908 per capita PPP$ in 2004) is below the EU average[36] and has been more or less constant over the past decade. Public expenditure in 2004 corresponds to 71.9% of total health care expenditure, showing a decrease over time. It thus appears financially feasible to spend more on improving access and quality of health and long-term care without endangering the sustainability of public finances. Indeed, recognising insufficient health care finance, authorities are allocating additional resources to the sector, increasing revenues to the regions from taxes on tobacco

[36] 8.87% and 2376.33 in 2004.

and allowing regions to obtain further revenues. Authorities see ageing as a major challenge to service provision and sustainability (the 2006 EPC/EC age-related projections foresee an increase in public expenditure of 2.3 percentage points of GDP by 2050). To improve system efficiency the report focuses on enhancing the use of PHC vis-à-vis the overuse of unnecessary hospital or emergency care, on ensuring the rational use of technology and medication, on developing incentives for staff, on centralising and standardising the procurement of health products and equipment and centralising highly specialised services. A serious concern stressed in the report is the financing of care for foreign patients as Spain is an important provider of services for people insured under other countries' regimes. The Ministry of Health together with the National Institute for Social Security and the autonomous regions are trying to increase revenue for this item from € 32 to 60 million. A number of initiatives are planned for promoting healthy life styles and preventing avoidable death (focusing on tobacco, obesity, traffic accidents, and exercise) and for strengthening disease surveillance systems.

5.2 Long-term care

Description of the system: Traditionally the family had the main role in care giving but ageing and socio-demographic changes (increased female labour participation) are making the provision of long-term care services an ever more pressing concern for authorities. Hence, various laws have been extending the range of services in this area over the past decade. They now include: PHC at home, day centres, temporary stays in residential homes, residential homes, telecare and financial aid to dependents and carers. Services to help those in a dependency situation are mostly organised by autonomous regions though sometimes they are jointly organised by the central government, regions and local authorities. They are part of the Social Security System.

Accessibility: Despite significant growth in services in recent years, authorities point to deficiencies in supply in view of the demand from dependents and from carers: e.g. only 3.5% of those 65+ received home help, 2.84% received telecare and 0.54% had a place in a day centre while 3.9% received residential care. They recognise that decentralised responsibilities have led to an uneven provision across regions. In this context, authorities have launched a major plan, the Autonomy and Dependency Care System, intended to increase coverage of all people in a situation of dependency (from disabled children to adults to the dependent elderly, some 650 000 people) by 2015 through a large boost in provision. The plan aims to ensure equity of access by using a common dependency scale and by defining a standard catalogue of services (wide range of home care, assistance and adjustment, day centres, night centres, residential care). It also aims to improve the integration of health and social services. Services may be supplied by public or private providers and each region organises service supply. Financial benefits will be allowed and family carers will enter the social security system and attend training courses when as caregivers. User charges are to be based on income and income brackets. The government recognises that this process will take some time and effort to accomplish.

Quality: A range of service charters, accreditation systems and quality indicators are being gradually adopted. The need for coordination between health and social care has been identified and several regions already have coordination plans.

Long-term sustainability: Current funding comes from regions, municipalities and central government. It is considered scarce in view of the needs. It is about 0.32% of GDP, and the 2006 EPC/EC age-related projections foresee an increase in 0.2 percentage points of GDP by

2050, without taking them into account in the financial impact of the new Law on the Promotion of Personal Autonomy and Care for People in a Situation on Dependency. Note, however, on the basis of the financial report of the Law that authorities are allocating an extra € 4,500 million to the sector in the near future and expenditure is expected to increase to 1% of GDP by 2015. Within the new plan the central government, regions, local authorities and users are to share the cost. Authorities highlight that this should also be seen as investment as it increases employment (300 000 new jobs), tax revenue and quality of life.

6. Challenges ahead

To break the intergenerational transmission of poverty, in particular by reducing the high rate of early school leavers. The new Education Law sets out to address this issue, but reaching the 2010 target will require sustained and comprehensive efforts.

To continue efforts to promote the active inclusion of vulnerable groups, such as the immigrant population and young people, and of women by reducing persistent inequalities in income, access to education and labour integration and to promote affordable housing through an appropriate and long-term public and rental housing policy.

To facilitate a higher level of participation, notably of women and older workers, in the labour market; this would help secure the sustainability and adequacy of the pension system.

To tackle regional differences in provision, reduce long waiting times and enhance the provision of long-term care and to improve efficiency, notably through an increased use and distribution of PHC and a rational use of services, technology and medication

Spain: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5,0	92.1	**2000**	56.3	71.2	41.3	32.5	37,0	**2000**	11.1	7.9	16,0	24.3
2002	2.7	95.2	**2002**	58.5	72.6	44.4	34,0	39.6	**2002**	11.1	8.1	15.7	24.2
2004	3.2	96.6	**2004**	61.1	73.8	48.3	35.2	41.3	**2004**	10.6	8,0	14.3	23.9
2006	3.8f	98.1f	**2005**	63.3b	75.2b	51.2b	38.3b	43.1b	**2005**	9.2	7,0	12.2	19.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast; b: break in series*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total Health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI** % of pop
	male	female	male	female	male	female							
1995	74.3	81.5	16,0	19.8	64.2	67.7	5.5	**1995**				99.8	
2000	75.8	82.5	16.6	20.4	66.5	69.3	4.4p	**2000**	7.4	71.6	23.6	(1997)	13
2004	76.9	83.6	17.2sp	21.2sp	66.8e	70.2e	4.0p	**2004**	7.8	71.9	23.3		

e: estimate; s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	21.6	43.9	28.6	16.5	2	1.6	7.4
2000	19.7	46.2	29.4	12	2.9	1.5	7.9
2004	20	43.7	30.8	12.9	3.5	1.7	7.5

** including administrative costs*

Age related projection of expenditures (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health Care	Long Term care
2005	24.5	./.	8.6	6.1	0.5
2010	25.4	-0.4	./.	./.	./.
2030	38.6	3.3	3.3	1.2	0
2050	66.8	8.5	7.1	2.2	0.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	24	19	16	29	25	29	25	29	22	**Total**	5.4
male	19	-	17	15	26	28	-	26	29	23	**male**	-
female	21	-	20	17	32	24	-	24	28	20	**female**	-

	People living in jobless households					Long Term Unemployment rate				Early school leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	7.3	8.5	7.7	9.3	**1999**	5.7	3.6	9,0	**1999**	29.5	35.3	23.6
2004	6.3	7.3	6.7	7.9	**2004**	3.4	2.2	5.1	**2004**	31.7	38.5	24.6
2006	5.1	6.3	5.8	6.8	**2005**	2.2b	1.4b	3.4b	**2005**	30.8b	36.4b	25.0b

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0.754	0.773	0.756	***Aggregate replacement ratio***	0.561	0.615	0.6

Change in theoretical replacement rates (2005-2050)

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)			Contribution rates	
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	Estimate of current (2002)	Assumption
-6	-5	-5	DB			89		28.3		

**:(DB / NDC/ DC); ** (DB / DC)*

2.10. FRANCE

1. Situation and key trends

GDP growth, which was modest in 2005 (1.2%), increased substantially in 2006 and was estimated to be 2.2%, with increased creation of jobs in the market sector. However, this development includes a surge in low-quality jobs, temporary work, fixed-term contracts or apprenticeships, traineeships and subsidised contracts (accounting for 13.6% of wage and salary earners in 2005). The number of poor workers was 1.933 million in 2003. The employment rate (63.1% in 2005) has hardly risen since 2002 and even declined slightly for men between 2002 (69.5%) and 2005 (68.8%). Only the rate of female activity, which has been steadily rising (57.6% in 2005), is approaching the Lisbon objectives. At the two extremities of the age pyramid, the main improvement concerns the 55-64 age group, whose employment rate (37.9% in 2005) has increased substantially since 2000 (+8%), mainly for demographic reasons, whereas the employment rate of young people (30.1% in 2005) has risen only marginally over the period (+1.5 percentage points). France's unemployment rate is still high (9.7% in 2005), even though it fell steadily between June 2005 and July 2006 to reach 8.9%. The unemployment rate among women is about 2% higher. The long-term unemployment rate is broadly the same as in 1999 (4% in 2005). 13% of the total population are at risk of poverty. The share of GDP accounted for by social security expenditure is stable (31.2% in 2004), with large proportions being spent on pensions (43.6% of the total) and health (30%). French demography is marked by a relatively high fertility rate (1.92) and life expectancy at birth above the Community average (76.7 years for men and 83.8 years for women in 2004), whereas life expectancy in good health is below the EU average[37] (60.6 years for men and 63.9 years for women in 2003). Infant mortality was 3.9/1000 in 2004, which is below the EU average, and has been falling steadily since 1970 (18.2). The old-age dependency ratio should rise less sharply than the European average from 25.3% in 2005 to 47.9% in 2050.

2. Overall policy approach

The report highlights the French social model, in which high-quality full employment and greater social cohesion are considered to be indispensable to growth. Its strategic dimension is far more marked than in previous plans, with three major thrusts consistent with the European overarching objectives: to improve the financial position of the social security schemes in order to make the French social model sustainable over the long term and maintain a high level of social protection; to enhance the quality and accessibility of health care and long-term care and ensure that they are adapted to needs; to pursue a global and integrated strategy of social inclusion based essentially on employment (with the emphasis on the integration of target groups, especially young people), housing and equal opportunities (over-arching approach). The interaction between social protection and social inclusion policies and the development of growth and employment is mentioned, whether for the measures in favour of the employment of the least-skilled workers, older people or women or for the extension of working life which the 2003 pension reform is seeking to achieve. The emphasis is placed on developing the governance of social policies and mainstreaming. In a context marked, in terms of equal opportunities, by the problem of unemployment and the exclusion of the visible minorities, equal opportunities for men and women is not in itself a policy priority.

[37] EU average of 64.5 years for men and 66 years for women in 2003.

Nevertheless, this topic is dealt with more extensively than in previous plans and the statistical data in the annex are provided by sex in most cases.

3. Social inclusion

3.1 Key trends

The poverty rate for the population as a whole was 13% in 2004 (14% for children and women). This rate rises to 26% before transfers (44% excluding pensions and survivor's benefits). Net income from social assistance amounts to 78.6% of the poverty threshold for a single person, 81.7% for a single parent with two children and 69.9% for a couple with two children. According to national sources, administrative poverty (recipients of minimum social income) increased in 2004 and 2005 with the rise in the number of people receiving minimum income benefit (RMI) and the fall in the number of people leaving the scheme in recent years. Unemployment remains a major problem, especially for two categories: the 15-24 age group (22.7% of unemployed people in 2005) and the immigrant population (15% for men and 22% for women, with far higher levels for immigrants from non-Community countries, even when they have the same characteristics as the rest of the population). In 2005, 10.9% of adults (9.5% of children) lived in jobless households. There was a school drop-out rate of 12.6% (14.6% for boys) in 2005.

3.2 Main challenges and priorities

The report identifies three priorities, which are consistent with the European objectives and the main challenges identified in the 2006 Joint Report: access and return to employment of people who are the furthest removed from the labour market, the social and occupational integration of young people, especially those affected by problems of discrimination, subsidised housing and the provision of accommodation. The last two issues have been the main social issues in the news since the autumn of 2005. The contribution of the social cohesion plan is underlined, especially in terms of employment, with the restructuring of the public employment service, the enhanced accompanying measures, the focus on apprenticeship or the root-and-branch reform of subsidised contracts, which have made a major contribution to the fall in the employment rate over the past year. However, several measures have been introduced too recently for their lasting contribution to the objectives to be assessed. Mention is also made of the success of the new recruitment contract (*contrat nouvelles embauches* = CNE) and the boom in personal service jobs, but they are marred by a substitution effect for the former and involuntary part-time working for the latter.

The systems of monitoring and evaluation have been strengthened, especially by grouping bodies together in order to improve synergies and by establishing agencies, making it possible to create new partnerships: the *Agence nationale pour la rénovation urbaine* (national agency for urban renovation = ANRU) is one of the good practices presented, and its social counterpart will be the *Agence nationale pour la cohésion sociale* (national agency for social cohesion) in 2007. The State's overall funding of social inclusion policies is estimated to be over €33 billion per year in 2006 and 2007. The report occasionally refers to the ESF contribution. Work is currently under way to establish numerical objectives and objectives by sex to be attained in the work to combat poverty and exclusion. At this stage, the report includes several results to be achieved, most of which relate to the creation of systems rather than the expected effects. Mention should be made, however, of the clear objective of increasing the employment rate of older workers by 2 percentage points a year to reach 50% in 2010.

3.3 Policy measures

Promoting the return to the labour market of those people furthest removed from it is the first priority with three thrusts, primarily the development of the supply of jobs through traditional measures such as reductions in employers' social security contributions (their abolition in 2007 at the level of the minimum wage (SMIC) for enterprises with fewer than 20 workers). It would be worthwhile evaluating the results in relation to the costs. The schemes that have been started are being continued, such as the CNE, encouragement of employment in certain sectors, the validation of experience acquired (VAE) or the new subsidised contracts. While the last-named have definitely been a success, it would seem that this has mainly been the case in the non-market sector. Necessary work on training through these schemes will be carried out. Work will also be done on VAE in order to ensure that it too benefits the people who are furthest removed from the labour market. There is also a focus on the integration by economic activity (which received €30 million per year from the ESF in the period 2000-2006). The scheme to encourage business creation will be strengthened (with particular reference to women) in terms of the support provided after the start of the activity. The plan for the employment of older workers 2006-2010 (with a budget allocation of €10 million) is the real innovation in this range of measures. The development of equality of remuneration is still a declared objective. An evaluation is planned for 2008. However, little attention is paid to the professionalisation of personal services jobs. The second focus is to help people to reduce their dependence on assistance and to return to employment with the readaptation of profit-sharing schemes and the employment premium, which was considerably increased in 2006 and 2007 but whose impact on return to activity is apparently very limited. The third focus concerns the removal of obstacles to access to employment. Here the emphasis is placed on existing support measures (with ESF participation for individually tailored social assistance of €12 million per year in the period 2000-2006), the reorganisation of the employment services, priority access for recipients of the minimum income to childcare facilities, measures to combat illiteracy, to promote health and to combat poor housing, over-indebtedness and employment discrimination based on sex, age, disability or ethnic origin. Cooperation is planned between the care services for immigrants and the ANPE.

The second priority is the social and occupational integration of young people, with measures to avert failure at school by providing assistance to 200 000 children and adolescents who are experiencing serious difficulties (the educational success programme, which is mentioned as a good practice, is an objective at this stage), the doubling of the number of mediators between families and State institutions, the strengthening of the schemes for the provision of advice at school and university and new grant and mentoring schemes. Secondly, to develop the range of employment opportunities on offer: the existing schemes (contracts for young people in enterprises, specific mechanisms for entry into the civil service, the results of which remain very limited) will be supplemented by greater use of employment policy resources to assist the least-skilled young people in disadvantaged neighbourhoods. The third focus is designed to promote apprenticeship and the development of integration programmes: an increase in the number of young people in work-linked training in enterprises of over 250 employees, a "junior" apprenticeship for the 14-16 year age group, the pursuit of the professionalisation contracts and the contract for integration into the life of society (CIVIS), which was extended in 2006 to new graduates who are furthest removed from the labour market, and voluntary civil service focused on occupations with spare capacity. Finally, the removal of obstacles to integration also involves legal information measures and access to housing, health care and leisure. Few measures specifically incorporate the gender dimension, even though a higher proportion of girls are unemployed. The only genuinely gendered measures are access to

apprenticeship and diversification of school guidance choices. However, no impact study seems to have been conducted on previous measures of this type.

Developing the supply of subsidised housing and quality accommodation is the third priority of the social cohesion plan and the national housing pact. While there is no denying the boost to construction (with an objective of 100 000 subsidised housing units in 2006 and 500 000 in the period 2005-2009), associations fear that this will mainly benefit the middle classes. Several measures should make it easier for people to find housing and to stay in it. The enforceable right to housing, which is something that associations have been advocating for a long time, will be tested at local level in conurbations with more than 50 000 inhabitants under arrangements that are not specified. The combating of accommodation unfit for habitation, which is cited as a good practice, is an objective that has started to be implemented. It is reinforced with the creation of an emergency rehousing assistance fund (€20 million over five years). It is planned to develop adapted types of housing and the system for assisting the most vulnerable groups, and the issues of travellers and immigrant women are taken into account. Double discrimination is dealt with in terms of access to separate housing in order to facilitate the separation of polygamous households, the granting of family allowances to the mother and access to training.

3.4 Governance

The report is essentially an interministerial effort. Mention is made of three bodies consulted, including the National Council for Combating Poverty and Social Exclusion (CNLE) and the National Council for Integration through Economic Activity. It was preceded by a national conference (April 2006) prepared by subject-based territorial meetings involving many players. The renewal of the State's steering work is continuing with ambitious objectives for the period 2006-2008. Systematic evaluation of the new measures is announced, as are the creation of a monitoring group for the 2006-2008 report at the CNLE and the continuation of the work under way on monitoring indicators, which are already very exhaustive. It is planned to hold a parliamentary debate on the inclusion plan, which is not widely known, and to disseminate it to the players. Evaluation by users will be developed, and the integrated approach will be strengthened through the existing mechanisms at interministerial level and the overarching policy document, the continuation of a national conference and meetings in the regions. The most innovative area of work is the announcement of the approximation of local-level systems with the committees of the Departments which are to have a coordinating role and be involved in the drafting, implementation and monitoring of the plan's objectives and indicators. This concern for consistency can also be seen in the wish to incorporate the integration and inclusion measures into local projects for sustainable development.

4. Pensions

In 2004, older people enjoyed a relative living standard close to that of the general population (90%), while the poverty risk among older people (16%) was slightly higher than for the population below the age of 65. The increase in the employment rate of older workers has slowed down, and remains relatively low at 37.9% in 2005.

The 2006 Sustainability Report assessed France as a medium-risk Member State as regards the sustainability of public finances, notably due to the current weak budgetary situation, but also reflecting the effects of enacted pension reforms. According to AWG projections, public spending on pensions is expected to increase by 1.9 p.p. between 2004 and 2050, while under ISG projections theoretical replacement rates are expected to decline in the future. For a

worker retiring at 65 after 40 years working for the average wage, the net replacement rate will decrease from 80% in 2005 to 63% in 2050 (gross replacement rate from 66% to 49%). In order to maintain adequate replacement rate levels, the reform nevertheless aims at increasing the insured period beyond 40 years, in accordance with increases in life expectancy.

The 2006 Joint Report highlighted recent progress in pension reform, while underlining the key importance of further improvements in the employment situation of older workers.

The 2003 reform has significantly improved the financing of the pension system for the decades ahead, thus preserving the basic architecture of the current system, while contributing to more equitable treatment of members of different schemes. While current adequacy does not constitute a key issue, projected replacement rates are expected to decline in the future, and the level of pensions will thus have to be monitored attentively, in particular for the most vulnerable groups of the population. But a net replacement rate of 85% has been fixed from 2008 as an objective for the lowest pensions (careers on minimum wage) and will be re-examined in 2008.

Incentives to work longer have been further strengthened in 2006 under a national action plan for older persons' employment (notably *surcote* and better possibilities to combine employment and pensions), this being a further step towards putting the pension system on a financially sustainable footing in the long run. In spite of recent increases, the employment rate of older workers remains low, and further measures will be necessary, in particular to reduce early exits from the labour market. Current reforms will only be fully successful if they are accompanied by a sustainable strategy to increase the participation of older workers in the labour market and to raise employment in general. The 2003 reform provides for quadrennial reviews, the first one being in 2008, which is projected to lead to a further one-year rise in the number of contributory years required for a full pension, from 40 to 41 years between 2009 and 2012 for employees in the public and private sectors.

5. Health and long-term care

5.1 Health

Description of the system: The French health system is based on principles of solidarity and universal access: it covers the entire population on a basis that is primarily occupational and that, since 2000, has secondarily been residential. The basic schemes, which are financed in a mixed manner (social security contributions and taxation), cover approximately 3/4 of healthcare expenditure but offer better coverage for persons with long-term disorders. Disadvantaged people enjoy supplementary health cover free of charge (CMUC). A considerable proportion of the population (92%) has contracted occupational or individual supplementary insurance. The basic principle is to reimburse insured persons for the healthcare costs that they have incurred, but direct billing (the "third party pays" principle) by sickness insurance funds or supplementary insurance funds is possible and is the rule for hospitalisation. The National Union of Sickness Insurance Funds (UNCAM), bringing together the main pre-existing sickness insurance schemes (general scheme, agricultural scheme and self-employed scheme), was set up in 2004. It is responsible for setting the reimbursement rates within the range set by the State and for deciding which treatments and care are eligible for reimbursement. The sickness insurance funds are involved in setting the annual objectives for expenditure that are adopted by Parliament and, to this end, they submit annual forecasts for expenditure and income that are taken into account in setting the national

objective for sickness insurance expenditure. The State generally sets the prices, especially the tariff structure for health establishments and reimbursable medicines. Health establishments and self-employed doctors are paid on an "activity-based tariff scale". Doctors employed in State hospitals are paid through a salary.

Access: Persons on low incomes benefit from supplementary instruments, such as full coverage of all healthcare costs without the need to pay for health care initially, under the CMUC. Households whose resources are slightly above the limit for entitlement to the CMUC are granted assistance towards the payment of supplementary health insurance in the form of a tax credit, the threshold for which will be increased from 15% to 20% of the CMU ceiling in 2007 in order to increase the number of beneficiaries. However, there are still major differences between social groups in terms of access to care, especially specialist treatment, medical auxiliaries, eye care and dental treatment. Geographical disparities in the provision of care can be seen at local level. Specific measures, such as bonuses to encourage general practitioners to work in areas with insufficient doctors, have been taken. Since 2004, greater patient responsibility has been introduced: in order to improve the coordination of care and to avoid superfluous medical treatment, people have an incentive to designate their own general practitioner and a computerised personal medical file is gradually being created with penalty clauses (lower coverage of costs for treatment outside a person's treatment programme, for failure to submit the personal medical file or for doctors' fees exceeding the limit) have been introduced. The proportion of healthcare expenditure payable by patients (not covered by the basic scheme or by the CMUC or by supplementary insurance schemes) in the form of a "patient's contribution" represents about 10% of total expenditure.

Quality: The assessment of the quality of practices and strategies in diagnosis and treatment has been strengthened and is the responsibility of the *Haute authorité de santé* (HAS). Its main tasks are to bring together knowledge on evaluation (technological evaluation, occupational practices, clinical audit training, etc.) and to draw up recommendations (recommendations for clinical practice, medical references, consensus conferences on major clinical, diagnosis or treatment topics). The HAS is also responsible for the accreditation procedure for healthcare establishments (procedure renewable at least every five years). The formalisation of public health strategies through national subject-based plans with regional variants (for cancer, chronic diseases, etc.) helps to improve quality standards. Patients are free to choose healthcare providers, including specialists, and there are few waiting lists. Patients' rights have gradually been improved (especially the right to freedom of consent with a knowledge of the facts and direct access to one's medical records) through legislative reforms comprising measures designed to improve the quality of the system (compulsory continuing training for doctors, evaluation of occupational practices, improvement of the functioning of the tribunals of the associations of the medical professions, and development of health networks). Prevention systems have been strengthened in order to promote a culture of public health and prevention.

Long-term viability: The main challenge is the gap between health income and expenditure. With expenditure rising faster than income, the measures taken to reduce the deficit of the National Sickness Insurance Scheme (CNAM), which amounted to €11.6 billion in 2004, started to bear fruit in 2005 (reduction to €8 billion). A monitoring committee has been set up in order to monitor compliance with the national expenditure objective. If it looks as though expenditure will exceed the objective by more than 0.75%, the committee will alert the authorities and the national funds so that remedial action is taken. Total expenditure on health accounted for 10% of GDP (or PPP$ 3 016 per capita) in 2004. In that year, the State accounted for 76.5% of this expenditure. According to the 2006 projections of EPC/EC,

public expenditure on health and care should rise by 1.8% of GDP between now and 2050 as a result of population ageing. Since control of expenditure by the patient's contribution can be lessened by the very extensive use of supplementary health insurance, more "medicalised" systems of regulation have been set up (assessment of the "medical service rendered" having an effect on the reimbursement rate, promotion of proper use of care, with positive effects on the consumption of antibiotics and greater use of generic medicines). The prices of medicines are regularly revised, and generic medicines are promoted. The 2005 medical agreement aimed to save €1 billion, especially in the areas in which consumption is far higher than in other countries (psychotropic medicines, antibiotics). A flat-rate contribution to treatment has been introduced. In hospitals, efforts to save money mainly take the form of a rationalisation of purchasing policy.

5.2 Long-term care

Description of the system: The system is based on double financial coverage. On the one hand, health insurance finances the care provided by institutions to their disabled or dependent residents, long-term care units (hospital services for patients who cannot live independently) and nursing care for people at home. The costs of care are paid directly by the sickness insurance funds through the "direct billing" system. Since the cost of care is covered by sickness insurance, the cost of accommodation is payable by the person concerned or by social security if he has insufficient resources. Sickness insurance is the only financer of socialised coverage of long-term care (8% of total sickness insurance expenditure). On the other hand, two schemes mainly financed by the State and local authorities provide benefits as a contribution towards the costs of loss of autonomy at home or in an institution: disability compensation benefit (*prestation de compensation du handicap* = PCH), personalised independence allowance (*allocation personnalisée d'autonomie* = APA) for dependent elderly people. Benefits to cover the cost of home help are also paid as part of the social action of the old-age pension insurance funds. Elderly or disabled people also use the ordinary care system, thus benefiting from the same services as other insured people. The *Caisse nationale de solidarité pour l'autonomie* (CNSA) pools the funds collected from the solidarity-based contribution for autonomy (*contribution de solidarité autonomie*) and the funding allocation of sickness insurance laid down in the national objective for sickness insurance expenditure. The CNSA pays the Departments a contribution towards the funding of the APA and the PCH, thus spreading the national solidarity effort between regions and Departments. The Departments finance the dependency component of the amount charged by establishments and generally provide compensation for loss of autonomy through benefits (APA, PCH).

5.2.2 Access: Recent reforms are designed to develop structures that provide appropriate health care by the end of 2007. A plan for the medicalisation of institutions for the elderly or dependent persons has been launched. In order to ensure access to long-term care, efforts have been made to structure financial assistance for autonomy, with positive results (financial assistance, reductions in taxation, choice of benefits in kind or in cash, financial assistance to cover the cost of home help, etc.), thereby reducing the costs of care at home and in institutions. However, there is still a problem of solvency and efforts need to be made to improve coordination of sources of funding in order to ensure uniform provision of services. The financing of assistance to cover the costs of home help by municipalities and old-age pension insurance funds, where a person's level of dependence is below that required to receive the APA, and the universal service employment voucher (CESU), which makes potential users of services at home more solvent and can be pre-financed by direct billing, are examples of the efforts made to help disabled or dependent people.

Quality: Medico-social establishments and services that are financed by sickness insurance must be jointly authorised in advance (State, Department). Their care budgets and their scales of charges are negotiated annually. Users' rights have been enhanced (welcome brochure, contract for a person's stay, work plan for an establishment). Quality policy is supported by voluntary guidelines (i.e. personal services at home). Increased training and the validation of experience, which is a key plank of the professionalisation of these occupations, address the growing need for qualified staff. The authorities wish to increase the coordination of the health sector and the medico-social sector by launching a new plan entitled "*solidarité grand âge 2007-2012*" (2007-2012 plan of solidarity with the very elderly), which will be designed to encourage alternatives to hospital care and to improve the structure of the provision of care in the regions, with geriatric medicine coordinating the various players. Family support leave, offering carers a protective legal framework for their jobs but no compensation, will be introduced in 2007.

Long-term viability: The funding allocated by sickness insurance to long-term care has increased at a rate of more than 7% in recent years (which is higher than the increase in the income of sickness insurance). New resources are allocated to the funding of the CNSA: the solidarity-based contribution for autonomy (0.3% on wages and salaries in return for an unpaid additional day of work) and an additional contribution of 0.3% to the social security charges levied on certain income from assets and investments. Part of these resources will supplement the contribution from sickness insurance to the financing of medico-social structures. The expenditure payable by residents of institutions is correlated with changes in the cost of the accommodation component. Since the development of expenditure (costs and wages/salaries) is limited by the national objective for expenditure on sickness insurance and the CNSA, the increase in resources is limited.

6. Challenges

to promote active inclusion, in particular access and lasting return to the labour market of persons who are the furthest removed from it, with particular attention being paid to effective, occupational and socio-economic integration of visible minorities, especially young people;

to deal with the housing crisis, especially in the urban areas with the greatest problems;

to ensure pension adequacy and financial sustainability by putting in place the conditions for older workers to remain longer in employment and positively respond to improved employment incentives in the pension system;

- to consolidate the financial sustainability of the healthcare system by further development of reforms to ensure better coordination and integration of the programme of care through steering by a person's chosen general practitioner, which could lead, among other things, to rationalisation of consumption of medicines and more direct involvement of all players in the more efficient use of resources;

- for long-term care, to ensure coordination of the various funding bodies in order to reduce the remaining cost payable by individuals, thus providing greater equality of access to long-term care and guaranteeing the long-term solvency of the system, the costs of which will necessarily increase due to demographic change, population ageing and medical and technological progress.

France: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.0	113.3	**2000**	62.1	69.2	55.2	28.6	29.9	**2000**	9.1	7.6	10.9	20.1
2002	1.0	112.0	**2002**	63.0	69.5	56.7	29.9	34.7	**2002**	8.7	7.8	9.8	19.7
2004	2.3	107.7	**2004**	63.1	69.0	57.4	30.4	37.3	**2004**	9.6	8.7	10.6	21.8
2006	2.2f	107.3f	**2005**	63.1	68.8	57.6	30.1	37.9	**2005**	9.7	8.8	10.7	22.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	73.9	81.8	16.1	20.6	60.0	62.4	4.9	**1995**	9.5	76.3	-		
2000	75.3	82.7	16.7	21.2	60.1	63.2e	4.4	**2000**	9.3	75.8	10.5	99.9	86
2004	76.7sp	83.8sp	17.7sp	22.1sp	60.6e	63.9e	3.9	**2004**	10	76.5	10.1		

e: estimate; p: provisional; s: eurostat estimate **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	30.3	43.5	28.3	7.9	10	4.5	5.9
2000	29.5	44.4	28.8	7.2	9.1	4.7	5.9
2004	31.2	43.6	30	7.8	8.5	4.4	5.8

** including administrative costs*

Age- related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	expenditure (% of GDP) Level in **2004** and changes since			
		Total social expend.	Public pensions	Health care	Long - term care
2005	25.3	26.7	12.8	7.7	
2010	25.9	0			
2030	40.7	1.9	1.5	1.2	
2050	47.9	2.9	2	1.8	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13	14	13	12	16	17	15	17	17	15	**Total**	4.0
Male	12	-	12	11	15	17	-	17	19	13	**Male**	-
Female	14	-	13	12	18	16	-	17	17	17	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	9.9	11.3	10.1	12.5	**1999**	4.1	3.4	4.9	**1999**	14.7	16.0	13.4
2004	9.6	10.8	9.5	12.1	**2004**	3.9	3.5	4.3	**2004**	14.2	16.1	12.3
2005	9.5	10.9	9.9	12.0	**2005**	4.0	3.5	4.6	**2005**	12.6	14.6	10.7

** excluding students*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.899	0.930	0.881	***Aggregate replacement ratio***	0.663	0.723	0.601

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or Social Security)	pensions Current estimate (2002)	Assumption
-17	-17	-17	DB			Nd			20		

- **:(DB / NDC/ DC); ** (DB / DC)*

2.11. ITALY

1. Situation and key trends

Following a period of poor economic trends, in 2005 Italy's GDP remained stable, along with the employment rate (but forecasts for 2006 show a 1.7 percentage points growth). The labour market experienced a slight improvement, with modest job creation and a reduction in unemployment between 2004 and 2005 (from 8% to 7.7%). This last outcome is due to some extent to a discouragement effect among the young and among women (especially southern women); in fact, between 2003 and 2005 the general activity rate decreased (-0.5%) and the female activity rate, after a long-term increasing trend, reversed from positive to negative in 2004, followed by a small contraction in 2005 (from 50.4% to 50.3%). The total employment rate has increased over recent years, but at 57.6% in 2005 is still well below the Lisbon targets. The situation is especially bad regarding older workers (aged 55-64), where in spite of recent increases, the employment rate of 31.4% in 2005 contrasts with the Lisbon target of 50%. Significant gender gaps and territorial imbalances still characterise the Italian labour market, as well as increasing flexibility – especially for younger generations – and the persistently high presence of irregular jobs.

In 2004 Italy's at-risk-of-poverty rate[38] was 19%, and national data show that it has remained relatively stable over recent years. According to the latest available Eurostat data (2004), Italy spends 26.1% of its GDP on social protection; such expenditure is primarily devoted to old age and survivors[39] (61.3%) and sickness and health care (25.9%), while unemployment, housing and social inclusion functions are chronically underdeveloped. Due to ageing and a low fertility rate (1.33 in 2004) Italy is expected to face strong adverse demographic trends over the coming decades: the old-age dependency ratio (29.4 in 2005) is expected to rise to 66 by 2050, with projected growth of social expenditures of 1.8 points. Life expectancy (77.1 for men and 82.8 years for women) and healthy life expectancy (70.9 and 74.4 years respectively) are high and above the EU average. Infant mortality, at 4.1 per 1000 in 2004, is slightly below the EU average.

2. Overall strategic approach

A new strategic approach is quite evident in this report: social inclusion and social protection policies seem to have gained in importance in the government agenda. Frequent references to gender issues are made throughout the text, and attention to and visibility of gender equality can be considered adequate. Good strategic guidelines represent the main strength of the document but, on the other hand, despite recent progress, too few objectives are clearly targeted.

[38] Please note that due to a methodological improvement in the EU-SILC implementation in 2005 which affected in different way different groups of the population and caused a large increase in the at-risk-of-poverty relative threshold, data shown for income year 2004 cannot be compared to the values published last year (2004 SILC exercise for income year 2003). In particular, large year to year differences (as for the values of elderly poverty indicators - at-risk-of poverty rate of the 65+, relative income of the 65+, aggregate replacement ratio, etc) cannot be considered significant. In the near future, data for 2004 SILC exercise will be retrospectively corrected in order to allow year to year comparisons.

[39] It should be noted, however, that in Italy benefits such as the TFR (trattamento di fine rapporto, sort of firm-based compulsory saving scheme) are classified under the old age function, but partly come under unemployment expenditure. These benefits represent some 5% of total social benefits.

The main challenge identified in the Italian report is related to ensuring long-term sustainability of public finances while promoting stronger economic growth and higher social cohesion and equity. In order to face this challenge Italy has selected four main priorities for action: 1. to reduce poverty; 2. to develop the pension system in order to ensure both its financial sustainability and adequacy; 3. to provide for accessible, more efficient and adequate health care services; 4. to reduce regional disparities.

In this way all three overarching objectives of the new OMC are addressed, but the result is not always satisfactory. The report is rich in references to priorities and measures able to meet the first objective (social cohesion, inclusion, protection, equal opportunities), and the third objective (governance) is explicitly mentioned, but not sufficiently developed. The second objective (integration with Lisbon and Gothenburg strategies) becomes more explicit in the text of the social inclusion strand, where it is illustrated through a concrete example regarding a labour-related tax reduction scheme; unfortunately no mention is made of the EU Sustainable Development Strategy.

3. Social inclusion

3.1. Key trends

The total at-risk-of-poverty rate after social transfers in 2004 is 19%, but as high as 24% for children under 18. The number of children in jobless households has declined steadily over recent years, down to 5.4% in 2006 (- 2.9% compared to 1999); also the number of people in jobless households decreased over the same period down to 9.2% in 2006. According to the national official statistics the overall poverty rate has remained relatively stable over recent years. However, it should be noted that Italy assesses poverty on the basis of consumption expenditure, which is influenced by the national consumption average; this means that when general living conditions are worsening, the value of the expenditure-based poverty line is consequently reduced and some areas could appear statistically less poor than they are in reality. The Italian national indicator tends, in fact, to reduce the population at-risk-of-poverty rate by nearly 6 percentage points compared with the EU indicator based on income.

The profile of poverty has not changed significantly: it is overwhelmingly concentrated in the south and affects mainly large households, households whose head is unemployed, a woman or with a low educational level, and in general families with three or more minors. The at-risk-of-poverty rate increases quite dramatically with the number of dependent children: from 15% (1 child), to 22% (2 children), to 35% (3 or more children). In general women record a higher at-risk-of-poverty rate, and the difference increases with age (up to 7 percentage points higher for people in old age).

Youth employment rates are particularly low in Italy, among the lowest in the EU; but these do not reflect high schooling rates or high educational attainment levels. In fact, youth educational attainment levels are low compared to other EU countries, though on the increase. The percentage of early school-leavers, although decreasing, is still high and well above (+6.8%) the EU average (21.9% in 2005) and with a substantial gender gap (17.8% for females and 25.9% for males). The poor performance in terms of educational attainment levels and employment rates signals the difficulties young people meet in the transition from school to work. These difficulties are evidenced by the concentration of unemployment among young people (over 50% of total unemployment) and by the long unemployment spells (long-term unemployment remains particularly high among the young).

3.2 Key challenges and priorities

The social inclusion strand of the Italian National Strategy Report is based on a multidimensional approach, and efforts to enhance the integration of policy fields and different government levels are clearly pursued. The report focuses on five national priorities for action: improved access to rights and services; reducing poverty, with particular reference to child poverty; strengthening the social inclusion of migrants and disabled people; increasing labour market participation, especially for women, young people and older workers; and reducing regional imbalances.

As far as the key challenges identified in the 2006 Joint Report are concerned, the most relevant progress concerns Italy's employment performance, but we are still a long way from achieving the Lisbon targets.

The importance of the ESF is stressed in relation to the financing of specific studies at national level.

3.3. Policy measures

The measures identified in the NRS under the five selected priorities, if properly implemented, could contribute to reducing poverty and social exclusion. However, the frequent lack of a sound analytical background and impact assessment of previous policies and the weakness in terms of targets and indicators make it difficult to judge their adequacy. The measures will be mainly funded from the national budget and SF, but the allocation of financial resources to specific measures is not always clear. There is a foreseeable risk of fragmented management and difficult evaluability.

The first priority (better access to rights and services) will be pursued mainly by making new efforts to define, through enhanced cooperation with the regions, the basic levels of social services, as required by the national reform of 2000 but still missing. Moreover, great attention is paid to the need for better monitoring and evaluation of the overall welfare system in order to target action and resources where most needed, and to reduce regional disparities. Concern is expressed about the persistent lack of care services for children and elderly people, and provision is made for specific measures and resources. Basic levels of benefits and services to be guaranteed all over the national territory will be defined starting from these two priority areas. A new National Fund for not-self-sufficient persons has just been created, according to the provisions contained in the budget law for 2007; implementing legislation will probably follow during the year. A special plan for increasing accessibility to child-care services for children aged 0-2 will be promoted (+ 6% in the next five years), but stronger efforts need to be made as Italy is still far removed from the target of 33% (9.9% in 2005).

As far as the second priority is concerned (reducing poverty), Italy is committed to reducing its at-risk-of-poverty rate to the EU average by 2010 (according to the latest available Eurostat data it is 3 percentage points higher). This priority will be pursued mainly through a fiscal reform that favours low-income and large families through the combined effects of tax rates, deductions and family allowances. There is also a specific undertaking by the Government to introduce a minimum income scheme, but no details of the practical arrangements are given. A national public housing plan for disadvantaged households and persons is announced, and the need to collect up-to-date data on homelessness briefly mentioned.

The third priority is related to two specific target groups: immigrants and disabled people. The political change arising from last spring's general election is particularly evident in the field of immigration policies, where recent years' restrictive approach is gradually moving towards a more open and multidimensional framework. National acts have been enforced and a bill presented in order to better meet labour market needs and tackle illegality and undeclared work. Significant changes are also expected concerning citizenship rules. A new National Fund for the social inclusion of migrants, addressing in particular social and housing difficulties, is provided for in the budget law for 2007. Finally, at a national level, appropriate financial resources are dedicated to the integration of foreign minors in school, and specific attention is given to minors from ethnic minorities. The report stresses the importance of mainstreaming disability policies, mainly through new forms of coordination between central and local authorities, with the active participation of social partners and NGOs. Measures are envisaged in the education and employment fields as well as initiatives to strengthen and simplify social protection-related procedures and to make the overall legal framework more coherent and clearer.

Regarding the fourth priority (increasing labour market participation), significant changes are expected in order to limit job insecurity and fragmentation, with particular attention being given to the North-South divide and equal opportunities. The most important measure presented in the report is the 5% reduction in labour-related taxation for permanent contracts; the reduction is even higher for employers based in the South of Italy who hire women. Incentives managed through collective bargaining agreements to transform temporary jobs into permanent jobs are being introduced. Some extensions of unemployment and social benefits to temporary and atypical workers are envisaged, but the provision of a more systematic and coherent reform of the overall "shock-absorbing" system is unfortunately still lacking. New mechanisms to fight undeclared work are being introduced and increased resources allocated to positive action in favour of female employment. To make it easier for young people to access employment, credit, housing and culture, Italy will adopt a National Youth Plan which will devote particular attention to education and training policies. Issues such as early school-leaving, apprenticeship and guidance are explicitly addressed, and a new dedicated National Fund has already been created. Specific measures to increase older workers' employment rate are envisaged, such as the "welfare to work" services for 3.000 redundant older workers introduced by law 202/2006, lifelong learning initiatives for 50.000 "over 50" employees over the next two years and a new experimental intergenerational solidarity agreement foreseen by the 2007 budget law.

The fifth and last priority is devoted to reducing regional disparities. As already mentioned above, tax advantages for female employment are foreseen for the South of Italy, together with a tax credit system for innovative investments in underdeveloped areas. A relevant financial effort will be devoted to the development of southern areas, according to the 2007 budget law which provides the stabilization of the FAS (Found for underdeveloped areas) for a seven-year period in accordance to the Structural Funds Regulations 2007-2013. In this new framework social inclusion is one of the priorities and, in particular, special attention is devoted to the development of care services for children and the elderly people. Furthermore, initiatives aiming at enhancing social development in the area have been launched also in the non-profit sector, such as the new "Foundation for the South" aimed at promoting and strengthening social infrastructure.

3.4. Governance

The new government seems intent on re-launching the approach introduced by the 2000 national reform, characterised by an institutional framework based on subsidiarity principles. A large number of governance instruments are mentioned, such as permanent conferences, programming agreements, co-decision mechanisms, monitoring systems and consultation bodies. For preparation of the NSR there was little opportunity to involve many stakeholders (mainly due to the limited time available since the formation of the new government), but some attempts were made to adopt a more systematic and coherent method. Hopefully there will be stronger involvement at the monitoring and implementation stages.

4. Pensions

In 2004, older people enjoyed a relative living standard which was close to that of the general population (84%), while the poverty risk among older people (23%) is estimated to be slightly higher than for the population below the age of 65. In spite of recent increases, the employment rate of older workers (aged 55-64) remains low, at 31.4% in 2005.

Despite unfavourable demographic trends, Italy is, as a result of the pension reforms undertaken since 1992, expected to face only small additional budgetary pressures due to ageing populations. The 2006 Sustainability Report assessed Italy as a medium-risk Member State as regards the sustainability of public finances. According to the budgetary projections made by the AWG in 2005, public expenditure on pensions will increase only marginally, from 14.2% of GDP in 2004 to 14.7% in 2050, and all age-related expenditure from 24.7% to 25.7% of GDP. Both trends are considerably slower than the EU average. According to ISG calculations, for a worker contributing 40 years on average earnings and retiring at 65, the gross replacement rate will decline from 79% today to 64% in 2050 (including the projected contribution of 6.91% to TFR, currently covering some 11% of the employed population). For people retiring at 60 after a career of 35 years, the decline in replacement rates is even more pronounced (about 20 p.p. between 2005 and 2050). For the self-employed, due to a lower level of pension contributions, the decline in the replacement rate is likely to be even sharper.

Italy undertook reforms in the 1990s leading to a gradual shift from the defined benefit scheme to a notional defined-contribution scheme. These reforms created a stronger link between contributions and benefits, thus providing appropriate incentives for new entrants to the labour market to work longer, but entailed a long transition period. After the increase in minimum pensions in 2002, new measures introduced in 2004 have strengthened these reforms and also affect those who still have the right to retire early under the old rules. New discussions with the social partners planned in 2007 should not undermine previous structural reforms.

As mentioned in the 2006 report, raising employment rates, particularly for women and older workers, remains crucial for meeting future challenges, and continuing the process aimed at harmonising the effective retirement age for men and women would help to reduce the gender gap in pension entitlements and would also help boost the employment rates of older workers. Future pensions adequacy will also depend on developing supplementary social security entitlements, by transforming the TFR (a firm-based compulsory saving scheme for private employees). The mechanism of automatic transfer of TFR contributions (starting from July 2007) to private pension schemes (except where the employee refuses) could do a lot to help develop supplementary pensions. The possibility of accumulating pension entitlements from different funds in order to have a single pension, and the increase in pension contributions for the self-employed and atypical workers included in the 2007 budget proposal, should lead to improved pension rights for atypical workers.

5. Health and long-term care

5.1. Health care

Description of the system: There is a public National Health Service (NHS), financed via general taxation. Since 2001, responsibility for local governance of healthcare has been devolved to the regions. The NHS retains the authority to define the framework of strategies and national policies, together with the basic benefit package (Livelli Essenziali di Assistenza, LEA) that must be provided uniformly throughout the country. Regions have responsibility for the organisation and administration of the healthcare system. Local health authorities, both community and hospital authorities, are responsible for the delivery of health care services. Coordination and the achievable degree of uniformity are set through coordination between the central government and the regional administrations, and also with local authorities whenever social matters are on the agenda. Funds are distributed from the central budget to the regions according to a series of parameters (population, frequency of health utilisation by age and sex, territorial epidemiological indicators); nonetheless, health spending per capita still varies substantially from region to region. Some regional taxation also helps to finance the system. There are co-payments but no pre-payments in the NHS. 16% of the population has complementary private health insurance either individually subscribed to or offered by employers, representing 23.6% of total health expenditure.

Primary health care is provided by general practitioners and paediatricians, who are independent contractors of the NHS. Patients can choose the place and professional to whom to address themselves (as long as the GP has not reached the maximum allowed number of patients), and generalists have a gate-keeping function. GPs are part of the network of services provided by the Health District, the basic community structure of the public health system.

District and hospital staffs are public sector employees. The reform of 2001 aimed to introduce elements of privatisation into the system (possibility to purchase services from outside the NHS) and to improve the management of the healthcare system resources. The real impact of these measures is still under evaluation.

Accessibility: The only category not covered by the NHS is illegal immigrants. Out-of-pocket payments covering cost-sharing for public services, pharmaceuticals and private healthcare services amounted to 19.6% of health expenditure in 2004. Since some concern has been expressed about the impact of cost-sharing on vulnerable groups, there are exemptions from co-payments based on age, income, disability/dependency and chronic or rare disease. Local authorities (municipalities) take charge of the institutional care costs of people on low incomes. There are still long waiting lists for hospital and specialised care. By contrast, there is a national plan for tackling waiting lists which should help to prioritise patients in order of urgency. There are differences in the quality of services offered between regions. This problem has been further exacerbated since 2001 and has lead to patients migrating to obtain highly specialised care from the best regions. A system of interregional financial compensation, for care provided to non-residents, allows citizens to choose services without geographic limitations.

Quality: A set of measures has been adopted to promote quality. These include the increased use of indicators to produce better monitoring of activity, quality standards, a public relations office to help users, patient surveys, technology assessment and benchmarking/rating. A new National Health Information System (NSIS), based on individual records, is under

construction, with the aim of both assuring better quality of care and helping to get expenditure under control. It should also be noted that health staff in all public services are obliged to follow, yearly, a certain number of refresher courses, in order to update their professional experience.

Long-term sustainability: Total health expenditure is around the EU average at 8.7% of GDP in 2004, but up from 8.1% in 2000. It is slightly below average at 2424 per capita PPP$ in 2004. Public health care expenditure as a share of total health care expenditure was about 76.4% in 2004. According to the 2006 EPC/EC projections public health care expenditure is expected to increase by 1.3 percentage points of GDP by 2050 due to population ageing. The main increases in expenditure are on pharmaceuticals, personnel and purchasing of goods and services. There were 6.1 physicians per 1000 population, among the highest ratios in Western Europe. The number of nurses was among the lowest in the EU at 3.0 per 1000 population in 1989 (Source: WHO-European Observatory). The national plan aims to improve efficiency and reduce waste. To this end it identifies the following measures: to impose stronger control on regional expenditures and on regions overrunning their budgets; to increase incentives for GPs to improve their prescription practice; to improve coordination between GPs to assure round the clock availability; to reduce the number of hospital beds aiming at 4.5 beds per 1000 inhabitants and to convert small hospitals into residential structures; to generally use resources more rationally (the compulsory introduction of district budgets is still experimental in some regions); to centralise public procurement. Cross-region comparisons across a series of indicators exist and are aimed at identifying and promoting the best national practices, and in controlling demand (for example identifying excessive use of certain procedures etc.).

There is a national plan of active prevention which is proposed as best practice. It aims to go beyond compulsory interventions (such as vaccinations and screening), by promoting active healthy behaviour and lifestyles on the part of citizens. It is carried out in collaboration with other ministries (Employment, Education, etc) as well as the regions. It gives high importance to prevention measures designed to change unhealthy habits in the population (tobacco, alcohol, nutrition, prevention of road and occupational accidents, etc)

5.2. Long-term care

Description of the system: The supply of long term care is based on a system combining integrated home assistance and residential care. Responsibility rests with the regional and local authorities, both health and social, depending on the specific kind of service provided. The government recognises that it is still insufficient for an ageing population and there are significant geographical disparities in supply and quality.

Accessibility: The general goal is to enable the elderly to remain in their home. People in need can obtain a large number of benefits, among which there are: direct free services, vouchers to buy services from accredited institutions, untied financial aid, which is mainly used to purchase the help, at home, of immigrant workers, and financial support for various degrees of invalidity. Better care coordination will be enhanced via the family doctor and the "Custode Sociale", who looks at the healthcare and social needs of elderly dependent people and drafts a patient care plan.

Quality: There is a lack of general standards for the quality of social care, both at home and in institutions. The (national) definition of essential levels of social service provision and quality (LIVEAS) – awaiting official approval – should help to address regional differences in standards, following the model already in use in the health sector (LEA). In this light, State,

regions, autonomous provinces and local authorities are to plan and work together on the definition and provision of services and establish their respective responsibilities.

Long-term sustainability: Long-term care is financed both from the NHS and from the social policy fund, distributed from central Government to local levels. However, there is a clear recognition that given the trend of demographic developments, the resources are insufficient. According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.7 percentage points of GDP by 2050 due to population ageing. The government also recognises, as a major issue, the need to improve coordination between health and social services. The first step is to move towards a more integrated approach between the regional and local levels. Some regions have instituted a dedicated fund for ageing people in dependency situations, aimed at financing services and allowances, within the framework of the essential levels of health services. A similar measure has recently been approved by the Parliament at national level (National Fund for not-self-sufficient persons).

6. Challenges ahead

To reduce regional disparities through improved co-ordination between national and sub-national measures;

To increase the level of participation on the labour market, especially for young people, women and older workers, in order to meet future challenges arising from demographic trends, and ensure adequacy of pensions and the long-term sustainability of public finances;

To ensure a more coherent and comprehensive coverage of the "shock absorbing" system;

To improve efficiency and reduce waste through the more rational use of resources, and to improve health and LTC service organisation and coordination whilst reducing geographic differences in provision.

In long-term care, to focus on community and home services as an alternative to residential and hospital care by moving towards an integrated approach between regional and local levels

Italy: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.6	113.1	**2000**	53.7	68,0	39.6	26.4	27.7	**2000**	10.1	7.8	13.6	27,0
2002	0.3	110,0	**2002**	55.5	69.1	42,0	25.8	28.9	**2002**	8.6	6.7	11.5	23.1
2004	1.1	103,0	**2004**	57.6b	70.1b	45.2b	27.6b	30.5b	**2004**	8,0	6.4	10.5	23.5
2006	1.7f	99.4f	**2005**	57.6	69.9	45.3	25.7	31.4	**2005**	7.7	6.2	10.1	24,0

*:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast; b:break in series

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth(2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	male	female	male	female	male	female							
1995	74.9	81.3	15.8	19.6	66.7	70,0	6.2	**1995**	7.3	71.9	-	100 (1997)	
2000	76.6	82.5	16.5	20.4	69.7	72.9	4.5	**2000**	8.1	73.5	22.8		15.6 (1999)
2004	77.1sp	82.8sp	16.8sp	20.6sp	70.9e	74.4e	4.1	**2004**	8.7	76.4	19.6		

s: Eurostat estimate; p: provisional — **THE: Total Health Expenditures* — ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	24.2	63.4	23.2	3	3.2	0.1	7
2000	24.7	63.2	25.1	1.7	3.8	0.2	6
2004	26.1	61.3	25.9	2	4.4	0.3	6.1

* including administrative costs

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	29.4	26.2	14.2	5.8	1.5
2010	31.3	-0.5			
2030	45.2	1.1	0.8	0.9	0.2
2050	66	1.8	0.4	1.3	0.7

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate

SILC income 2004	Total	Children 0-17	18+	18-64	65+
Total	19	24	18	16	23
male	17	-	16	15	19
female	21	-	20	18	26

Poverty risk gap

	Total	Children 0-17	18+	18-64	65+
Total	24	28	23	27	18
male	25	-	24	27	16
female	24	-	22	28	19

Income inequalities

	S80/S20
Total	5.6
male	-
female	-

People living in jobless households

	Children Total	% of people aged 18-59* Total	male	female
1999	8.3	11.7	9.8	13.5
2004	5.7	9.1	7.9	10.4
2006	5.4	9.2	7.8	10.6

Long-term unemployment rate

	% of people aged 15-64 Total	male	female
1999	6.7	5.2	9,0
2004	4,0	2.9	5.5
2005	3.9	2.9	5.2

Early school-leavers

	% of people aged 18-24 Total	male	female
1999	27.2	30.3	24.2
2004	22.3	26.2	18.4
2006	21.9	25.9	17.8

*: excluding students; p: provisional; b: break in series

SILC income 2004	Total	male	female
Relative income of 65+	0.844	0.871	0.835

SILC income 2004	Total	male	female
Aggregate replacement ratio	0.583	0.639	0.492

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)

Net	Gross replacement rate					Assumptions: Coverage rate (%)			Contribution rates		
										Occupational & voluntary pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or social security)	Current estimate (2002)	Assumption
4	1	-15	DB & DC	16	DC	100	11.4		32.7	5.7	6.91

*(DB / NDC/ DC); ** (DB / DC)

2.12. CYPRUS

1. Situation and key trends

Cyprus continues to return a satisfactory economic and labour market performance. GDP growth remained buoyant at 3.8 percent (2005), and the fiscal deficit declined (from 4.1% in 2004 and a troublesome 6.3% in 2003) to 2.5% in 2005, better than expected. Consistent with the GDP growth, the employment rate was sustained at good levels (68.5% in 2005). Unemployment rose to 5.2% in 2005 but remains low in comparison to the EU average (8.8%). The employment rate for older workers (50.6%) is above the Lisbon target. The female employment rate, at 58.4%, is close to the EU target, despite a minor drop from previous years. On the other hand, youth unemployment, at 14%, shows a clear upward trend. Additionally, it is higher for women and includes a large share of persons with higher education.

The risk of poverty[40] for the general population was 16% in 2004, comparing well with the EU average. For the age group over 65, the risk of poverty (51%) remains troublesome[41]. It is as high as 73% for single elderly people.

According to the latest available Eurostat data (2004), social protection expenditure as a percentage of GDP stood at 17.8%. Total pension expenditure is set to rise from 6.9% of GDP in 2004 to 19.8% in 2050, causing serious concern as regards the financial sustainability of the system.

It is expected that the old-age dependency ratio will more than double between 2004 and 2050 from the present very low 17% to 43% (but still well below the EU25 average of 52% in 2050). Life expectancy (76.8 years for males and 81.9 years for females in 2004) is above the EU average[42], showing a 2-year increase since 1995. Healthy life expectancy (68.4 for men and 69.6 for women in 2003) is well above the EU average[43] and the second highest in the EU. Infant mortality (3.5 in 2004) is below the 2004 EU average of 4.5, continuing a consistent decrease from 26 in 1970. The gender pay gap, although on a somewhat downward trend over recent years, remains high at 25%. As a response to labour shortages, foreign workers have entered the local job market on a temporary basis, their numbers being roughly estimated at 14% of the workforce. There is no reliable estimate for the number of undeclared workers.

2. Overall strategic approach

The overall strategic approach of Cyprus, in line with its National Reform Programme, is concerned with embedding in the country the conditions for improving social cohesion, for

[40] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national family expenditure survey that was not fully compatible with the SILC methodology based on detailed income data.

[41] Provident funds (lump sum benefits in case of retirement, death, invalidity, or termination of employment) are not included in the calculation of retired people's income

[42] 75.1 and 81.2 for males and females in 2003

[43] 64.5 and 66 for males and females in 2003

the most part through the active inclusion of vulnerable groups into employment. The priorities selected respond to the main challenges faced by the country.

The priorities set by the Commission in 2005 for inclusion are addressed in the report, although analysed in different degrees of detail. Thus, the eradication of child poverty, flexibility in the labour market, longer working lives, the integration of migrants, improving access and tackling inequalities in health care, bettering the position of persons with disabilities, modernising the social protection system and tackling educational disadvantages, all receive attention. Access to housing for low-income families is also touched upon.

In the field of social inclusion, the main priorities for action concern the reduction of the risk of poverty for the overall population, and in particular for the high-risk group of persons aged 65 or more, the integration of vulnerable groups into the labour market and the prevention of exclusion for children. The development of human capital, with a focus on those groups who are most exposed to risk, remains a key challenge.

Modernisation of the social protection system is treated as an immediate priority, with a view to rendering it more efficient, and principally to ensuring its financial sustainability. The importance of social dialogue for reaching consensus on introducing changes to the pensions system features prominently in the report.

The main policy aim in the field of health and long-term care is to maintain and improve the standard of living of the population. Key consideration is given to ensuring access to health for all, and on eliminating inequalities in terms of financing the system. Furthermore, the agenda takes on board measures to modernise the organisation of government institutions and public health service providers. Emphasis is also placed on strengthening structures developed by local government and voluntary organisations. The inter-linkages between the Lisbon objectives for greater economic growth and employment, and the policy objectives reflected in the strategy report are apparent. The detailed description of the interventions of the ESF makes clear the role that the European Social Fund ('ESF') plays in the country's development strategy, and thereby in pursuing the Lisbon agenda

The broad consultation process on the various aspects of the strategy confirms the existence of a long tradition of social dialogue. The upgrading of the functions of the Pancyprian Volunteerism Coordinative Council adds to the involvement of those more directly concerned by social exclusion, while the reported establishment of a monitoring and evaluation committee will help maximise the involvement of stakeholders.

The issue of gender equality is primarily addressed in the framework of employment. Despite a set of positive developments, and the adoption of measures promoting gender equality, a true gender mainstreaming approach is not evident in all policies.

3. Social inclusion

3.1 Key trends

Economic disparities and poverty are not widespread in Cyprus. In 2004, the risk of poverty for the overall population was on a par with the EU average, and remains very high for persons over 65 (51%), for persons living in single-member households (48%) and for single-parent families (35%). Inequality of income distribution (S80/S20) was 4.3 in 2004. The rate

of childhood poverty was 13% in 2004, below the EU average (19% in 2004). 3.9% of children lived in a jobless household in 2006.

Social transfers reduce the overall at-risk-of-poverty rate from 29% to 16%. Access to decent housing is not considered to be a challenge for the overall population. In 2003, 91% of the population lived in owner-occupied or rent-free houses. Nevertheless, problems of access to decent housing may be faced by groups of persons such as foreign workers from third countries living temporarily in Cyprus on a contract basis.

Cyprus can boast high levels of educational attainment. Nonetheless, youth unemployment is both on an upward trend (14% in 2005 as compared to 11.3% in 2004) and more than twice the overall unemployment rate (5.2%: 2005). It is to be noted that a large proportion of the young unemployed are tertiary education graduates.

Persons with disabilities face a multitude of problems, the greatest being that of effectively entering the labour market.

3.2 Key challenges and priorities

Ensuring an adequate standard of living for disadvantaged and vulnerable groups and facilitating their integration into the labour market are key issues in Cyprus' efforts to enhance social cohesion. The modernisation of the social protection system, in order to enhance its effectiveness and respond to high pressure as regards its financial sustainability, is also a key priority. Nonetheless, the modernisation agenda remains open-ended and subject to social partner consultation. The main challenges identified for Cyprus in the 2006 Joint Report on social protection and social inclusion remain pertinent, and are indeed addressed in the 2006-2008 report. The government's approach is in line with the three overarching objectives for social protection and social inclusion.

The priorities for social inclusion have been structured around three main pillars. A first priority concerns reducing the risk of poverty for the general population, and in particular for the age group of 65 and older. A number of interventions are of relevance to this.

Secondly, priority is given to the integration of vulnerable groups into the labour market. In this respect, particular importance is placed on increasing access to employment of women, older persons, persons with disabilities, public assistance recipients, young persons and unemployed persons in general. In relation to the above, furthering the development of human capital and eliminating gender inequalities are key policy aims.

A third priority relates to preventing exclusion of children, which though lower than the EU equivalent, is considered important in preventing social exclusion in the next generation.

Other key priorities relate to safeguarding access to services, including education and health for all. Providing access to care services for children, older persons and other dependent persons also receives attention.

Finally, the contribution of the Structural Funds, and particularly of the ESF, in supporting the National Strategic Report objectives is clearly indicated in the report.

3.3 Policy measures

The strategy adopted by Cyprus focuses strongly on access to the labour market for vulnerable groups. It aims to increase flexibility in the labour market, to further develop human capital though vocational training activities and to manage economic migration (especially for third-country workers). Additionally, the strategy prioritises the reduction of poverty for the overall population, and provides for specific measures for the population aged 65 and above, and for children.

The integration of vulnerable groups into the labour market is pursued mainly through active policies, the focus being on such target groups as women, older persons, public assistance recipients, persons with disabilities and young persons. The provision of a personalised approach to the unemployed by the Public Employment Services and the promotion of flexible forms of employment are complemented by better care services for children and other dependent persons.

Several quantified targets are set, amongst them an employment rate for women of 63% by 2010 (58.4% in 2005), an employment rate for older women of 32% by 2006 (31.5% in 2005) and for 6,000 unemployed persons to be employed by 2008. Quantified targets are also set for the reduction of child poverty and for the increase of the minimum wage to reach 50% of the median national wage by 2008.

It is noted that Cyprus does not have a statutory national minimum wage, with the minimum wage rate applying only to a small sector of the labour market. In relation to the set target, the effects of the increases in the minimum wage should be monitored, to ensure that they do not have an adverse impact on employment.

Moreover, incentives are offered to recipients of public assistance in order to encourage them to take up employment, such as the continuation of public assistance to long-term unemployed persons for up to one year after taking a job and the availability of unemployment benefits to those receiving training to help them enter or re-enter the labour market. In addition, incentives exist for postponing retirement in the form of reasonable increases in pension benefits[44].

Young persons are clearly identified as a target group. Measures to help them include the modernisation of the apprenticeship scheme, schemes to raise their employability and a scheme for providing financial assistance for the re-integration of people with addiction problems. In addition to the latter, a coordination committee for health education and citizenship has been set up within the Ministry of Education and Culture, in order to promote programmes for the prevention of drug dependency. It is worth noting that the government had been criticised in the past for its modest support to persons dependent on drugs, a problem which has been rising fast. On the use of ICTs in education, the report displays a somewhat simplistic approach.

Although the reduction of youth unemployment is not mentioned as a target per se, the National Reform Programme deals with that issue in more detail. Moreover, progress on modernising the apprenticeship scheme and reforming secondary vocational education has been slow.

44 a) For every postponed month after the age of 65, pensions increase by 0.5 % with a maximum at age 68 b) The payment of a pension is not conditional on retirement from regular employment and c) A 'Self-employment scheme' provides grants to people over 63 in order to support them being actively involved in economic activity as self-employed

Quite a few measures have been put in place to assist persons with disabilities, mainly in the form of facilitating their integration into the labour market, improving their accessibility and improving financial assistance offered to them. This approach is solid, given the extent of the problems faced by persons with disabilities, in terms of their integration in the labour market and in society at large. A close monitoring of interventions should be put into practice.

Although women benefit from a series of measures, which aim primarily at their integration into the labour market, a true gender mainstreaming policy is to some extent lacking. Amongst other measures, support is offered to enhance women's employability. Other issues, for example violence in the family, are not touched upon. The issue of reconciliation of work and family life is adequately dealt with.

On the issue of reducing child poverty, emphasis is placed on educational support, with supportive teaching programmes, literacy programmes and support to children with special needs. The creation of 'educational priority zones' recognises the particular needs of children with a different cultural background, and is seen as a positive step in embedding a true policy of integration for these individuals.

The resources allocated to the achievement of the identified priorities are not consistently indicated. ESF funds in support of policies are visibly set. Changes to schemes providing financial assistance are also clearly indicated.

Although most challenges are adequately addressed, and progress can already be observed in terms of implementation, the policy on some key challenges, for example regarding the management of economic migration, remains general and vague. Other issues, such as reducing the gender pay gap, are only implicitly addressed.

Moreover, despite a clear policy line on reforming the health and long-term care systems (for example the reorganisation of public hospitals or the issue of de-institutionalisation), the timeframe and the budgetary implications of these operations are left open. Regarding social protection (pensions), the government has reported its commitment to adopting the necessary reform measures by the end of 2006. Nevertheless, these reforms also depend on the outcome of social dialogue. Both these issues are directly linked to the social inclusion strand.

3.4 Governance

The NSR was adopted by the Council of Ministers. The Social Welfare Services (SWS) of the Ministry of Labour and Social Insurance have the coordinating role in drafting the NSR. In this capacity, the SWS received contributions from other government departments, and held meetings with representatives of local authorities, social partners and NGOs.

Progress has been made on the issue of monitoring and evaluation of policies, with efforts being deployed to assume a comprehensive approach, even though monitoring and evaluation arrangements remain stronger for some policies and weaker for others, with the policies supported by the ESF receiving a better follow-up. In this context, a proposal to set up a monitoring and evaluation committee has been put forward. Proceeding with this arrangement would politically strengthen the social inclusion policy.

The clear setting of targets in the report will inevitably facilitate the monitoring of the situation. Nevertheless, lack of know-how and limited human resources, such as in the case of NGOs involved in the area, sometimes hinder this process.

4. Pensions

Pensioner incomes in Cyprus are among the lowest in the EU-25, relative to the overall population (57% of those aged 0-64), and the risk of poverty in the 65+ age group in Cyprus is the highest among all Member States (51% in 2004). The highest incidence of poverty occurs amongst persons living in single-adult households, though the gender disparity is less pronounced (47% for men and 53% for women).

The 2006 Sustainability Report assessed Cyprus as a high-risk Member State as regards the sustainability of public finances, notably due to the high projected increase in age-related expenditures and the high level of debt. According to the AWG projections, Cyprus is expected to increase its spending on public pensions (including public sector employees' pensions) from 6.9% of GDP in 2004 to 19.8% of GDP in 2050. The projected growth of 12.9 percentage points of GDP is the largest in the EU-25 and will exhaust the reserve fund by about 2040. According to ISG projections, theoretical replacement rate calculations put the gross replacement rate from the statutory pillar at 46% (net 52%) in 2005, increasing to 57% (net 66%) by 2030 and 57% (net 70%) by 2050.

Cyprus faces considerable challenges as identified in the 2006 Joint Report, chief of which is to ensure the adequacy of its pension system and to reduce the poverty levels of those over 65[45]

The value of minimum pensions (85% of the full basic old age pension), and social pensions (81%) for people aged over 65, do not protect against the risk of poverty. Reforms under consideration refer mainly to the General Social Insurance Scheme and include a gradual increase in social insurance contributions, an increase in the minimum qualifying period for pensions and the re-examination of pension entitlement between the ages of 63 and 65.

To tackle the problem of pensioner poverty, the Cypriot Government intends to carry out a study in 2007 on the possibility of fixing a minimum income targeted at those households at most risk of poverty, replacing the current inefficient supplementary Special Allowance Scheme to pensioners. A further study on the possibility of developing a second pillar, with defined contribution provision for those not covered by occupational pensions, is also envisaged in 2007.

5. Health and long-term care

5.1 Health care

Description of the system: Health care is provided by the Public Health Services (PHS) and the private health sector. The PHS, financed out of general taxation, co-payments and fees paid, covers 65-70% of the population, free of charge, and 5-10% at reduced fees. Free of charge health care is provided through the PHS to public sector employees irrespective of income. The remainder of the population is classified into two categories: those entitled to free of charge care (families with four or more children, severely disabled, the poor, etc), and those entitled to care at reduced fees (according to income level and number of family members). Private health services are financed by patients' out-of–pocket payments or

[45] The level of social insurance pension is still influenced by the insurance time completed under the scheme in force before October 1980.

through occupational medical funds. Treatment in emergency cases is free of charge for all residents at public hospitals. Coverage is not universal and the health care provided benefits are means-tested (except for the above-mentioned categories). Individuals who are not entitled to either free care or at reduced fees care, purchase private health services and pay out-of-pocket. There is no gate-keeping system at the moment and thus patients are free to choose the physician of their choice. Maternal and child health services are available to everyone, free, at the point of use. Public sector physicians are salaried employees, whereas physicians in the private, largely unregulated, sector are paid on a fee-for-service basis.

Awareness of serious organisational and financing difficulties of the health care system has led to the enactment in 2001 of a National Health Scheme (NHS) with an implementation target for 2008. The main characteristics of the reform are:

-Universal residence-based coverage of the population

-Financing through an insurance scheme based on earnings-related tripartite contributions

-Freedom of choice of provider between the private and public sector

-Separation of provision from financing of healthcare

-Management of the NHS by an independent public law Health Insurance Organisation

-Introduction of a referral system and obligatory enrolment with a GP to strengthen PHC

In 2006, the Health Insurance Organisation (HIO) worked on formulating a strategy and proceeded with the implementation phases of the National Health Scheme (NHS).

Accessibility: Despite the fact that the PHS covers the majority of the population (free of charge or at reduced fees), its capacity is limited and results in an increasing use of private health services paid on an out-of-pocket basis. Lower-income households have a higher burden of payment for private health services (between 4.6% and 6.4% of household income as opposed to 4% for median income households). Additionally, inequities in access result from the varying qualifying conditions for PHS coverage (free care without income test for some and means-testing for others). The introduction of the NHS will address these access inequities (universal coverage) and end differentiated care provision through the free choice of provision. Geographical disparities exist and also explain the increased use of private health services, which cover most of primary health care needs of the population. The authorities have strengthened primary care facilities to increase overall supply and address geographical disparities.

Quality: There is no comprehensive quality assurance system. Introducing an integrated quality assurance system is a priority for the authorities. The implementation of the reforms will address purchase management (largely uncoordinated) in both public and private sectors. Patient rights legislation has been enacted by Parliament, and patients participate in decision-making through the Patients Welfare Committees set up at each hospital. Patient choice of doctor and hospital, currently limited to the public sector, will be addressed by the introduction of the NHS, with free choice of GP in either public or private hospital, subject to referral. There is no use of technology assessment. Specific action plans for disease prevention are in place (e.g. cancer screening, infectious disease control network).

Long-term Sustainability: Total health expenditure (6.2% of GDP and 972 per capita PPP$ in 2004) is one of the lowest in the EU[46] despite a consistent increase over time. The public share of health spending (47.8% of total health expenditure in 2004) is the EU's lowest despite a substantial increase in the last decade. In 2004, the private share of health spending was 52.2% of total expenditure funded mainly through out-of-pocket payments. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.1 percentage points of GDP by 2050 due to population ageing. The relatively low share of public health expenditure is expected to rise with the introduction of the NHS and the creation of a medical school. The high level of private health expenditure is due to under-resourced PHS and a lack of coordination between the private and public sectors of health provision. The reform and introduction of the NHS is expected to resolve problems of governance and strengthen the role of PHC. A unitary system of family doctors with gate-keeping and referral functions paid on a capitation basis, to be introduced, would address the problems of coordination between the competing sectors if accompanied by freedom of provider choice with regulated uniform pricing. Additionally, the reform will introduce a single Health Insurance Organisation (HIO), a financing agency, which will assure equal footing pricing between private and public providers, coordination between the sectors and will effectively consolidate a purchaser/provider split. The public sector dominates in the number of nurses and the private sector in the number of doctors. The reform is intended to address this problem with the new payment method for medical staff. Emphasis is placed on health promotion and disease prevention, through the creation of an integrated PHC system.

5.2 Long-term care

Description of the system: LTC services include residential care, home care and day care. LTC is available to residents who are unable to secure it by their own means. It is provided directly by governmental, community and private institutions with state financing. State subsidies are provided for public assistance recipients and in support of government, community and private carers as well as for house adjustments costs to promote home care. The private sector dominates LTC provision (residential care mainly available in privately-run homes, home care private carers) with state subsidies for vulnerable groups. Hence the state, in addition to direct provision of services, subsidises voluntary and private organisations that provide LTC. Co-payments by persons in care depend on household income. NGOs have a growing role in LTC provision.

Accessibility: The authorities' overall aim is to keep elderly and dependent persons in home care and/or within the family. This is the main mechanism for ensuring access to LTC services. A family member can be a home carer and will be financially supported if not in employment. Home care will be further enhanced through specific measures aimed at providing information for people who are not in receipt of public assistance. In terms of LTC for the mentally ill, measures are in place to upgrade and expand LTC in this area (institutional, non-institutional and creation of a National Mental Health Centre). In residential care, the limited supply of services by the state and the community is tackled by using private homes facilities with state subsidies (to reduce waiting lists).

Quality: Minimum quality requirements, registration and regular inspections in residential and day care in private and community homes are guaranteed by law. A law is expected to be enacted to regulate the provision of LTC (home care) by private and non-governmental

[46] EU average of 8.87% and 2376.33 in 2004

organisations and to set standards for carers' qualifications. Institutionalisation is used as a last resort in cases where the family is unable to meet the care needs of a member, with an emphasis on home and community care.

Long-term sustainability: Steps have been taken to ensure the requisite coordination for promoting financial sustainability in LTC (Social Welfare Services, the Pancyprian Volunteerism Coordinative Council and local authorities), aimed at the rational distribution of subsidies between the various private and voluntary organisations and local authorities and the efficient use of resources. Additionally, in view of demographic developments, a plan to integrate geriatric services at all levels of health provision and promotion of prevention policies is being implemented. The authorities have opted to target resources to the neediest and to support home care rather than institutionalisation as the way to promote the financial sustainability of LTC.

6. Challenges ahead

To continue to improve the position of vulnerable groups in society, by strengthening steps towards active inclusion in terms of pathways to employment and equal access to all services.

To continue efforts to improve governance by supporting the institutional capacity and involvement of local authorities, NGOs and social partners and by strengthening the development, implementation, monitoring and evaluation of policy interventions.

To address the long-term sustainability of pensions, notably by increasing incentives to work longer, while addressing the high risk of poverty among people aged 65 and over.

– To accelerate the process of reform to guarantee universal comprehensive care coverage and equitable financing through increased funding and efficient service provision.

To establish good coordination between the public and private sectors, to further the decentralisation process with the focus on improving the institutional capacity of local authorities, NGOs and social partners, and to enhance monitoring and quality assurance mechanisms.

Cyprus: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.0	82.2	**2000**	65.7	78.7	53.5	37,0	49.4	**2000**	4.9	3.2	7.2	10.1
2002	2.0	82.6	**2002**	68.6	78.9	59.1	37,0	49.4	**2002**	3.6	2.9	4.5	8.1
2004	4.2	87.7	**2004**	68.9	79.8	58.7	37.5	49.9	**2004**	4.6	3.6	6,0	10.5
2006	3.8f	88.3f	**2005**	68.5	79.2	58.4	36.7	50.6	**2005**	5.2	4.3	6.5	13.0

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	75.3	79.8	16.3	18.6	n/a	n/a	9.7	**1995**	n/a	n/a	-	n/a	n/a
2000	n/a	n/a	n/a	n/a	n/a	n/a	5.6	**2000**	5.8	41.6	55.7		
2004	76.8sp	81.9sp	16.7sp	19.4sp	68.4	69.6	3.5	**2004**	6.2	47.8	50		

**THE: Total Health Expenditure* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	14.8	48.8	27.2	7.2	6.3	7.1	3.4
2004	17.8	48.3	24.1	4.9	11.4	6.9	4.3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public Pensions	Health Care	Long-Term Care
2005					
2010	19.1	n/a	n/a	n/a	n/a
2030	32.9	n/a	n/a	n/a	n/a
2050	43.2	n/a	n/a	n/a	n/a

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	16b	13b	17b	11b	51b	19b	17b	21b	19b	21b	**Total**	4.3b
Male	15b	-	15b	10b	47b	17b	-	18b	17b	20b	**Male**	-
femal	18b	-	19b	13b	53b	21b	-	22b	21b	23b	**Female**	-

	People living in jobless households					***Long-Term Unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	n/a	n/a	n/a	n/a	**1999**	n/a	n/a	n/a	**1999**	17.5	24.6	12.3
2004	2.6	5,0	3.8	6.1	**2004**	1.2	0.9	1.6	**2004**	20.6	27.2	14.9
2006	3.9	4.9	3.7	5.9	**2005**	1.2	0.8	1.8	**2005**	18.1	26.6	10.6

** excluding students; b: break in data series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.57b	0.59b	0.55b	***Aggregate replacement ratio***	0.28b	0.34b	0.34b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
n/a	n/a		n/a		n/a	n/a		n/a	n/a	

** (DB / NDC/ DC); ** (DB / DC)*

2.13. LATVIA

1. Situation and key trends

High GDP growth rates continued in 2006 (around 11%). The overall employment rate reached 63.3% in 2005 (EU-25:- 63.8%). Employment for older workers (49.5%) and women (59.3%) was above the EU-25 average, while male employment, although growing, remained relatively low (67.6%). In a labour market, tightened by outward labour migration and a decreasing working age population, the unemployment rate continued to fall (8.9%), but remained slightly above the EU average (8.7%). Long- term unemployment (4.1%) has decreased at a slower rate. Although female unemployment (8.7%) was below the EU average, male unemployment (9.1%) was relatively high. Youth unemployment dropped to 13.6%. There was a slight decrease in the overall activity rate (69.6%), which now stands below the EU average (70.2%). The share of undeclared work in Latvia is high. Labour shortages have emerged and productivity remains the lowest in the EU.

Average living standards, although growing fast, are still low (GDP per capita in PPS stands at 52% of the EU average in 2006). High inflation (6.6%) erodes the income of low and average wage earners and household debt is rising. Income inequalities persist, as evidenced by a Gini coefficient of 36 in 2004. There are considerable regional disparities and a rural-urban divide. The at-risk-of-poverty[47] rate was 19%. Poverty risk for some population groups (like single pensioners, single-parent families) increased. Early school leaving (11.9%) is very much a male problem (15.5%, the female indicator being 8.2%). The share of persons with low educational attainment in the age group 25-34 is a concern for a country aiming at creating a knowledge-based economy (20.1% total, 24.6% for males and 15.6%- for females), while older cohorts up to 54 have performed much better (6.8% in the age group 35-44).

Population numbers have been decreasing since 1991, and are projected to decrease further over the coming decades, yet absolute decline in the population size is accompanied only by moderate increases in the old- age dependency ratio (from the current 24.1% to 44.1% in 2050). Total social protection expenditure as a percentage of GDP in 2004 was low (12.6%) and on a declining trend. Life expectancy at birth is among the lowest in the EU (67.1 years for males and 77.2 for females in 2004; almost 10 years lower than the EU average for males), but it has increased substantially since 1995. Infant mortality rates, although consistently falling (from 26.9 in 1960), remain high (at 9.4 in 2004, infant mortality was the highest in the EU and more than twice the average). Perinatal mortality, at 9.9 in 2005, is also among the highest. Total health expenditure as a percentage of GDP was 6.4% in 2004 (public expenditure accounts for about half of this).

2. Overall strategic approach

The Latvian National Report on Strategy for Social Protection and Social Inclusion 2006-2008 (NRS) emphasises the importance of integrated and mutually supportive policies in the fields of social inclusion, pensions, health and long-term care. Latvia, striving to ensure flexicurity, focuses on the social protection system's ability to react to population ageing, a

47 Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.

shrinking labour force and to adequacy of benefits. An inclusive labour market is being developed. There is a strong focus on health care, preventive measures and healthy lifestyles. Latvia also puts emphasis on promoting education and a family-friendly environment. The reduction of social exclusion risks for pensioners is among the national priorities. Overall social inclusion issues raised in the NRS include barriers faced by at-risk groups in access to resources, education, quality jobs, social care and health care, ICT and housing. As regards its strengths, the NRS demonstrates that the choice of new inclusion priorities is a result of analyses of the current situation and wide consultations.

Latvia recognises the need to give attention to the adequacy, modernisation and financial sustainability of the social protection system, particularly pensions and health. The approach to a substantially different demographic situation is stressed. Pensions receive considerable attention, even though the reform has been completed. Latvia is confident about its pension policy, seeing it as progressive, modern and financially stable in the long term. Latvia is currently raising the retirement age for women (to 62, the same as the male retirement age). Poverty for the elderly is relatively low; however, the gender gap in poverty risk remains high. Latvia has indicated the need for a Reserve Fund for pensions (because of the demographic load). This is important to guarantee pension system financial sustainability, therefore measures relating to the fund should be reflected in greater detail. Latvia intends to reform its health care system in order to improve its long-term sustainability, raise its quality and enhance access to health care services. The programmes for modernising the emergency medical service and optimising the structure of health-care service providers should contribute to this. Particular emphasis should be placed on better integrating Primary Health Care. To improve general coverage of services and geographic access (through expanding emergency care), it is necessary to reduce the individual financial burden and address the human resources issues. The latter will be achieved through an increased allocation of public resources to the health sector and the development of training and staff retention policies (to be achieved through the Structural Funds). However, access by the poor is not sufficiently elaborated in the NRS.

When translating the strategies into action to be taken in the field of social inclusion, the NRS concentrates on a life cycle approach and on some family types. The NRS identifies three broad priorities for action to improve access to services and resources: (a) education and jobs for children and youth at risk of poverty and social exclusion; (b) resources and services for families, in particular large and lone-parent families; and (c) resources and services for pensioners at risk of poverty, in particular single pensioners. However, the NRS mentions also other numerous at- risk groups, but does not tackle the issues further. On the whole, the NRS provides a summary of actions, but is not always underpinned by a clear and coherent strategy. Being a forward- looking document, the Latvian NRS regrettably does not discuss to what extent the 2004 -2006 targets were achieved or the impact of past policies. Shortcomings remain in the NRS, regarding targets and indicators for monitoring the 2006-2008 period and this aspect needs to be strengthened significantly. As clear targets relating to poverty reduction are not included, some social inclusion commitments from the Lisbon NRP (such as lowering the at-risk-of-poverty rate to 11% by 2008) have disappeared from the agenda. The role of Structural Funds support in implementing the priority measures is not sufficiently highlighted, and details of funding are lacking. This adds to concerns that social inclusion and human resource development goals might not receive the attention they deserve. The three examples of good practice do not exactly correspond to the four selected areas, and are neither fully implemented nor evaluated.

3. Social inclusion

3.1 Key trends

Recent developments in Latvia include enhanced social security benefits for families with children and introduction of new support measures. Lower pension amounts have been are increased. In 2005 the tax-free personal income threshold was increased (and will be increased again in future) and the guaranteed minimum income benefit was also increased. Possibilities to lower the personal income tax rate (currently 25%) are being looked into. A decision was taken to substantially increase the minimum wage as of 2007 (by more than 30%). As the poorest households spend a large share of their income on housing and food (41% in 2004), inflation erodes efforts to improve their situation. Increases in the prices of education (+10.3% in the current academic year, according to national statistics) health care services, food, housing, heating and transport all negatively affect the situation of medium wage earners as well. Household debt is rising and there is a need for advice about the consequences of taking on heavy financial commitments.

Although the average wages are growing rapidly and disposable income is increasing for all types of households, considerable income disparities remain between rural and urban areas and between Riga and other regions. The Gini coefficient decreased only in Riga. The relative poverty line in 2004 was EUR €110 per month. Owing to a dynamic income growth for higher wage earners and inflation, poverty risk for several groups, like single pensioners, single-parent families and for large families with dependent children remains high. Taxation on low-wage earners and the unemployment trap are also high (41.1% and 87.10 % in 2004). Educational attainment for young people is 81.8% (the female indicator being 86.6%). According to the NRS, numbers of drop-outs grew recently, both in vocational and in comprehensive day schools. The scope of Latvian language training has been increased, but lifelong learning is a concept still to be implemented, while 2005 has already seen a decrease in adult participation in education and training. Several policy documents benefiting vulnerable groups (Roma, the disabled, ex-convicts and the poor) were elaborated during 2006, but their impact will depend on resources allocated for achieving the objectives.

3.2 Key challenges and priorities:

Efforts are made to have an impact on the eradication of poverty and social exclusion by improving access to basic resources and social services. Still, the needs of Latvian society are huge. Social inclusion policies involve all government levels; however, there is a need to improve their efficiency, effectiveness and mainstreaming in relevant public policies and Structural Funds programmes. As regards the two social inclusion challenges presented by the 2006 Joint Report on Social Protection and Social Inclusion, they remain valid (development of a coherent strategic approach to promoting social inclusion, and introducing more targeted measures for vulnerable groups).

Considerable efforts are made to better include relevant actors, and to accommodate the needs of local governments and at-risk groups; still, the issue of tackling regional differences remains important. Actions taken and planned fall short of fully addressing the problems identified. Unfortunately, research and statistical data reveal no significant progress in reducing risks of poverty and social exclusion for vulnerable groups, neither by region, nor by gender. Inflation growth has eradicated the attempts of government to help lower income groups, while inequality in income distribution has not been tackled. The new priority actions will mostly target the at-risk groups by offering the same approach for both genders and all

regions and territories. The needs of other groups at risk (like the homeless, the long-term unemployed, addicts, victims of trafficking) will also have to be addressed and lifelong learning will be important to achieve the social inclusion goals. As regards positive developments, the ESF has enabled Latvia to increase the numbers of those benefiting from active labour- market policies and the gender dimension has become more visible. The NRS only mentions the SF and EQUAL contribution as supportive to key policy objectives and ERDF support is reflected in best practice examples.

3.3 Policy measures

Education and jobs for children and youth at risk of poverty and social exclusion:

Action taken under this priority is aimed at increasing the efficiency of the teaching process in basic education, and reducing numbers of early school leavers and low performing students. Better opportunities to enrol in catch-up and remedial teaching programmes will be offered. Assistant teachers will be available, as well as consultations. ICT support and skills will be improved. Children with special needs will be integrated into the general education system and labour market. Problems faced by young offenders will be tackled and action taken to help the Roma children. Better access to vocational education for at-risk groups is envisaged, as well as overall improvements in vocational guidance and career development support. Improvements in job- related skills benefiting young people are planned.

Resources and services for families, in particular large and lone-parent families:

There is an intention to further reduce the tax burden, increase benefit amounts and improve the benefit system by making it more family- friendly. Tax exemptions will be offered for the households purchasing ICT. Improvement of access to housing is planned. Health improvement measures include free lunch in primary schools, testing of pregnant women to reduce the numbers of HIV/AIDS- infected newborns and establishing two mobile palliative care teams (comprising a psychologist, a social and medical worker and chaplain). Alternative social care and social services will be further promoted, including child-care services. Support to families in critical situations will be improved and family- friendly environments and infrastructure promoted. 900 social workers in municipalities will receive wages paid partially from the central budget.

Resources and services for pensioners at risk of poverty, in particular single pensioners:

To reduce the poverty and social exclusion that pensioners are facing, basic benefit amounts will be increased, lower pensions go up, supplements to benefits introduced, non-taxable minimum incomes increased. Access to housing, health care and social services will improve. New initiatives to be introduced will promote the access to cultural events and ICT.

NRS targets and indicators still need to be strengthened, to allow measuring the effect on Latvian society (including differences between genders and regions). In combination with scarce information on timeframes, the finances allocated for implementing NRS priorities, weaknesses in target setting and use of indicators do not allow the possible impact of proposed actions to be evaluated. The overall policy measures seem realistic, but, in the light of socio- economic developments in Latvia, higher ambitions reflected in specific targets for tackling poverty and social exclusion would have benefited the NRS. Latvia addresses gender issues by stressing the need for of better reconciliation of work and family life and increased prevention of the risk of discrimination. It mentions the national action to ensure such

reconciliation via a state support system to families during the child care period, when one of the parents receives a child care allowance. Considering that usually women take care of children, this provides an opportunity to retain professional qualifications and labour market competitiveness. Latvia states the importance of developing short-term alternative child care centres and nursing services. However, there is an urgent need for decisive state support to develop these services. Current action at national level to create such services is mostly limited to encouragement for employers and local governments, methodological recommendations and campaigns. The NRS also sees the need to increase the role and responsibility of the father and to develop day care centres for the elderly and disabled.

3.4 Governance

There have been efforts to achieve better governance, transparency and involvement of stakeholders. To better target the needs of social risk groups in all regions, an extensive consultation was carried out, first with local governments and NGOs. It was followed by wider public consultations. In the end 101 proposals were put forward. Involvement of relevant actors in drafting of the NRS was ensured by establishing a representative working group. The monitoring mechanism for the next implementation period will be similar to the current one: a Monitoring Committee and an implementation report. The NRS envisages (in 2007) promoting social cohesion and gender equality by mainstreaming social inclusion policy in relevant policy fields and by identifying and implementing best practices from other Member States. These possible developments are most welcome. Concerns remain as there are huge social inclusion needs in the country, numerous proposals coming from NGOs and local governments and only few priorities selected, concentrating very much on family structure and age. Concerns relate to adequate financing for social inclusion activities, especially in the period 2007-2013. Also, in preparations for the next SF planning period, Latvia acknowledges a "lack of in-depth research" on implementation of the National Action Plan on Eradication of Poverty and Social Exclusion 2004-2006. The lack of such information can undermine the success of the current NRS.

4. Pensions

Pensioner incomes are relatively close to those of the overall population (75% of those aged 0-64 in 2003) and the risk of poverty among the 65+ age group 21% (in 2005) is slightly higher than that of the general population, but the gender gap is significant (12% for men and 26% for women). The 2006 Sustainability Report assessed Latvia as a low-risk Member State as regards the sustainability of public finances. According to the AWG projections of 2005, Latvia forecasts a decrease in public pension expenditure from 6.8% to 5.2% between 2004 and 2009 and thereafter a marginal increase from 5.2% to 5.6% of GDP over the period 2009-2050, an overall fall of 1.2 p.p. in public pension spending over the period 2004-2050. Taking into account pension expenditures from the mandatory funded scheme, expenditures are projected to increase from 6.8% of GDP in 2004 to 8.3% of GDP in 2050. ISG projections for the net replacement rate show a fall from 78% in 2005 to 67% in 2030 and then increase to 72% in 2050 (gross replacement rates are projected to decline from 61% in 2005 to 51% in 2030 and then increase to 55% in 2050).

The 2006 Joint Report set out the challenges that Latvia faces, namely the necessity of reducing the informal economy, to ensure individuals are contributing to the pensions system, and to ensure that those on low incomes are protected in retirement, particularly as Latvia increases the link between contributions made and benefits paid. One key development in meeting the latter of these challenges has been the significant increase in the guaranteed

minimum pension, paid to those with low incomes or shorter time spent in paid work. The national pension system was transformed into a 3-tier pension system consisting of a notional defined contribution scheme (NDC pay-as-you-go pension scheme), a state-funded pension scheme and private pension schemes. Regarding the impact of ageing on pensions, the policy objective is a balanced budget position in the long term. The government expects the decline in the rate of contributions to the NDC scheme to be compensated by increased employment and an increase in declared work. The early retirement option is to be eliminated by 2008 under present plans. The risk of poverty among the 65+ age group is currently only slightly higher than for the working-age population. Still, the new pension formula, which establishes a strong link between personal contributions to the system and benefits, could lead to adequacy issues as the overall replacement rate is expected to fall until 2030, before increasing again when the mandatory private pensions come to fruition. This could affect lower income earners and people who have taken career breaks, particularly women.

5. Health and long-term care

5.1 Health care

Description of the system: The Health Compulsory Insurance State Agency (HCISA) provides coverage to all citizens. The HCISA, through the regional sickness funds (5), purchases care for their respective populations on the basis of contractual agreements. The range of primary and secondary services included within statutory provision is determined annually in the Basic Care Programme. Primary healthcare (PHC), provided in single or joint practices of general practitioners (GPs) and nurses, plays a central role. GPs are independent contractors and act as gatekeepers to specialist and hospital care. The costs of healthcare services that are not included in the Basic Care Programme must be covered by the patient. During the interim implementation period for the PHC system, patients' first registration can take place in various outpatient institutions. Most specialist and hospital care provision is public (some state and mostly municipal). Dental practices and pharmacies have been privatised. GPs are paid on a mixed capitation basis while hospital physicians are paid on a fixed salary plus a points system. The HCISA administers the tax-based health care budget, allocating it to the regional HCISA offices, which then allocate resources to primary, secondary and tertiary care, and emergency medical assistance. Patients have to pay a patient contribution in order to receive health care, while patients' co-payments apply to partly refunded pharmaceuticals. Out-of-pocket payments including informal payments constitute a large part of private expenditure on healthcare. National policy aims at concentrating resources of inpatient care, decentralising resource allocation for outpatient care, promoting cooperation in outpatient care and establishing a network of secondary care providers according to population needs.

Accessibility: Although coverage is universal, the services available totally free of charge are limited (e.g. emergency care) and individuals experience difficulties in access. Services unavailability is a major issue in PHC led systems, due to the remoteness of healthcare facilities in rural regions. This results in significant socio-economic and regional (urban/rural) access disparities. Several categories (1/3 of the total population) are exempted from patient contributions (disabled, mental patients, children, poor persons etc). Similarly, in emergency care, which is to be developed, patients do not have to pay a contribution. In order to tackle high patient costs that hinder access to health services, the authorities have introduced a "ceiling" for patient contributions, which if reached triggers exemption of payment of additional costs. Drug reimbursement procedures have been changed but resource allocation

for reimbursement remains low. In PHC, the low number of GPs, their concentration in urban centres and the low ratio of nurses to doctors has severe consequences for the establishment of strong PHC teams and thus results in long waiting times for inpatient healthcare services and problematic access (related to insufficient specialised institutions, the referral process and the GP workload and payment method). The authorities recognise that the low number of physicians and the small share of public resources allocated to healthcare hinder universal access of the population.

Quality: Special supervisory bodies in charge of quality control are the Quality Control Inspectorate on Medical Care and the Health and Working Capacity Medical Experts Commission. In order to ensure quality, medical staff have to recertify every five years. Patients can choose their GP and reregister up to twice a year. They can choose the hospital if it is contracted by the HCISA. Patients' rights are being consolidated and patients' awareness of their rights increases annually (increased number of complaints and petitions). The authorities state that outdated technology, difficulties in certifying institutions and closure of uncertified institutions, inadequate training/qualifications of staff and lack of coordination between PHC, specialist and hospital care providers constitute remaining problems. Preventive health care is being promoted with the involvement of NGOs, extended use of ICT, a free telephone information line and population education on healthy living.

Long-term Sustainability: Total health expenditure (6.4% of GDP and 751 per capita PPP$ in 2004) is below the EU average[48]. In 2004, public health expenditure stood at 51.6% and private health expenditure at 48.4% of total health expenditure. In 2004, out-of-pocket payments represented 45.9% of total health expenditure. According to the 2006 EPC/EC projections public healthcare expenditure is set to increase by 1.1 percentage points of GDP by 2050 due to population ageing. These numbers demand attention especially with regard to population health status and facilities' need for resources. The authorities recognise the need to increase public expenditure to finance effective prevention, reduce the financial burden of care, increase hospital supplies and reimburse sickness funds. The system appears underfinanced in comparison with neighbouring Member States. To achieve cost-efficiency, hospital care dependency is being reduced with plans to use hospital resources more effectively (hospital conglomerates, better coordination and concentration) and to build new PHC centres. The number of acute hospital beds[49] is declining and several hospitals have been transformed into LTC facilities. Staff and hospital payments (introduction of a GP referral and gate-keeping role) have been shifting to create incentives for PHC provision and reduce unnecessary specialist and hospital care. The authorities are concerned about potential staff shortages due to low pay, difficult working conditions and the retirement of the majority of acting physicians. The adopted strategy aims to increase wages and provide professional guarantees with the development of health education programmes.

5.2. Long-term care

Description of the system: Long-term care is provided on the basis of individual needs' and means assessment by municipal social workers. The evaluation assesses firstly whether residential or home care is a possibility and if not refers persons to the LTC institutions. LTC is financed from state and municipal budgets. Patients have to pay for LTC unless they belong to exempted groups. Municipalities are responsible for LTC provision and finance persons

[48] EU average total health expenditure: 8.87% of GDP and 2376.33 per capita PPP$ in 2004
[49] though still above the EU average (555.7 in 2003)

without means. National policy aims to develop care provision that is adjusted to each patient needs and economically justified including alternatives to institutional care.

Accessibility: Authorities emphasise the provision of alternatives to institutional care to meet LTC needs. The municipalities are responsible for providing adequate care services to elderly and disabled people. The finances of the municipality, which are exacerbated by regional (rural/urban) disparities, determine the availability of LTC institutions and hence access. A particular concern is the long-waiting times to enter facilities. Long queues for institutional access are due to the lack of LTC alternatives for particular groups (mental patients) and to insufficient municipal resources. Although home or residential care is favoured, lack of coordination between municipal and state budgets results in a growing but poor provision of these alternatives to institutional care. The state budget co-finances day care centres for the first 4 years, after which they fall under municipal responsibility. Authorities wish to develop service apartments and group houses[50] without however allocating the necessary funds towards this end.

Quality: Quality standards and a supervisory system have been developed. A social work coordinator post has been introduced at regional level. Cooperation with the PHC centres and physicians is promoted for the continuation of care and care programmes development. The quality of LTC services is hampered by the unsatisfactory finances of municipalities, low staff salaries and poor conditions in care facilities.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.3 percentage points of GDP by 2050 due to population ageing. To provide adequate care and achieve cost efficiency, the strategy focuses on limiting the overuse of expensive institutional care and on stimulating the development of alternative care. The authorities recognise the need to address the problem of negative effects of decentralisation such as the arbitrariness of municipalities in setting up criteria for social benefits and their tendency to place patients in state care facilities to reduce the local costs. This requires the creation of vertical and horizontal control mechanisms and stronger coordination. Delays in the implementation of the administrative reforms impair the long-term sustainability of the system.

6. Challenges ahead:

To develop a coherent strategic approach to promoting social inclusion and breaking the cycle of deprivation, especially for families, including quantified targets, which take into account regional and gender dimensions;

To promote targeted active inclusion measures for the full range of vulnerable groups, by addressing the adverse effects of inflation on low and medium income groups and enhancing associated services and employment opportunities;

To ensure that sufficient resources for adequate pensions are available until the funded schemes have matured and to monitor future adequacy;

[50] Separate apartments for people with mental disorders and individual support. As of 1st January 2007, the state requires a 50% co-payment.

To improve general coverage of health services, geographic access to care and reduce the individual financial burden of care, address human resources issues, continue deinstitutionalisation of LTC services and increase the resources allocated to this sector;

To finalise the reform of PHC, reduce hospital care dependency and improve care coordination in order to have a properly functioning referral process in a system that emphasises PHC and preventive care;

To clarify competencies and responsibilities between the state and the municipalities in terms of financing and organisation of healthcare and LTC, in order to enhance quality and uniformity of provision and put an end to discretion and discrepancies, particularly in LTC.

LATVIA: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	6.9	35.3	**2000**	57.5	61.5	53.8	29.6	36,0	**2000**	13.7	14.4	12.9	21.4
2002	6.5	38.7	**2002**	60.4	64.3	56.8	31,0	41.7	**2002**	12.2	13.3	11,0	22,0
2004	8.6	43.6	**2004**	62.3	66.4	58.5	30.5	47.9	**2004**	10.4	10.6	10.2	18.1
2006	11.0f	52.3f	**2005**	63.3	67.6	59.3	32.6	49.5	**2005**	8.9	9.1	8.7	13.6

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	60,3	73.1	11,7	15,8	n/a	n/a	18.8	**1995**	4.2	95	-	:	:
2000	65.0	76.0	11,9	17,6	n/a	n/a	10.4	**2000**	6	55	45	:	:
2004	67,1	77,2	12.6sp	17.2sp	n/a	n/a	9.4	**2004**	6.4	51.6	45.9	:	:

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	15.3	57.1	16.7	3.8	10.2	1.4	10.7
2004	12.6	50	24.5	3.4	10.5	1.8	9.8

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long term care
2005	24.1	:	:	:	:
2010	25.2	(-) 2.9	:	:	:
2030	33.4	(-)1.5	(-)1.2	0.8	0.1
2050	44.1	(-)1.3	(-)1.2	1.1	0.3

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	19b	22b	19b	18b	21b	27b	31b	26b	33b	11b	**Total**	6.7b
Male	18b	-	17b	18b	12b	33b	-	33b	36b	13b	**Male**	-
Female	20b	-	20b	18b	26b	23b	-	22b	30b	10b	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	12.0b	14.9b	13.4b	16.4b	**1999**	7.6	7.6	7.6	**1999**	na	na	na
2004	7.2	7.8	7.1	8.4	**2004**	4.6	4.8	4.3	**2004**	15.6	20.5	10.7
2006	7.1	6.8	7.5	6.2	**2005**	4.1	4.4	3.7	**2005**	11.9	15.5	8.2

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0,746b	0,777b	0,735b	***Aggregate replacement ratio***	0,61b	0,52b	0,7b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	Pension (or Social Security)	Current estimate(2002)	Assumption
(-)6	(-)6	(-)6	NDC, DC			100		20		

**(DB / NDC/ DC); ** (DB / DC)*

2.14. LITHUANIA

1. Situation and key trends

GDP growth in Lithuania remains one of the highest in the EU (7.8% in 2006). GDP per capita in PPS has also increased rapidly but is still just about half of the EU average (55% in 2006). The rapid GDP growth has been driven mainly by the growth of exports, productivity and internal consumption in different time periods, while employment is growing at a slower pace. The employment rate was 62.6% in 2005 (men 66.1%; women 59.4%). A sharp drop in unemployment (to 8.3% in 2005 from 16.4% in 2000) is only partly mirrored by employment growth, largely due to movement of the labour force out of Lithuania (the migration saldo was -2.6 of population in 2005, the highest in the EU). However, LT registers a relatively high employment rate among older workers (49.2%, almost reaching the EU target). Long-term unemployment (4.3%) and youth unemployment (15.7%) have fallen but remain relatively high. The at-risk-of-poverty rate[51] after social transfers was relatively high in 2004 (21%).

Life expectancy is low for men (66.3 years; 77.7 years for women in 2004). Owing to high emigration, ageing and a low fertility rate (1.27 in 2005) the old-age dependency ratio (22.5 in 2005) is projected to double by 2050 (44.9). Total expenditure for social protection as a percentage of GDP (13.3% of GDP in 2004) was amongst the lowest in the EU and yet shows a declining trend (although the total amount is increasing in absolute terms). Pensions (47.3%) and health care expenses (29.5%) claim the biggest shares of social expenditure.

2. Overall strategic approach

The overall strategic approach to social protection and social inclusion is to promote social integration through employment of all those able to work and to ensure efficient and adequate social protection for those who are unable. The National Strategy Report on social protection and social inclusion identifies five key challenges: (1) to increase the activity rate of vulnerable groups; (2) to use the means available to the social protection system more efficiently and fairly; (3) to ensure the rights of children and youth; (4) to create more possibilities of social integration for vulnerable groups; and (5) to mainstream gender equality. Lithuania has addressed all three overarching objectives of the OMC.

On social cohesion, Lithuania aims to develop adequate, accessible and efficient social protection systems and social services. Another specific focus of the National Strategy Report is on support to families, children and youth. There are also some elements of gender mainstreaming. The streamlined National Strategy Report has become more focused in terms of priorities but lacks analytical background for the various initiatives and multifaceted strategy, most of the targets are not measurable, and there are very few arrangements for monitoring and none at all for evaluation.

[51] Following the implementation of EU-SILC in 2005, the values of all indicators related to income and living condition (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years, the large year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data. The most important factors having an impact on the poverty indicators between HBS 2004 and EU-SILC 2005 are the derogations on income from employment in kind and social benefits in kind.

The National Strategy Report interacts with the Lisbon objectives. Its focus on employability and activation of vulnerable groups, and the declared intentions to increase the average exit age from the labour market and to improve social, health and long-term care services should contribute to one of the key Lisbon challenges for Lithuania on increasing the supply of the labour force. Equally, social inclusion policies are presented as an integral part of the Lithuanian National Reform Programme. However, effectiveness of this mutual interaction could be further strengthened by addressing attractiveness of employment for vulnerable groups.

Efforts have been made to promote good governance. A partnership-based group was established to draft the National Strategy Report and a similar group is intended to be used for monitoring the Strategy. Those groups could benefit from strengthening of their administrative and representative capacity and more transparency. The significance of mainstreaming of social policies is recognised but the concrete tools are still to be developed.

3. Social inclusion

3.1. Key trends

Relative poverty after social transfers was relatively high in 2004 (21% and 16% in the EU) the threshold value being the lowest in the EU[52]. The at-risk-of-poverty rate before social transfers was at the EU average (26%) indicating lower efficiency of the social benefits. Although the population is getting richer as a whole, gains in wealth are unevenly spread and the income inequalities were considerably higher than the EU average (6.9 and 4.9 in the EU). National statistics reveal the increasing rural/urban divide.

The at-risk-of-poverty-rate is considerably higher among certain population groups, such as the unemployed (63%), single parents with dependant children (48%), families with three and more children (44%), single adult households (32%, higher for men) and tenants (33%). The in-work poverty risk was also relatively high in 2004 (10% and 8% in the EU). Working poor comprised 28% of the total at risk of poverty population. One third of the Lithuanian population is rural. National statistics reveal that the rural population was three times more at risk of poverty compared to the urban population of the five largest cities in 2005 and highly dependent on social benefits (29% of the total disposable income in 2005).

The at-risk-of-poverty rate for children is higher than the average for the population as a whole, standing at 27% after and 34% before social transfers (19% and 34% in the EU). 66% (57% in the EU) of jobless households had dependent children in 2004. The NRS reveals that the highest risk of poverty is amongst children 3-5 years old. Early school leaving was relatively low at 9.2% (15.2% in the EU) in 2005 (6.2% female, 12.2% male). The educational attainment level was relatively high (85.2% of 22-year olds had at least upper secondary education in 2005).

3.2 Key challenges and priorities

The social inclusion strand of the National Strategy Report focuses on four national priorities for action: increasing labour market participation; improving access to quality services; eliminating child poverty and enhancing assistance to families and tackling disadvantages in

[52] 1235 EUR in 2004

education and training. The relevance of the selected priorities is indisputable and the Strategy is more focused thanks to the prioritisation. However, the analytical justification for their choice over the other three priorities is not given. To some extent that may be due to the broader nature of the selected priorities and their partial coverage of the ones left aside (such as housing). The integration of a relatively small but socially disadvantaged Roma community is not addressed.

In the 2006 Joint Report, two challenges were identified for Lithuania. The challenge of developing and implementing a comprehensive regional policy to tackle regional imbalances and rural poverty is recognised in the National Strategy Report but the policy response has remained fragmented and lacks prioritisation, clear targets and guidelines for implementation, monitoring and evaluation. National statistics reveal an increasing rural/urban divide. Limited progress has been achieved as regards the second challenge on better governance which is analysed in section 3.4.

3.3. Policy measures

The NRS identifies a number of measures under the four selected priorities which can greatly contribute to reducing poverty and social exclusion if properly implemented. However, it is difficult to judge their adequacy due to the insufficient analytical background presented for the various measures and the social situation of certain vulnerable groups and the lack of an assessment of the impact of previous policies (which is expected to be done later). Many of the measures are target group and activity specific and the multifaceted approach is therefore fragmented. The scope of the many measures is not defined and there are very few measurable targets. There is therefore a risk of limited evaluability and fragmented management. The measures will be mainly funded from the national budget and Structural Funds (ESF, ERDF and EAGGF). The list indicating the resources allocated to measures has not been submitted.

The measures under the first priority, *to increase labour market participation*, are intended to serve two important tasks, namely to promote social integration through quality employment and activation of the disadvantaged groups and to increase the labour supply in the context of declining availability of the labour force. While there is an improvement in the variety of the activation measures and the coverage of the targets groups, the focus on the efficiency and quality management of the measures is not sufficient. The entrepreneurship measures are intended to promote self-employment of youth, disabled and unemployed persons, and the microcredit system which is currently under development can contribute greatly to that if provided with adequate resources. Promotion of subsidised employment is foreseen for the most vulnerable groups. Specific support for the rural population at high risk of poverty is basically limited to the EAGGF measures, which include various subsidies to farmers and support for the diversification of rural economies. The measures under the first priority should take better account of the relatively high in-work poverty most relevant to the disadvantaged groups and the high share of working poor in the overall at-risk-of-poverty population. The attractiveness of employment, support for the transition to work as well as remaining and progressing in employment should be further addressed. As regards the funding of these measures, the ESF will be an important financial instrument for the ALMP.

The second priority, *to improve access to quality services*, covers measures addressing social, legal and cultural services. The main focus is on social services, which reflects the new Law on Social Services in force since July 2006. The quality of social services should be improved by setting standards for all providers and creating quality control mechanisms. As regards the

provision of services, the disabled receive particular attention. Regional availability and variety of social services should be increased by the creation and implementation of the Programme for Development of Social infrastructure 2007-2009. Advanced social services can contribute to the first priority of increasing labour market participation through family/working life reconciliation measures and provide better social integration possibilities for those incapable of working. This link is obvious but not elaborated. The provision of some social services is to be supported by the ESF.

The measures under the third priority, *to eliminate child poverty and enhance assistance to families*, focus on the prevention of poverty and social exclusion among children and support for families with children to break the intergenerational transmission of poverty. In many cases this is still at the conceptual level. The National Programme on assistance to parents before and after child birth until the start of school (to be prepared by 2007) can have a significant impact on the well-being, health and education of preschool age children, if properly implemented and accessible to all. The strategy on decentralisation and non-institutionalised child care is being developed. The planned development of day care centres for children and youth and specific funding of projects presented by disadvantaged youth can increase their empowerment. The balance between planned monetary and in-kind benefits for families would need further elaboration in respect of potential work disincentives. Important plans for housing are announced as well.

The measures under the fourth priority should help *tackle disadvantage in education and training*. Many measures under this priority are of a mainstream nature such as the development of vocational training and LLL systems. Specific measures are also tailored for children from families at risk. Preschool age children should benefit from the education measures of the programme on the assistance to parents before and after child birth until the start of school, already mentioned under the third priority. Development of the specific programme to prevent non-attendance of school is planned. Students should benefit from the intended revision of the law regulating funding of studies. An important set of measures aimed at the development of civil society is also presented.

3.4. Governance

The Ministry of Social Security and Labour has overall responsibility for development and implementation of the NRS. The Ministry was assisted in the drafting process by a joint task group comprising representatives from governmental institutions, social partners, NGOs and the Association of Municipalities. It is also planned to establish a wide partnership-based NRS Monitoring Group to take over the tasks of the current NAP Monitoring Group during the period 2006-2008. While the strengthening of partnership is a very positive development, the criteria for the stakeholders' selection in the groups and their roles are not defined, while the activities of the groups lack visibility. This undermines to the groups' representative capacity to some extent. More active involvement of the most senior level government officials (for ensuring political commitment), social partners (especially regarding measures to increase labour market participation) and municipalities (having a key role in addressing regional imbalances) would be beneficial.

The National Strategy Report contains strong statements of intent to further develop the existing social assistance information system and e-services in the social sector. However, no specific measures have been planned to strengthen the capacity for monitoring and evaluating implementation of the Strategy or to enhance visibility of the social inclusion policy, although these areas were highlighted as a key challenge for Lithuania in the 2006 Joint Report. It is

also important that the intentions to mainstream social inclusion policies result in concrete measures such as impact assessment of legislation on poverty and establishing principles for adequate and effective funding.

4. Pensions

Pensioner incomes in Lithuania are close to those of the overall population (81% of those aged 0-64 in 2004). The poverty risk of the elderly (17% in 2004) is slightly lower than that of the general population, but the gender difference is significant (for older men it was 6% and 22% for women).

The 2006 Sustainability Report assessed Lithuania as a low-risk Member States as regards the sustainability of public finances. According to the AWG projections of 2005, Lithuania is projecting a moderate 1.9p.p. of GDP increase in public pension expenditure (3.7% of GDP when taking into account the funded tier of the statutory scheme) over the period 2004-2050 The State social insurance fund is expected to be in balance or surplus up to 2020. Thereafter, a deficit is anticipated, peaking at 0.7 % of GDP in 2030. ISG projections for net replacement rate show a slight decline from 55% in 2005 to 51% in 2050 (gross replacement rates are projected to increase slightly from 40% in 2005 to 42% in 2050).

The challenges identified in the 2006 Joint Report, raised issues of increasing employment and ensuring adequacy, as pension incomes especially social assistance pensions, are low in comparison with other Member States. Recent increases in the social assistant pension may go some way towards addressing this last challenge. However future adequacy should be closely monitored.

Since the 2004 reform, the State-managed statutory pay-as-you-go pension scheme has been supplemented with a privately managed funded pension scheme. This scheme cover gainful employment (although significant portions of the population are not covered), while a social assistance pension provides a minimum retirement income for those not entitled to a social insurance pension, including farmers and some categories of self-employed. Legislation on voluntary supplementary pension provision is in place, and tax incentives were recently introduced. The financial sustainability of the public pension scheme will have to be closely monitored, although the transition costs are not expected to cause problems before 2020. However, thereafter, the ageing of the population could result in a deficit in the social insurance pension scheme. Further measures to increase employment rates and raise the retirement age (including equalising statutory retirement ages for men and women) would contribute to both future adequacy and sustainability of pensions. In that respect, while early retirement provisions were terminated in 1995, the introduction of an early retirement pension scheme for the long-term unemployed in 2004 seems to be in contradiction with the general trend.

5. Health and long-term care

5.1. Health care

Description of the system: The Lithuanian National Health System (LNHS) provides healthcare services organised at three levels (municipal, county and national). Provision is decentralised and mostly public. Completely or partly free care is provided to the compulsorily insured population through the statutory health insurance system, which covers all contributing residents and certain groups (children), achieving 99% coverage. Primary care

(PHC) is delivered in health centres, GPs' own surgeries, community posts, ambulatories and polyclinics by a variety of staff. GPs have a gate-keeping role (with an extra cost for non-referral visits) with regard to specialist and hospital care but many specialist consultations take place without a referral. Specialist ambulatory care is provided in polyclinics and hospital outpatient departments. Inpatient care rests with general and specialised hospitals. Health care providers operate on the basis of contract with the statutory health insurance funds. Private provision of outpatient specialist care, notably by public hospital specialists, is growing. GPs are paid a salary, although an additional fee-for-service payment for preventive care and specialist services is being introduced. Whereas PHC is financed on a capitation basis according to the number of GP referrals, secondary care, in-patient and other services are financed on a capitation basis according to the number of residents and a rural/urban model. The LNHS is financed by compulsory insurance contributions, taxation revenues (from the state budget and municipalities) and direct patient payments to service providers. Statutory health insurance funds are transacted through the State Patients' Fund (SPF) and its regional branches: the Territorial Patients' Funds (TPFs). TPFs contract with care institutions for service provision and reimburse the insured (medication and added costs). Funds are allocated to TPFs on the basis of the proportion of residents in the county and service use. Co-payments apply for a variety of services (visits, hospital stays, drugs, dental services) and informal payments are common. The authorities wish to promote better accessibility to healthcare and social services, particularly in rural areas.

Accessibility: Free emergency care is provided by law to the entire population. Although services and population coverage is high some regional inequalities in distribution of health care services exist: health care facilities are concentrated in the major cities, certain specialties are lacking in rural areas and there are differences in hospital capacity. Also, out-of-pocket payments are high (24.2% of total health spending in 2004), particularly for pharmaceuticals, while informal payments appear to be decreasing. The authorities acknowledge that stronger PHC (including use of private providers) and better coordination of health care institutions can bring patients better access to different types of care. The financing structure aims to address regional inequalities of access by targeting funding according the medical needs of the population. Although the number of GPs and of PHC units has increased substantially, the system is still under-resourced and oriented towards acute and hospital care. The authorities recognise that the sector suffers from a lack of resources as well as a lack of cooperation between primary care, hospital and other services. Reforms are aimed at developing private provision (insurance and care institutions).

Quality: The authorities have identified quality limitations, including the poor conditions of buildings and equipment. TPFs carry out quality controls. The authorities are seeking to introduce modern medical technologies and to improve the qualifications and remuneration of staff. An information system based on comparable indicators is under development. Patients are free to choose the PHC facility, the GP within this and the hospital provider. Lithuania aims to improve the legal framework for quality assurance of the system. In addition to large-scale immunisation and vaccination programmes, introduction of the 2005 WHO International Health Regulations and intensification of preventive healthcare are planned.

Long-term sustainability: Total healthcare expenditure (6.5% of GDP and 816 per capita PPP$ in 2004) is below the EU average (8.87% and 2376.33 in 2004) despite having increased throughout the 1990s. The share of public health care expenditure[53] has decreased

[53] As a percentage of total health care expenditure

and stood at 75.4% in 2004 with private health expenditure representing 24.6% of total health expenditure. Out-of-pocket payments in 2004 represented 24.2% of total health expenditure. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 0.9 percentage points of GDP by 2050 due to population ageing. The authorities expect public expenditure to increase in view of economic growth while ageing and demographic changes are seen as a challenge to service provision and sustainability. The authorities have identified the clear lack of resource allocation to the healthcare system, and its orientation towards hospital and specialised provision, as a problem. In addressing these challenges, the reforms aim to reduce the weight of specialist and hospital care while strengthening PHC, outpatient care and day case surgery, reducing length of hospital stay and increasing bed use (which has been rising). The number of acute hospital beds in Lithuania has decreased over time, but is still above the EU average54. The development of quality healthcare human resources is seen as a priority. Although the increased number of GPs has contributed positively to the development of PHC, staff migration remains a serious problem and the authorities have put a staff retention policy in place. Improving the health status of the population and tackling health inequalities through an active health policy based on promotion, prevention and inter-sectoral collaboration is the adopted strategy. Developing an integrated and efficient PHC infrastructure as well as the integration of various entities dealing with LTC, at municipal level constitute a priority for the authorities.

5.2. Long-Term Care

Description of the system: Social care institutions vary in nature and financing. There are county, municipal and non-governmental institutions financed by the state (county), municipal and private (municipal and welfare funds) budgets respectively. LTC is provided in in-patient institutions and nursing services are provided both in in-patient and out-patient institutions. Funding for social services is provided by the municipal budgets and target subsidies from the state budget. Some social care is provided in nursing hospitals. More recently community-based non-institutional care has started to develop, including home nursing, home assistance and housekeeping services provided by carers and social workers. Most community care is, however, provided by families and relatives. Developing long-term care services, currently deemed insufficient, constitutes a priority for the authorities.

Accessibility: Despite the fact that the number of long-term care beds increased by 12.2% in 2004 compared to 2002, there are still problems of access, with an underdeveloped structure for care at home or within the community. Queuing for institutional care is still the norm. In addressing these issues, the authorities are looking to develop nursing services (payment, nurses' qualifications) and promote home care. Additionally, legislation is in preparation for integrating social and healthcare services in order to ensure access to LTC for residents. Although legally there is no discrimination in access to LTC services, the uneven location and provision of LTC institutions creates geographical inequalities. The allocation of subsidies to municipalities for the provision of LTC has been formalised, allowing municipalities to purchase services even in localities that lack the necessary services. In addressing this, new legislation provides for the establishment of a prior individual needs assessment for the provision of LTC as well as validating and formalising new types of LTC (day care, palliative care).

[54] 579.9 per 100.000 inhabitants

Quality: The aim is to move away from institutional care towards home-provided care. Targets for bed reduction in institutional care, development of nursing services, establishment of universal quality standards and licensing are legally entrenched and will take effect in January 2007. The establishment of private social care institutions and of a private market in LTC is being encouraged.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.4 percentage points of GDP by 2050 due to population ageing. In addition to the (needs based) budget allocated from municipal sources, out-of-pocket payments will be calculated from the individual's various resources (property has been added). Individuals are required to contribute partially towards the costs of their LTC. The authorities view the development of appropriate day social care services and home care as necessary for reducing the financial costs of LTC institutions.

6. Challenges ahead

To combat child poverty, in particular by focusing on assistance to parents of pre-school age children and by opening up educational opportunities;

To combat rural poverty by promoting active inclusion, enhancing local development opportunities together with local partners and accessibility of quality social services;

To improve governance by developing, in partnership with all the relevant stakeholders, monitoring, evaluation and mainstreaming systems;

To ensure wider coverage of the population by the statutory pension system and longer working lives;

To ensure the availability of adequate pensions from the modernised pension system, as well as address transition costs beyond 2020;

To reinforce PHC, address geographic disparities in PHC supply and reduce the financial burden of care for vulnerable groups, enhance the provision of community long-term care services and support to informal carers, develop a human resources strategy;

To improve basic quality of facilities, implement information and monitoring systems and allocate additional resources to the sector, whilst ensuring more efficient provision (reduce high dependency on specialist and hospital inpatient care and improve the population health status through effective health prevention and disease prevention), given the low population health status and access problems.

Lithuania: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.1	37.9	**2000**	59.1	60.5	57.7	25.9	40.4	**2000**	16.4	18.6	14.1	30.6
2002	6.9	41.9	**2002**	59.9	62.7	57.2	23.8	41.6	**2002**	13.5	14.2	12.8	22.5
2004	7.3	49,0	**2004**	61.2	64.7	57.8	20.3	47.1	**2004**	11.4	11,0	11.8	22.7
2006	7.8f	55.0f	**2005**	62.6	66.1	59.4	21.2	49.2	**2005**	8.3	8.2	8.3	15.7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	63.3	75,0	12.8	16.8	n/a	n/a	12.5	**1995**	4.9	86.3	-	:	:
2000	66.8	77.4	13.6	17.8	n/a	n/a	8.6	**2000**	6.5	69.7	26.1	:	:
2004	66.3sp	77.7sp	13.5sp	18sp	n/a	n/a	7.9	**2004**	6.5	75.4	24.2	:	:

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	15.8	47.8	29.8	1.8	8.8	3.4	8.4
2004	13.3	47.3	29.5	1.6	8.8	2.6	10.2

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP)Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	22.5	16	6.7	3.7	0.5
2010	23.4	-0.7	:	:	:
2030	33.4	0.3	1.2	0.7	0.2
2050	44.9	1.4	1.8	0.9	0.4

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	21b	27b	19b	19b	17b	28b	30b	28b	31b	13b	**Total**	6.9b
Male	20b	-	18b	20b	6b	31b	-	32b	33b	11b	**Male**	-
Female	21b	-	19b	18b	22b	26b	-	24b	30b	13b	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	8.8	9,0	8.5	**1999**	5.3	6.1	4.4	**1999**	na	na	na
2004	6.5	8.1	8.3	8,0	**2004**	5.8	5.5	6.2	**2004**	9.5b	11.6u	7.4u
2006	5.3	7	7.2	6.9	**2005**	4.3	4.2	4.5	**2005**	9.2	12.2u	6.2u

**: excluding students; b: break in series; u: unreliable*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.81b	0.90b	0.76b	***Aggregate replacement ratio***	0.47b	0.50b	0.45b

Change in theoretical replacement rates (2005-2050) - source ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or social security)	Current estimate (2002)	Assumption
-4	2	2	DB and DC	/	/	83	/	26	/	/

** (DB / NDC/ DC); ** (DB / DC)*

2.15. LUXEMBOURG

1. Situation and key trends

The Luxembourg economy is still registering a much higher growth than neighboring countries (3.6% of GDP in 2004). After noticeable decreases in 2002 and 2003, there has been healthy growth in internal employment (2.3% in 2004, 3% in 2005), particularly among women. Internal unemployment, while relatively low from the outset, has fallen only moderately (5.1% of the working population in 2004 and 4.5% in 2005). The overall employment rate has only improved marginally since 2000 (63.6% in 2005, close to the EU average but still well below the Lisbon targets). The situation is especially bad regarding older workers (31.7% in 2005 - in spite of recent increases -, which is way below the EU target of 50%) and among young people (24.9% in 2005; 36.8% in the EU). The risk-of-poverty rate is low (13% in 200455), but nearly identical to the EU average among the children from 0 to 17 years (19% as against 20%). Life expectancy (75 and 81 years for males and females in 2003) is close to the EU average. The level of expenditure on social welfare was equal to 22.6% of GDP in 2004. Total health expenditure was 6.9% of GDP in 2004, below the EU average, in spite of a steady increase in recent years, while per capita spending on health in PPP$ (3190) is the EU's highest. Luxembourg is expected to experience major demographic developments over the coming decades, due in particular to net migration inflows among the highest in the EU-25. The old-age dependency ratio (21% in 2004 and 36% in 2050) is already somewhat lower than the EU average of 24% and is projected by 2050 to become by far the lowest in the whole European Union (36%, compared to 52% as expected for EU as a whole).

2. Overall strategic approach

Emphasising the need to adapt the social inclusion and protection system (owing to the evolution of the family model, the increasing share of crossborder workers and the growth in unemployment) and the will to maintain the viability of this system, the strategic approach chosen reaffirms five principles of system management: (1) free access to services, appropriate level of benefits, promoting social cohesion, (2) quality of the services and individualised follow-up, 3) financial sustainability of the social protection system, (4) priority to integration through work and (5) maintaining the social dialogue.

Following consultation of stakeholders, six policies are presented, four of which (called "priority policy objectives", hereafter: "objectives") cover the Inclusion chapter: restoring full employment; preventing school failure and increasing the level of skills; reconciling family life and working life; and access to housing. The two additional policies are: "access to quality health care" and "maintaining a viable and sustainable statutory pension scheme".

The strategic choices and the objectives (although the issue of access to housing did not appear in the NRP) are in line with the Lisbon strategy, with the priorities established in the Luxembourg NRP and with the challenges formulated in the 2006 JR. With respect to governance, the system presented provides the means for a wide consultation process, enabling the stakeholders to propose measures to the Government and taking the local dimension (municipalities) into account.

[55] SILC(2005) income reference year 2004

The gender dimension is examined throughout, with special reference to an objective linked to the question of equality of men and women and the participation of women in working life.

The report does not always establish an explicit linkage between the diagnosis formulated in the first part (evaluation of the situation) and the selected policies, nor between the strategic approach and these policies.

3. Social inclusion

3.1 Key trends

In 2004[56], the at-risk-of-poverty rate in Luxembourg was 13%, well below the EU25 average (16% in 2004). Luxembourg reports a growing unemployment (from 2.7% in 1998 to 4.5% in 2005), especially among young people (from 6.9% in 1998 to 13.7% in 2005) and, to a lesser extent, the long term unemployed (from 0.7% to 1.2% between 1999 and 2005). For reasons which should be examined, the at-risk-of-poverty rate is much higher among children: (19% in 2004 against 11% for the rest of the population). The percentage of early school leavers grew slightly between 2004 and 2005 (+ 0.4 pt); one out of 5 early school leavers still becomes inactive. The retention rate for young people between 15 and 24 years old remains much lower than in the EU (40.8% as against 56.4% in 2000; 44.4% as against 60.5% in 2004). To face the problem of current and future internal unemployment, the Luxembourg authorities aim to mobilise their "residents' reserves", while the share of cross border workers in the internal labour market keeps increasing (from 29.8% in 2000 to 35.1% in 2005). The priorities are therefore to encourage labour market inclusion of women, young people or people over 55 years old (the latter also to reinforce the viability of the retirement system), and also to strengthen the fight against long-term unemployment. Luxembourg wants to combat intergenerational transmission of poverty by raising the skills level as from the earliest age, improving educational performance and offering an alternative to early school leavers; it also aims to tackle child poverty in particular by developing child care facilities to encourage parents' participation in the labour market.

3 .2 Key challenges and priorities

The strategic approach related to inclusion policies is included in the 5 general "priority policy objectives" presented here above.. The four objectives (restoring full employment; preventing school failure and increasing the level of skills; reconciling family life and working life; and access to housing) build to a large extent on the 2006 challenges: by focusing on residents furthest from the labour market and on a policy aimed at maintaining employment, the higher rate of unemployment has been taken into account; on the other hand, the effort to raise the employment rate among the over-55 is too briefly considered, as the measures presented are merely statements of intent, similar to those formulated in the 2005 NRP. The evolution of childhood poverty should, however, be addressed in more detail and the fourth objective should be more clearly focussed on populations in need.

The systematic fixing of indicators, for each objective, as well as the description of the envisaged follow-up methods must be welcomed. Moreover, the effort by Luxembourg authorities to concentrate on a restricted number of major issues is worth mentioning, too; but this selection of objectives, although appropriate, should be explained in more detail.

[56] SILC(2005) income reference year 2004

The links with the ESF are simply mentioned twice, regarding the objective "Restoring full employment" and the objective "Reconciling family life and working life".

3.3 Policy measures

Most of the policies implemented aim to encourage maintenance on (or entry or return to) the labour market of people excluded or likely to be excluded: women finding it difficult to work because of care responsibilities, older workers put prematurely into retirement, young people leaving school without qualifications. They mainly target groups particularly at risk of poverty (single-parent households, large families, jobless households, young people without qualification) and aim to anticipate to a certain extent the risks of persistence of poverty (children under 15). However, certain groups of marginalised persons with social problems regardless of professional inactivity, e.g. drug addicts are treated in specific sectoral plans. Access to basic services and infrastructures is primarily the subject of the objective relating to access to housing (tenants also tend to be particularly at risk of poverty).

The measures submitted for each of the 4 objectives are consistent and show continuity with the previous report. New measures are limited following up on the objective "Restoring full employment". The report rather tends to confirm the targeting at persons furthest from the labour market and the will to apply the common labour law scheme to them (the draft law on "social unemployment" is redefined from this perspective). The report also develops the direction taken by the tripartite agreement of April 2006, which decided to give priority to measures promoting maintenance in employment. The rest of the measures are directed at young people and over-55 year old; for the latter, the ambitions (at the level of simple intentions) seem insufficient, while the average age of labour market exit fell between 2003 and 2004 and the rate of employment of older workers improved only marginally. "Preventing school failure and increasing the level of qualifications" is implemented by several measures, some of which are new: this is the case of the rapidly described process of identifying pupils at risk (leaving school before the end of compulsory education, or after but without qualifications) and of a project to take these in charge ("voluntary guidance service"). While more than one young person out of 5 having left the school system prematurely remains inactive, coercive measures previously envisaged are abandoned in favour of a new approach, where assistance and incentive prevail: a new draft law tabled in June 2006 provides for aid for training people under 18 years old and for paying a training allowance to people between 18 and 25 years old. According to the latest OECD study on education in Luxembourg, the performance gap between children of nationals and children of immigrants has been reduced at primary-school level: several measures taken in recent years have helped limit the adverse effect of immigrant or lower socio-economic backgrounds on PISA results to around the OECD average. But in secondary education, some problems still remain (which are not always questioned in the report) like the high proportion of pupils in vocational training channels (45%) or the low share of certified teachers (75%). "Reconciling family life and working life" is pursued by continuing or developing the actions listed in the last Inclusion NAP (and in the NRP): a new draft law is to organise parental assistance work. Within the framework of the objective "Access to housing", the Plan on housing is to be re-examined (establishing the legal framework for State assistance to the municipalities), as already described in the 2005 NAP but not specifically devoted to low-earnings populations; the report also presents a policy programme providing instruments for land price control, one of the measures of which is targeted at low-cost housings.

3.4 Governance

In order to prepare and draft the report, the Government and its acknowledged stakeholders (Ministerial Committees and NGO involved in the inclusion policy) met regularly between December 2005 and June 2006. The authorities involved in the coordination and implementation of the social inclusion policies are presented. But the efficiency of the whole mechanism should be evaluated further.

For each objective, reference indicators are specified together with, in general, the targeted figures ("Lisbon targets"); however, the indicators relating to the increase in places in childcare facilities are not harmonised with those specified in the 2005 NRP. But in spite of the specification of indicators and the presence of clearly identified steering committees, the report does not give enough quantitative estimates of the populations targeted by each objective and measure nor does it provide details of a fully adapted monitoring system.

4. Pensions

On the basis of 2004 figures, older people enjoy a living standard among the highest in EU-25 and virtually equal that of the general population, while the poverty risk among older people (7%) is significantly lower than for the population below the age of 65.

The 2006 Sustainability Report assessed Luxembourg as a medium-risk Member State as regards the sustainability of public finances, owing in particular to the high cost of ageing and despite the current strong budgetary position. Luxembourg is facing substantial budgetary pressures due to ageing populations. According to "Ageing Working Group" 2005 projections, public pension expenditures show a large increase of 7.4 p.p. of GDP, from 10% of GDP in 2004 to 17.4% of GDP in 2050, if according to ISG projections, the theoretical replacement rate will remain at current levels (about 90% in gross terms and 100% in net terms).

The 2006 Joint Report highlighted the fact that the Luxembourg pension system is based on a strong political consensus and ensures a high level of adequacy, but that its financial sustainability would be reinforced by an increase in employment rates among the resident population and in particular women and over-55 year olds.

The financial sustainability of the pension system depends not only on relatively high rates of economic growth in the future, but also on a very large contribution to the Luxembourg economy and pension schemes by non-resident workers. Despite the existence of a reserve fund, the fact remains that in the event of a decline in the employment of non-residents, an ageing population would then have to finance not only resident pensioners' pensions, but also those of a large number of pensioners outside Luxembourg.

5. Health and long-term care

5.1 Health care

Description of the system: Compulsory health insurance provides coverage to 99.9% of the population. The standard contribution rate is set by the Union of Sickness Funds (UCM) which, together with nine other profession-based funds, manage and provide statutory health insurance. Civil servants and employees of European and international institutions have their own health insurance funds. Health care providers are usually contracted out. Any level of care provision that is chosen is eligible for reimbursement. Preventive services are the responsibility of the Ministry of Health. Healthcare is provided by public services, private

practitioners and not-for-profit associations paid from the Ministry's budget. Luxembourg imports all pharmaceutical products and bases most retail prices on those determined in the country of origin. The healthcare system is mainly publicly financed through social health insurance. Health professionals' payments are based on a fixed statutory fee level (payment for a service which is then reimbursed), whilst hospitals are financed through annual budgets negotiated with the UCM. 75% of the population purchases complementary health insurance coverage, in order to pay for services that are categorised as non-essential under the compulsory schemes. Generally, however, complementary health insurance has always played a limited role. The national strategy is focused on the financial sustainability of the system and is aimed towards cost containment and better use of resources. Additionally, common drug and technology purchasing is envisaged (single hospital purchasing centre) with a view to achieving efficiency gains and moving towards a higher use of generic medicines.

Accessibility: Irrespective of someone's income, all insured persons benefit from the same service coverage and the same reimbursement conditions. For vulnerable groups, however, the sickness insurance funds provide both favourable rates of reimbursement and pre-financing of healthcare services. Ongoing extra investment in capacity is aimed at improving general access to health services. In terms of invalidity, a new framework facilitates appropriate resource allocation and service provision for the incapacitated (choice between sickness insurance, invalidity pension and professional training), thereby improving the management of long-term work incapacity.

Quality: The establishment of best practice guides and scientific recommendations has helped in assuring a high level of quality in health care. In terms of quality assurance, there are several consultative bodies that evaluate and monitor the quality of the services provided (a quadripartite committee, a scientific council, a standing hospital committee). There is a free choice of provision for the insured and providers must comply with the fixed set of fees for services. The authorities are encouraging hospitals and healthcare units to establish synergies and to collaborate with other healthcare providers at the wider regional level. The aim is to increase the quality of care through the creation of specialised care centres. In order to maintain a good standard of quality, health professionals have signed agreements with the UCM aimed at improving their qualifications through their participation in seminars (continuous training).

Long-term sustainability: Total health expenditure was estimated to be 6.9% of GDP in 2004. Public sources were estimated to account for 90.2% of total health expenditure in 2004, with the private share of total health expenditure standing at 9.8%. Out-of-pocket payments in 2004, represented 6.8% of total health expenditure In the same year, total healthcare expenditure per capita calculated in PPP$ was 3992. According to the 2006 EPC/EC projections, public health care expenditure is set to increase by 1.2 percentage points of GDP by 2050 due to population ageing. The concentration and grouping of low-activity care units is planned with a view to more rational and efficient use of these resources. Extensive hospital planning, based on periodic evaluations, makes for efficient use of resources and the non-proliferation of specialised services in more than one hospital or health centre. The reforms in the 1980s and 90s focused mainly on attaining financial stability for the sickness funds. The main measures introduced during this period were an increase in co-payments, the establishment of the Union of Sickness Funds' reserve for dealing with any budget imbalance and the transfer of responsibilities from individual sickness funds to the UCM. In 1995 a change in the payment system was introduced in response to spiralling hospital costs: a tariff scheme with global prospective budgets negotiated annually between the individual hospitals and the UCM. Measures aimed at financial stabilisation and controlling costs have been

introduced. They relate to evaluating doctors' prescription behaviour, controlling antibiotic overuse, encouraging the use of generics, as well as hospital collaboration and the designation of centres of excellence, the development of new management practices and centralised procurement of medicines. Strong health promotion and prevention policies (e.g. screening, immunisation, AIDS, TB, nutrition and physical activity campaigns), pursued on a multidisciplinary basis, are intended to improve the long-term financial sustainability of the system.

5.2 Long-term care

Description of the system: Long-term care has been identified by the authorities as a risk to the social security system. As a result, LTC services are provided in a social security framework. A compulsory social contribution based on various revenue sources has been established allowing access to long-term care services on the basis of need, independently of the ability to pay. In the case of home care, there is a possibility for the recipient of care to receive a cash payment that would allow the person to receive care from an informal carer. The cash payment is equivalent to half the cost of the service provided. This cash payment is regulated and limited to 10.5 hours a week for the informal carer in order to guarantee follow-up by the formal care services. The informal carers also benefit from specific insurance coverage. Palliative care is under the responsibility of the hospitals. The authorities intend to promote palliative care outside the hospitals and to ensure that it is financed through the social security system.

Accessibility: A comprehensive and obligatory (insurance) framework is in place for long-term care. For persons in need of additional care who are not covered by the dependence insurance, the state provides a form of co-payment (reimbursing the difference between the payment by the beneficiary and the actual cost of additional care) to the providers of these additional services, since the costs incurred by the beneficiary of these additional services are determined by a social tariff.

Quality: For the elderly, greater emphasis has been placed on geriatric care, gerontology education and the establishment of requirements for facilities and staff. In order to improve the quality of the long-term care provided, measures regarding the definition of clinical practice recommendations based on assessment and evidence-based studies have been introduced. In palliative care, specific training programmes have been introduced in order to meet the changing needs and demands in this specialised area.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.6 percentage points of GDP by 2050 due to population ageing. Preventive care programmes have been strengthened and are co-financed by the social security system. In addition to the fund reserve (which cannot be lower than 10% of annual expenditure for the LTC scheme), there is a 1% contributory rate (1.4% since January 2007) applicable to the total income of the insured population and a state contribution in order to maintain the financial sustainability of the LTC scheme.

6. Challenges ahead

To ensure better control and coordination of the inclusion strategy and to improve the mechanism for monitoring and evaluation;

To perform an analysis of the social implications of the relatively high level of unemployment in general and of long term unemployment;

To raise the employment rate of the resident young people and of the resident population aged 55-64 and to address the long-term sustainability of the pension system so as to make the system sustainable also in circumstances of low economic growth.

To address the financial sustainability of LTC and improve the quality of LTC services through the integration of the various LTC services with health care services in order to ensure continuation of care at home and in the institutional setting.

To limit the overuse of antibiotics and improve the use of generic medicines (quality and financial sustainability).

Luxembourg: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	FeMale				Total	Male	FeMale	
2000	8.4	222.0	**2000**	62.7	75.0	50.1	31.9	26.7	**2000**	2.3	1.8	3.1	7.1
2002	3.8	220.7	**2002**	63.4	75.1	51.6	31.2	28.1	**2002**	2.7	2.0	3.7	7.7
2004	3.6	240.8	**2004**	62.5	72.8	51.9	23.3	30.4	**2004**	5.1	3.7	7.1	16.8
2006	5.5f	257.1f	**2005**	63.6	73.3	53.7	24.9	31.7	**2005**	4.5	3.5	5.8	13.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO	Total health exp. %GDP	Public health Exp % of THE*	Out-of-pocket pay-ments % of THE	Public System covera-ge % of pop.	Pop covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	73.0	80.2	14.7	19.2	na	na	5.6	**1995**	5.7				
2000	74.8	81.1	15.5	19.7	na	na	5.1	**2000**	6.0	90.3	7.0		
2004	76sp	82.3sp	16.6sp	20.5sp	na	na	3.9	**2004**	6.9	90.2	6.8		

s: Eurostat estimate; p: provisional **THE: Total health expenditure* ***PHI: Private health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	20.7	45.1	24.9	3.1	13.1	1.2	12.7
2000	19.6	39.9	25.4	3.2	16.6	1.5	13.4
2004	22.6	36.5	25.0	4.7	17.4	2.9	13.5

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2004	21.2	19.5			
2010	21.6	-0.9			
2030	31.5	5.5			
2050	36.1	8.3			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13	19	11	12	7	18	18	20	20	13	**Total**	3,8
Male	13	-	11	11	9	19	-	18	20	16	**Male**	-
Female	13	-	12	13	5	18	-	20	20	13	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 15-64					% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	4.0	6.7	5.1	8.4	**1999**	0.7	0.6	0.9		**1999**	19.1b	18.9b	19.4b
2004	3.4	7.1	5.7	8.5	**2004**	1.1	0.8	1.4		**2004**	12.7	12.6	12.7
2006	2.7p	6.7p	5.4p	8.1p	**2005**	1.2	1.2	1.2		**2005**	13.3	17.0	9.6

**: excluding students; p: provisional; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.967	0.955	0.988	***Aggregate replacement ratio***	0.625	0.561	0.596

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates	
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	Current estimate (2002)	Assumption
1	0	0	DB			92		24		

**:(DB / NDC/ DC); ** (DB / DC)*

2.16. HUNGARY

1. Situation and key trends

Although the Hungarian economy continued to expand at a rate (4% in 2006 is the Eurostat forecast) well above the European average, the stagnation of employment persisted (56.9% in 2005). The overall rate reflects an enduring negative trend in the youth employment rate (down from 23.6% in 2004 to 21.8% in 2005) which was counteracted by a further increase in the employment of older people (from 31.1% in 2004 to 33% in 2005 which contrasts however with the 50% Lisbon target). The most serious problem of the labour market, however, continued to be the very low level of activity, despite the rising trend (up by 0.8 percentage points to 61.3% in 2005). Growth in activity has been followed by an increase in unemployment to 7.2 % (2005), although this is still relatively low in the light of the high level of inactivity. Unemployed and jobless households are the most exposed to poverty; both joblessness and poverty continue to be strongly correlated with educational, health, territorial and ethnic factors. The employment level of low-skilled people is only one third of high-skilled (28.4% vs. 82.4% in 2003). The health status of the population remains a real concern, with important implications for labour market performance. The old-age dependency ratio is projected to rise from 23% in 2004 to 48% in 2050, close to the EU average. Regional labour market differences are the second highest in the Union, and are marked by even more serious sub-regional differences. In addition to employment opportunities, territorial differences are equally important in terms of access to public services. All these disadvantages are affecting the Roma community especially. Nevertheless, poverty has remained at a relatively moderate level (a 13% at risk of poverty rate in 2004[57]), but children are exposed to a higher risk (20%) especially in lone parent families. Notwithstanding this social context, total social expenditures as a percentage of GDP have fallen (from 21.4% in 2003 to 20.7% in 2004). Social benefits for old-age make up the most important share in the expenditures, with 42.5%; these are followed by health-related spending (29.5%), family and children (12.1%) and disability benefits (10.3%) (2004).

Life expectancy (68.7 years for men and 77.2 years for women in 2004) is one of the lowest in the EU[58]. It has increased by 3.4 years for men and 2.7 years for women since 1995, a remarkable rise after the 1988-1994 decreases. Healthy life expectancy (53.5 and 57.8 years in 2004) remains well below the EU15 average (by more than 10 years)[59].The infant mortality rate is one of the highest in the EU (6.6‰ in 2004 against the 2004 EU average of 4.5‰), though it has improved considerably (47.6‰ in 1960 and 10.7‰ in 1995). Perinatal mortality is also high at 9.1‰ in 2003, although significantly lower than the 1960 figure of 35‰, having remained stable since 1995 (9‰).

2. Overall strategic approach

[57] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data

[58] EU average of 75.8 and 81.9 years for males and females in 2004.

[59] EU average of 64.5 and 66 years for males and females in 2003.

The report demonstrates a significant strengthening of strategic orientation since the 2004 National Action Plan on Social Inclusion. To a large extent the strategy builds on the overall reform agenda of the government across the three strands, and is consistent with the National Reform Programme. At the same time, the NSR addresses most of the main elements of the three overarching objectives. The linkages between the National Strategic Report and the strategy of growth and jobs are strong (feeding-in), - especially as regards attracting people to employment and active inclusion, as well as through pension and health care reform. On the other hand, while the analysis shows that increasing economic competitiveness should deliver greater social cohesion, it does not allow for the necessary conditions to make this happen. Important policies necessary for the social inclusion priorities, such as incentives to mobility for tackling territorial disparities, are not accentuated enough (feeding-out).

While initiating broad reforms the strategy also shows continuity with the previous National Action Plan in focusing on children, disabled persons and the Roma. At the same time the main priorities of the strategy also build to a large extent on the previous strategic approach and interventions, especially in the area of access to employment (active inclusion) and tackling child poverty. In the priority of decreasing regional and territorial disparities the plan focuses on the poorest areas of the country where all social disadvantages, especially in terms of poor access to services are concentrated. The complex problems of these areas and the focus groups will be addressed through programmes carrying out integrated policy mixes (so-called complex programmes) according to the NSR. The intervention logic of coordinated efforts via a range of interventions from different sectors, involving the increased complexity of funding from numerous sources (from both Structural Funds eventually) remains to be seen.

The Government plans to use cohesion policy sources to a large extent in the implementation of the NSR. However, at this stage of planning detailed information on the modalities of structural programming has not been provided. Because of the deficits in monitoring results, the effectiveness of European funding in delivering the interventions of the 2004-2006 NAP is not clearly visible either. Nonetheless the drawing up and submission of a report on the implementation of the previous action plan is a welcome step. With the launch of the new plan, follow-up is to be supported by a better coordinated monitoring system that encompasses all relevant measures of the social inclusion strategy. Social partners and a wide range of civil society stakeholders have been intensively involved in the preparation of the plan. On the other hand, no information has been given concerning their role in implementation and monitoring of the priorities.

3. Social inclusion

3.1 Key trends

Although increasing activity creates a favourable context for the strategy, stagnating labour demand remains an obstacle to attaining the objective of better access to employment. In addition to jobless growth, a detailed analysis of the poverty rate also seems to indicate that the gains economic development are not reaching all segments of society. In terms of segmentation, low-skilled people, the Roma, children of lone parent families, large families, women lone parents and disabled persons are the most exposed to poverty. The child poverty rate, for instance, is 7 p.p. higher than the average.

In view of the very low employment and activity rate, attracting more people to the labour market through active inclusion will continue to be a main challenge. Although nominal

inactivity or unemployment traps are not high, making work pay could be strengthened in the lower wage segments. In this respect the review of access to and the design of social benefits, especially disability pensions, has a very important role.

The new system of family allowances, in which tax credits - available only to those with taxable income - have been replaced by an increase in the universal allowance, has been successful in reaching the needy more effectively. However, in addition to better targeted income redistribution, it is also important to prevent the intergenerational transmission of poverty. Although the proportion of school drop-outs is below the EU average (12.3%), early school leaving affects the young Roma disproportionately (around 20% of Roma pupils do not complete elementary schooling, another 20% complete their basic education late and a further 40-50% terminate their studies immediately after the elementary level or drop out from secondary school). This reflects the inequalities in access to quality primary education and the lack of basic competencies demonstrated by large groups of pupils. According to the PISA 2000 survey, the gap between the performance in reading and maths of 15-year-old pupils living in small settlements and those from major cities was almost four-times the OECD average.

There are very significant regional differences in terms of income, labour market situation, and access to services and housing. The dispersion of regional employment rates (9.4% in 2004) is the second largest in the EU and sub-regional differences are manifold. The risk of poverty strongly correlates with growing segregation and the overrepresentation of Roma people in disadvantaged areas.

3.2 Key challenges and priorities

The overarching objective of the social inclusion strand is the prevention of further increases in social inequalities, the strengthening of social inclusion and the compensation of disadvantaged people in the period of budgetary adjustment. However the third element has only received limited attention in the priorities. For the rest, the specific objectives correspond to the priorities: active inclusion, tackling child poverty and helping the most disadvantaged areas to catch up. Better monitoring of social inclusion through the establishment of an integrated system is an additional objective, in reaction to the lack of any systematic follow up of social inclusion interventions so far. The mainstreaming of inclusion policies is mainly demonstrated by multi-dimensional ("complex") programmes that bring together various sectors in the implementation of a project.

In line with the challenge identified by the 2006 Joint Report of *improving employment performance and addressing inactivity, including the review of benefit systems* the first priority targets labour market inclusion in a manner that is consistent with the NRP. This is based on the "work first" principle without, however, limiting the scope of benefits and services. The interventions address crucial elements of the interaction between the social and the employment spheres, such as the redesign of the rehabilitation services and disability benefits. On the other hand, *resources dedicated to fighting poverty and exclusion, in particular among the Roma minority* are unlikely to be increased in the context of budgetary restraint. Considerable efforts have been made *to improve cooperation among the relevant governmental bodies and to better mobilise civil society in the preparation of policies*, however their role in *implementation* and monitoring is not visible.

3.3 Policy measures

The promotion of labour market integration and decreasing inactivity is based on active inclusion policies in line with the NRP. The priority lists a number of (context) target indicators on overall, females and older people employment rate, on overall activity and gender disaggregated activity rates; early school leaving, LLL participation and active age population living in jobless households. The employment targets appear optimistic in view of the substantial job cuts in the public sector. The targets in the field of education are not underpinned by far-reaching interventions. The policy mix of the priority is mainly made up of fiscal incentives to work and the promotion of more active job search. In spite of the Government's austerity measures, tax wedge reduction programmes targeted at young labour market entrants, parents returning to the labour market and the long-term unemployed over 50 will be continued and expanded. Measures to promote active job search contain the most important reform initiatives in the social strand of the National Strategic Report. These concern the services and benefits that jobless people, and particularly disability pensioners, receive. With intensive support from the ESF, an integrated system of social and employment services based on PES will be established. Employment rehabilitation will also be reshaped with a view to placing greater emphasis on labour market outcomes. At the same time, for those, who have not completely lost the ability to work, the disability pension will be replaced by a transitional benefit attached to rehabilitation services leading to the labour market. Old age pensions will also be reviewed, so that those taking early retirement and those working longer receive financial incentives for higher effective exit ages through actuarially proportionate pensions. These policies are complemented by actions that try to make better use of alternative employment opportunities (e.g. social economy). On the other hand, lifelong learning measures and plans to eliminate obstacles to employment and, in particular, to overcome the constant mismatch between the outcomes of the education and training system and labour market demand, do not seem to reflect a coherent approach. Moreover, there are hardly any initiatives promoting geographical mobility.

The original target on the priority tackling child poverty was to reduce the child poverty rate to the 2003 overall average level (i.e. to 12%) by 2013. This is due to be revised as the child poverty rate is higher in 2004 than 2003 owing to the new methodology. An output target is also set for to pursuing better reconciliation of work and family life (namely a 6% increase in the capacity of child care facilities for 0-3 year olds, which is a more modest objective than the unachieved 10% target of the previous plan). The most important initiatives concern prevention of intergenerational transmission of poverty, as well as tackling poverty through better targeted income redistribution and better access to child welfare services in small settlements and disadvantaged areas. Breaking the cycle of poverty transmission needs to focus on pre-education and public education. In this context, the plan to establish integrated institutions providing services for children in both the 0-3 and 4-6 age groups in small settlements where the number of children is decreasing is welcome. Concentration of schools in small settlements with a view to abolishing segregated, poor quality education would be an important reform step towards tackling segregation and also towards ensuring more equal quality education in public education. However, the plan for the revision of school districts in order to avoid segregation still does not seem to have been properly thought out. In addition to the better targeted family allowances system, the new calculus for regular social assistance on the basis of consumption units also serves the interest of children. Better and more equal access is promoted through the encouragement of integrated services for children (e.g. through the setting up of child welfare centres in towns with more than 40 000 inhabitants or in the cooperation between smaller municipalities and the dissemination of the Sure Start programme, which complements the coordination of child services by the development of local community support for children's education). Moves to provide better access to these

institutions, to increase the capacity of crèches and to tackle family violence reflect the higher priority being given to gender mainstreaming in comparison to the previous NAP.

The priority to reduce territorial and housing disadvantages has set a number of specific, quantified output and result targets. The plans to improve the territorial accessibility of social services are welcome. The reform of personal care services by introducing a management system to allocate capacity more rationally allocation according to local needs and the quality of service providers is especially encouraging. To this end, service provision will be monitored and measured by standard quality protocols. Furthermore, the NSR is continuing on good initiatives from the previous NAP to tackle indebtedness and to address homelessness, although these are still on a rather limited scale in terms of their budget. Finally, interventions aimed at helping disadvantaged regions to catch up seem unable to overcome immense regional differences.

3.4 Governance

Hungary has made a significant effort to involve all relevant actors in the preparation of the new social inclusion strategy. Consultation should, however, be better coordinated and it should ensure that genuine account is taken of the views of stakeholders concerned. Exactly how stakeholders are to be involved in implementation has not yet been worked out. Although the Government plans to set up an integrated monitoring system to follow up all social inclusion measures, its planning is at an early stage at the moment. Such a system could also enable a more extensive collection and use of gender-specific statistics.

4. Pensions

In 2004 the relative living standard of older people was nearly equal to that of the 0-64 population. Hungary's poverty rates are relatively low and slightly lower for the 65+ cohort (6%)[60].

The 2006 Sustainability Report assessed Hungary as a high-risk Member State as regards the sustainability of public finances, in particular due to the high cost of ageing. The projected increase in pension spending is well above the EU average, rising by 6.7% points of GDP between 2004 and 2050. According to ISG calculations, prospective theoretical replacement rates (including the two tiers of the mandatory scheme) are expected to remain more or less constant for workers at the average wage (about 100% as a net replacement rate for a 40-year career retiring at 65, and about 80% for a 38-year career retiring at 62).

The 2006 Joint Report outlined the challenges faced by the Hungarian system, namely ensuring adequate coverage for all workers within the state system - in particular farmers - and improving employment, especially for older workers. Although no major reforms have been instigated in recent years, the Hungarian authorities report that steps have been taken to include private farmers within the insurance system. Similarly the employment of older workers remains low, but has seen a marked increase of more than 10 percentage points since 2000, including a 2% increase in the last year.

[60] Source: SILC 2004 income year. The Hungarian authorities however, feel that the poverty rate for older people may be considerably higher than the SILC data shows. Separate national surveys give a relative poverty rate of 13% for the over 65s.

The Hungarian pension system has been in the process of reform since 1997, involving an overhaul of the public pension scheme and the introduction of a mandatory funded scheme; a voluntary funded pillar was established in 1993. The introduction of the funded tier has led to transition costs which will pose a major challenge to the sustainability of public finances. Further reforms will be needed in order to limit the scope for early retirement, as 94% of the working population retired before the official retirement age (in 2004). The Hungarian administration has reported initiatives to combat this, which will require close monitoring. The introduction of linear accrual rates in the pension formula in 2013 will provide greater incentives to longer working lives and fairness, although this process could be accelerated.

Older people in general enjoy incomes almost comparable to those of the active population. However, under the reformed system contributions are more closely linked to benefits; thus, high levels of unemployment, as well as incomplete work records, together with the fact that a significant proportion of the contributors are low wage earners (30% of all contributions derive from minimum wages) suggest that adequacy issues are likely to arise in the future, beyond 2010.

5. Health and long-term care

5.1 Health care

Description of the system: A mandatory health insurance scheme administered by the National Health Insurance Fund (NHIF) – the main purchaser of care – gives universal access to comprehensive care. Municipalities and local governments are responsible for providing primary health care (PHC) and specialist care, and they own most PHC sites, polyclinics and hospitals. They can contract out services to private providers. Both private and public outpatient and inpatient care providers enter into contracts with the NHIF, which meets all operational costs but not running costs. General practitioners (GPs) are independent contractors, typically renting accommodation and equipment from municipalities, who define their client catchment areas. Mother and child health services are provided by qualified nurses. School health services represent a special form of medical care. A GP referral is needed to access specialist and hospital care, but the gate-keeping system is often bypassed. Specialist and hospital care is provided in hospitals and polyclinics. GPs are funded through an adjusted capitation basis or a fee-for-service when providing fully private services. Outpatient specialist care is financed by performance points, while in-patient care reimbursement is calculated on a DRG basis (acute care) or *per diem* (long-term care). Specialists are mainly salaried. Despite the dominance of public institutions within specialist care, there is a significant share of private ownership in a few areas (dialysis, hi-tech diagnostics, dentistry). The system is financed through an earmarked payroll tax on employers (11% of gross salary), employees (6% of gross salary) and the self-employed and through contributions from national and local government. Co-payments apply for drugs (total pharmaceutical expenditure was 27.6% of total health expenditure in 2002). Informal payments are common. Complementary private health insurance is negligible. Recognising the low health status of the population, barriers to access and a clear need for better resource allocation, the authorities aim to continue the 2005 "21 steps" programme notably by improving efficiency through substantial restructuring, putting more emphasis on the principle of insurance and transferring capacity.

Accessibility: Despite high coverage, there are some regional inequalities in the distribution of health care services: facilities are concentrated in the major cities, there is a lack of GPs and specialists in some disadvantaged rural areas and there are significant differences in

hospital capacity. Shortcomings as well as overlaps in service provision cause barriers to access. The report highlights existing geographical disparities in access to ambulatory care. Out-of–pocket payments are high (25.1% of total health expenditure) and increasing, mainly due to co-payments for pharmaceuticals and informal payments. By law, emergency care is provided free to the entire population. To improve the accessibility of emergency care ambulance capacity and coverage increased, but further investments are needed. To reduce health inequalities access to preventive and curative care by disadvantaged groups (e.g. Roma, the disabled, poor, unemployed, or homeless) needs to improve. Within the reform a strategic aim is to introduce a basic package of universal health services whilst increasing inpatient charges.

Quality: Minimum quality criteria, standards of care and service and professional guidelines are in place and accreditation programmes for providers have been improved upon. Surveys were conducted to identify the demand for care and to develop a needs-based approach. Improving quality will involve the implementation of a monitoring and evaluation system based on defined indicators and databases. The authorities plan to make a greater use of ICT. Average salary in the health care sector is still lower than in most other sectors of the economy, although it rose by an average of 50% in 2002. Several measures have been/are being undertaken to improve administrative capacity (strengthening community action through the development of the Healthy Cities movement, extending of public health-related research). Patients can freely choose a GP and switch every six month. Satisfaction's surveys are conducted to obtain feedback on services. The report also states that medical equipment and infrastructure are poor and may present a risk in terms of security of supply and the working conditions of health professionals. Authorities are satisfied with the immunisation coverage (vaccination) already achieved.

Long-term sustainability: Health care expenditure (8.4% of GDP and 1334 per capita PPP$ in 2004) is at the EU average in GDP terms[61] and one of the highest among the new Member States and growing slightly (7.3% in 1998, 7.8% in 2002). Its share of public health expenditure (71.8% of total health expenditure) has decreased substantially in the last decade. The most important contribution provided by the central budget is the offset of NHIF budget deficit, which is continually increasing and putting a high financial burden on the sustainability of public finances. To reduce NHIF expenditures, competition between care providers for the NHIF reimbursement will be enhanced and a co-payment scheme will be introduced as of 15 February 2007 for visits to the doctor and for days spent in hospital. Under the new system the NHIF will buy no more services than it actually needs and a health insurance authority will be created. The health problems of the population create a high financial burden, which is amplified by a low income base and high tax evasion. Ageing (2006 EPC/EU shows public health care expenditure is projected to increase by 1 percentage point of GDP by 2050), a low employment rate, the early retirement age and high morbidity are challenges to sustainability in that they limit the inflow of funds. Inpatient specialist care and a drug reimbursement scheme are two areas identified by the government as needing reform in the first phase. Hungary has one of the highest numbers of acute hospital beds in the EU (806.3 per 100.000 inhabitants in 2001) and incentives still lead to inappropriate and excessive use of hospital care. To address this, the authorities intend to replace the overuse of inpatient hospital acute care by day-case hospital care and outpatient specialist care as well as by rehabilitation, chronic care, possibly home nursing and a focus on strengthening the role of PHC and GPs' gate-keeping function. The reform is also expected to create new incentives for

[61] EU average of 8.87% of GDP and 2376.33 per capita PPP$ in 2004.

prescribing drugs, tight monitoring of the system and more responsible pharmaceutical management. The report highlights the fact that the structure of human resource capacity is incomplete and wasteful. Moreover, international migration of qualified staff is not negligible. The need for an overall human resources strategy is stated in the report. Various actions with regards to promotion and prevention are underway, such as comprehensive screening programmes for target groups, tackling tobacco addiction, public health training for staff, healthy lifestyle campaigns adapted to men and women of all ages.

5.2. Long-term care

Description of the system: Social care institutions vary in nature and financing. Long-term care services are provided by both the health and social care sectors. Local governments play a vital role in the provision/purchasing of services, mainly through home help. Funding for social services is provided in the form of earmarked central budget support. The institutional framework includes chronic and nursing wards and live-in social institutions maintained mainly by municipalities. In practice, hospitals also provide a proportion of long-term care in the acute care sector. NGOs and religious organisations also provide long-term and transitional tailor-made nursing care to elderly residents. Family carers can apply to local authorities for a nursing fee, which may not be lower than 80% of the minimum old-age pension. Other benefits include an old-age allowance and home maintenance support.

Accessibility: The authorities emphasize that the long-term care system is underdeveloped and hospital-centric. Insufficient capacity, long waiting times for nursing care and geographical disparities in day and residential care lead to an overuse of acute hospital beds by chronic patients. To tackle this, the authorities want to enhance provision by increasing home care and assistance and reorganising excessive acute capacity to convert it into long-term care. Geographical disparities may decrease due to the introduction of a capacity regulation scheme. New geriatric wards are planned and geriatric services will be offered in day hospitals. Rehabilitative care will also be offered in day-hospitals or at home.

Quality: The report states that long-term care is in need of modernisation. Apart from standards and quality protocols, staff training and a patient follow-up system are also needed. A record of social facilities' and a national capacity monitoring system is planned. The aim is to develop a special home-assistance on-request system to allow the elderly to stay in their homes for as long as possible.

Long-term sustainability: Authorities have been looking at ways of financing long-term care which is currently overly reliant on hospitals. Better coordination between health and social sectors and a differentiated financing system are planned. Regional coordination is to be strengthened through the development of care networks involving different stakeholders. The authorities' priority is to define an explicit and sustainable package of long-term care in order to ensure acceptable service provision for the aging population.

6. Challenges ahead:

To promote active inclusion by implementing the reform of the social benefit system, including by further limiting early retirement and reducing the inflow into disability pensions by revising the eligibility criteria, ensuring the conditions for comprehensive rehabilitation and introducing further incentives to remain on the labour market.

In the context of budgetary restraint, to maintain the level of resources dedicated to combating poverty and exclusion, in particular among the Roma minority.

To strengthen the governance of social inclusion policies by improving monitoring and by supporting the involvement of civil society, especially in the implementation of policies.

To address the long-term sustainability of the pension system and ensure adequacy of pensions, in particular by implementing measures to reduce the evasion of contributions and handling effectively the transition costs arising from the partial shift into private funded schemes.

To implement healthcare reform, to monitor its medical, social and financial effects and to improve the health status of the population through the promotion of healthy life styles and diseases prevention.

To strengthen PHC (enhance the number of GPs and the distribution of PHC, as well as its role in promotion and prevention activities) and enforce GPs' referral and gate-keeping role, to tackle the financial burden of care in particular for disadvantaged groups (reduction of health inequalities) and to improve transparency of patient routes.

To enhance long-term care provision, especially home care.

Hungary: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate*	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	8.1	53.9	**2000**	56.3	63.1	49.7	33.5	22.2	**2000**	6.4	7	5.6	12.4
2002	4.3	59.1	**2002**	56.2	62.9	49.8	28.5	25.6	**2002**	5.8	6.2	5.4	12.7
2004	4.9	61.3	**2004**	56.8	63.1	50.7	23.6	31.1	**2004**	6.1	6.1	6,1	15.5
2006	4.0f	63.6f	**2005**	56.9	63.1	51	21.8	33	**2005**	7.2	7	7.4	19.4

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	65.3	74.5	12.1	15.8	n/a	n/a	10.7	**1995**	7.5	84			
2000	67.4	75.9	12.7	16.5	n/a	n/a	9.2	**2000**	7.1	70.7	26.3	100	Negligible
2004	68.7sp	77.2sp	13.4sp	17.3sp	53.5p	57.8p	6.6	**2004**	8.4	71.8	25.1		

p: provisional **THE: Total health expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	19.3	41.4	27.9	4	13.2	3.8	9.6
2004	20.7	42.5	29.5	2.9	12.1	2.6	10.3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	22.8				
2010	24.3	0.3			
2030	35.1	2.8	3.1	0.8	
2050	48.3	7	6.7	1.0	

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate

SILC income 2004	Total	Children 0-17	18+	18-64	65+
Total	13pb	20pb	12pb	13pb	6pb
Male	14pb	-	12pb	13pb	4pb
Female	13pb	-	12pb	13pb	8pb

Poverty risk gap

Total	Children 0-17	18+	18-64	65+
19pb	19pb	18pb	20pb	9pb
19pb	-	20pb	21pb	8pb
18pb	-	18pb	19pb	11pb

Income inequalities

	S80/S20
Total	4.0pb
Male	-
Female	-

People living in jobless households

	Children	% of people aged 18-59*		
	Total	Total	Male	Female
1999	15.5	14.2	12.8	15.6
2004	13.2	11.9	11.1	12.7
2006	13.3	11.6	10.6	12.6

Long-term unemployment rate

	% of people aged 15-64		
	Total	Male	Female
1999	3.3	3.7	2.9
2004	2.7	2.8	2.6
2005	3.2	3.2	3.2

Early school-leavers

	% of people aged 18-24		
	Total	Male	Female
1999	13	13.3	12.7
2004	12.6	13.7	11.4
2005	12.3	13.5	11.1

** excluding students; p: provisional; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	1.009b	1.071b	0.971b	***Aggregate replacement ratio***	0.611b	0.6b	0.638b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Current estimate (2002)	Assumption
-4	11	11	DB and DC			100		26.5		

**(DB / NDC/ DC); ** (DB / DC)*

2.17. MALTA

1. Situation and key trends:

The Maltese economy has expanded at a steady pace in recent years, after experiencing negative growth in 2003. GDP grew in 2005 by 2.2% and the forecast for 2006 is 2.3%. Activity and employment rates (especially for women) remain low when compared to the EU-25 averages (53.9%), with no considerable change in recent years. The female employment rate increased to 33.7% in 2005 while the older workers' rate decreased to 30.8%; this contrasts with the Lisbon target of 50% in 2010. The unemployment rate remains relatively low compared to the EU average; after rising steadily, the unemployment rate has decreased in the last two years, down to 7.3% in 2005. By contrast, the long-term unemployment rate has remained stable in recent years, staying below the EU average. Youth employment, although declined in recent years (52.8% in 2000), is not an emergency, since the rate in 2005 was 45.3% - well above the EU average.

Life expectancy at birth (75.9 for males and 81 for females in 2002) is equivalent to 2002 EU average (75 and 81.2), having increased by 1 year for men and 2 years for women in less than a decade (compared to 74.9 and 79.5 in 1995) and showing a consistent increase over time (68.4 and 72.56 in 1970). Healthy life expectancy (65.1 and 65.7 in 2002) is slightly above the 2002 EU average (64.3 and 65.8) for men and on the average for women. The social protection system, coupled with an active role played by NGOs and strong family and community ties, explains the low level of poverty in Malta. The percentage of people at-risk-of-poverty is 15%, slightly below the EU average. In any event, social protection expenditure has increased in recent years, reaching 18.5% of GDP in 2004. Single parents, the unemployed, children, persons aged 65 and over and persons in rented housing are those most at-risk-of-poverty. The early school-leavers rate remains by far the highest in the EU (41.2% in 2003), but it is showing a marked downward trend (from 52.7% in 2002); the rate refers to school-leaving age relative to a country's legal provisions.

Malta is expected to experience similar demographic trends to most other Member States, due to a decrease in the fertility rate. The old-age dependency ratio (19% in 2004) is lower than the EU average of 25% and is projected to increase at the same pace as the EU as a whole (41% and 52% respectively) by 2050. Demographic trends indicate a slow gradual ageing of the population with life expectancy at 76.7 for men and 80.7 for women, and a decreasing fertility rate. The demographic ratio is also affected by the immigration increase. According to estimates, social protection expenditure on health care is likely to increase (+1.8%) until 2050; however, public pension expenditure should be offset by a higher employment rate (overall and older workers), thus being contained to 7.0% of GDP from 7.4% in 2004.

2. Overall strategic approach:

Strategic Approach: The Maltese government has confirmed its commitment to ensure adequate social protection and to consolidate social cohesion. Increasing the overall employment rate (with special attention to measures favouring the participation of women) by investing in human capital, strengthening the welfare system through pension reform, improving access to health-care services and guaranteeing quality health services for all are the four pillars of the Maltese strategy. The strategy is sufficiently ambitious and well focused on the key priorities for Malta, with a good comprehensive approach. In addition, the first part of the document highlights employment as a key issue bridging economic and social

development. Economic growth and better jobs are the two linchpins of Malta's current economic and social policy. In this regard, there is a clearly visible link with the Lisbon strategy and the NRP, ensuring the necessary coherence between the two strategies. The overarching objectives for social protection/social inclusion are correctly addressed, with an extensive involvement of other stakeholders in the process. As for gender, the strategy makes an important contribution to the promotion of women's participation in employment with comprehensive measures.

The strategy report also displays some weaknesses. There is little quantification of expected results and indicators are supplied sparingly. Synergies and connections among the three strands (social inclusion, pensions and health care) could be further exploited. References to the previous plan in the main text are very limited, and there is no 'lessons learned' exercise; a detailed update on the previous NAP is contained in a section of its own in the annex.

3. Social inclusion:

3.1 Key trends

The situation in Malta is characterised by slow progress on some of the key issues relative to the Lisbon objectives. This is mainly reflected in low employment and activity rates when compared to the EU25 averages. The trend over recent years has been stable, with a slight decrease in the employment rate from 54.4% in 2002 to 53.9% in 2005. The need to reduce the public deficit and the likely growing demand for increasing social expenditure due to the projected ageing of the population, as well as unemployment, inevitably put conflicting pressures on the social protection system.

Against this background, achieving the Lisbon target on employment is proving to be quite challenging, in particular as concerns the female employment rate, which is by far the lowest in the EU. Although the government has confirmed in different strategy documents (NRP, NSRF) that it considers this issue a priority, the increase in female participation in the workforce has been very modest in the past few years, from 33.1% in 2000 to 33.7% in 2005. Most females seek work when they are young, but many stop working when they have to look after young children, and not all return to work afterwards. The employment of older people is also an issue of concern, being the lowest in the EU: after a gradual increase between 2000 and 2003, it fell back to 30.8% in 2005. The unemployment rate remains relatively low compared to the EU average; after a steady increase during the previous years (from 6.7% in 2000 to 7.6% in 2003), the unemployment rate decreased in the last two years, falling back to 7.3% in 2005. The long-term unemployment rate remained stable in recent years, reaching 3.4% in 2005, which is still below the EU average.

These figures also highlight why the percentage of people living in jobless households is comparatively low: it was 8.2% in 2005, resulting in a slight decrease from 8.6% in 2004, whereas the EU average is 10.2%. The trend is similar when considering children living in jobless households, even though the rate here is closer to the EU average (8.9% compared to 9.6% for EU-25). Although youth employment has fallen in recent years (52.8% in 2000), there is no emergency: the rate in 2005 was 45.3%, well above the EU average. The Maltese government for several years has attached great importance to education and training, in order to combat illiteracy and raise the general level of education. The data on early school leavers, in particular, are worrying; at 42.1%, Malta has by far the highest percentage of early school leavers in the EU. However, the trend in recent years is positive, with the number of early

school leavers gradually falling as a direct result of all the special attention directed towards this issue by the Maltese government.

As regards the segments of population at risk of poverty, according to 2000 data the overall rate is 15% - just below the EU average (16%); children and people over 65 are the most vulnerable categories (21% and 20% above the EU average respectively). The wide-ranging social protection system absorbs 18.5% of the GDP; this figure, coupled with the active role played by NGOs and strong family and community ties, explains the low poverty rate. However, the demographic dynamics, coupled with recent poor economic growth and the large fiscal deficits, are putting a strain on the sustainability of the social protection system. The need for reform has been recognized and the process has been initiated.

3.2 Key Challenges and Priorities:

The Maltese National Strategy identifies the following priorities as its main pillars: increasing the overall employment rate (with special attention for measures favouring female participation and making work pay), combating illiteracy, supporting education, training and lifelong learning, strengthening the welfare system through pensions reform, improving access to health services and the quality of services provided. The plan is fully consistent with the NRP and the use of the ESF to support the activities is also referred to in the document.

In general, the strategy explains that Malta is going through a comprehensive reform, marked by a shift from government provision to a growing emphasis on the responsibilities of the individual. Malta's employment strategy addresses in particular the need to increase access to employment through the introduction of more flexible forms of work, and through the provision of services aimed at reconciling family and work. Beside active measures, the Maltese government intends to overhaul the interaction of taxes and benefits, to ensure a positive impact on the labour market.

In order to address these challenges, the plan identifies four major overarching policy priorities, namely: 1) empowering social cohesion, 2) building stronger communities, 3) strengthening the voluntary sector and 4) networking the social welfare sector. The strategy described here is well in tune with the overarching objectives of EU social policy, and in general addresses the seven key EU policies. However, the strategy report is characterised by some weak points. The document is not very clear on the detailed ways of tackling the different challenges. Although there is a very long list of actions described in the annexes, referring to ongoing and future initiatives along with potentially EU funded initiatives, however the document tends to miss a clear link between the strategy report and the different projects. In particular, the document contains no plan identifying specific measures to be implemented in the different sectors, timing, financial resources, expected results and indicators. In particular, the absence of indicators and quantified objectives is a key point, because it risks undermining the future evaluation of the measures. Synergies and connections between the individual strands (social inclusion, pensions, and health care) are not always sufficiently underlined and explained; synergies exist and can be found by reading through the different parts of the document, but the impact of specific activities across the different strands is not adequately explained.

While the strategy document is exhaustive in setting out the range of short and medium term solutions to Malta’s immediate problems, further in-depth analysis would be needed for it to achieve a truly multi-dimensional approach.

3.3 Policy measures

In this chapter, the strategy illustrates the specific measures aimed at fostering social inclusion. The content of the planned activities is consistent with the overall objectives and the approach is comprehensive, addressing overarching issues. As already stated, there are no specific targets or indicators in this chapter and no mention is made of financial resources allocated; this specific point is a major weakness of the document. Very little account has been taken of gender issues in the single projects. The social inclusion strategy mainly focuses on the empowerment of children and young people and on the reinforcement of the local community and particularly through strengthening the voluntary sector and networking, in order to provide the future prospect of a cohesive society achieved through a bottom-up approach.

The strategy identifies a set of measures for each of the key priorities. Under priority 1, "Empowering Social Cohesion", the emphasis is on the education reform undertaken; actions are aimed at tackling early school leaving, reducing illiteracy and enhancing inclusive and quality education. The inclusion dimension of government action is present in the form of measures targeting low-skilled young people, or young people with particular needs. Other measures will address children's rights and child protection. Under priority 2, "Building Stronger Communities", the activities are supposed to build on the specific characteristic of Maltese society, founded on family and local community ties. Particular importance is attached to the need to reinforce the necessary policy and legal framework beyond the existing legislation, to safeguard the rights of the most vulnerable and prevent social exclusion. In this respect, the strategy defines a set of measures to reach these objectives. Priority 3: Strengthening of the voluntary sector. This objective is in some way consistent with priority 2, since the voluntary organisations provide vital support to the development of local communities, adopting a bottom-up approach. Here, too, actions will be oriented towards the development of the necessary legislative structures. Networking the social welfare sector is identified by the Maltese government as the fourth priority, and regarded as an organisational tool to promote a transformation of social welfare.

3.4 Governance:

Care was taken to secure the extensive involvement of all the various actors and stakeholders in the preparation of the document from the earliest stage. This involvement took the form of a national seminar and questionnaires submitted to service providers and users. Public departments, voluntary organisations and the general public have been involved in the consultation process. The document also presents some indication, albeit not exhaustive, of how the implementation of the various actions is monitored.

4. Pensions:

In 2003, older people had a relative living standard close to that of the general population (90%), while the poverty risk among older people (20%) was significantly higher than for the population below the age of 65 (14%). The employment rate of older workers remains at low levels (30.8% in 2005), significantly below the Lisbon target of 50%.

The 2006 Sustainability Report assessed Malta as a medium-risk Member State as regards the sustainability of public finances, in particular because of the current budgetary position. According to the AWG 2005 projections, public spending on pensions was due to fall slightly from 7.4% of GDP in 2005 to 7.0% of GDP in 2050, reflecting the fact that under former

rules indexation of the maximum pension was based solely on the increase in the cost of living. Calculations of the prospective theoretical replacement rates also showed that, in the absence of reform, the gross replacement rates would fall from the current level of 72% to 53% in 2030 and 31% in 2050 (net: 88% current, 61% in 2030 and 34% in 2050).

The 2006 Joint Report underlined that Malta was in the middle of a reform process and stressed the need to strengthen incentives for people to work longer and to ensure adequate replacement income, including through easy access to pension provision. Following a consultation process that began with the launch of a White Paper in November 2004, the Government announced in March 2006 an extensive pension reform which has been enacted by the Maltese Parliament. While the government also announced the introduction at a later stage of a second pension (mandatory occupational scheme) depending on the fiscal position, the current reform proposal should make significant steps towards adequacy by reforming indexation rules and strengthening incentives to work longer.

The national minimum pension will be calculated at a rate of not less than 60% of the national median income, which will be capitalised every year and will translate into a significant reduction of the poverty situation of pensioners. In addition, the proposed new system includes a revision of the calculation of mandatory pensions for both employed and self-employed persons: the contribution period will be gradually increased from 30 to 40 years, while the maximum ceiling on pension payments will be raised significantly between 2010 and 2013 and thereafter indexed on both prices (30%) and wages (70%). Furthermore, the retirement age is to be gradually raised from the present 60 years for women and 61 years for men to 65 years for both men and women from 2015 to 2027, while pension credits are to be introduced for periods of child care. These measures will contribute to an increase in the employment rates of older people and improve gender equality.

While the recent reforms review conditions of early exit through invalidity pension and introduce more flexibility for those who wish to retire before 65, the employment rates of older workers have fallen slightly in recent years; further steps regarding early exit from the labour market may therefore be necessary. Current proposed reforms will only be fully effective if they are accompanied by an effective and sustainable strategy to increase participation by older workers in the labour market and to raise employment in general, while it remains to be seen how far the introduction of a second pension would contribute to adequate and sustainable pensions (particularly as regards access).

5. Health and long-term care

5.1. Health Care

Description of the System: A National Health Service (NHS) provides comprehensive public healthcare free at the point of delivery to all residents. Primary healthcare (PHC) is provided through eight health centres offering a full range of preventive, curative and rehabilitative services. General practitioners (GPs) and nurses are supplemented by various specialised services (e.g. antenatal, postnatal, gynaecology, physiotherapy, ophthalmology, psychiatry and diabetes). A referral system is in place, though often bypassed. Specialist and hospital care is provided in public hospitals. A growing private sector (PHC and basic outpatient specialist care) co-exists with public services, and many residents opt for its services. Most public sector doctors also conduct private practice. Public sector doctors are salaried while private sector doctors are paid a fee for their services. The system is funded out of general taxation. Some types of medicines, some dental and optical care, are available on a means-

tested basis. Around 25% of the population purchases voluntary private health insurance for basic care plans. When using the private sector, patients pay directly out of their own pockets. The authorities, together with the country's main stakeholders, have recognised the need to enhance equity in access to care, promote quality and excellence and safeguard sustainability as the main priorities.

Accessibility: Free comprehensive public healthcare (including preventive care such as child immunisation) contributes to ensure access to all. This is coupled with means-tested entitlement (for those on low incomes and the chronically ill) to pharmaceuticals, dental and optical care, i.e. benefits that are excluded from the public healthcare basket. The report states that an elderly population has resulted in a higher demand for certain elective procedures (e.g. cataracts) and thus longer waiting lists and overcrowding of hospital facilities. Authorities anticipate that a new hospital and better management in existing facilities will provide extra care and help bring waiting times down. Extra capacity is to be coupled with an analysis of waiting lists and a new waiting list management system. The government wants to ensure fairer and more transparent prices for medicines, including by increasing the use of generics. A pilot "pharmacy of your choice" scheme is being launched to enhance access to medicines. Several proposed e-health solutions (health portal, electronic patient record) should improve information to patients and patient flows through the system.

Quality: The report states that the new Mater Dei hospital and a new cancer treatment facility will offer modern/latest medical equipment and ICT. It also indicates that a number of quality services charters have been implemented. Authorities stress that the future Bill on Health Services will ensure that uniform standards are applied throughout the system (public and private providers). Providers will be encouraged to set up systematic patient care protocols to enhance patient safety and clinical outcomes. Comparable indicators are seen as relevant to allow informed decision making. According to the authorities there is a large degree of patient choice and the above Bill will further consolidate patient rights, responsibilities and representation within the system. It is hoped that this will lead to a more sensible use of the system. The plan is to use population surveys to monitor satisfaction on the nature and quality of health services, and providers will be required to conduct an in-depth survey of the views of service users. Authorities further expect that ICT and e-health solutions can improve coordination between PHC and secondary care and supply providers with better information. Authorities are satisfied that immunisation rates will help to improve influenza and hepatitis B vaccination coverage.

Long-term Sustainability: Total health care expenditure (9.27% of GDP and 1634.58 per capita PPP$ in 2003) is slightly above the EU average in GDP terms. Public expenditure accounts for 78.19% of the total health care expenditure. Ageing is seen as a challenge (the 2006 EPC/EC age-related projections predict an increase in public expenditure of 1.8 percentage points of GDP by 2050)[62] resulting in an increasing demand for services, together with increased costs of medical devices and pharmaceuticals (also related to stricter quality requirements). The report mentions the setting up of a new earmarked National Insurance Fund for Health that brings together all sources of funding. The Bill on Health Services will introduce a purchaser-provider split, involving a contract system and giving providers more management autonomy, which the authorities expect can bring about efficiency gains and better coordination between public and private services. On staff, to tackle stress and burnout,

[62] Malta has some reservations in relation to the EPC/EC population and labour market projections which impact on expenditure projections that overestimate expenditure projection values.

authorities are introducing psychological and emotional support systems for staff. To maintain/retain staff in the sector a strong focus is put on training, retraining, continuous education and new career pathways. On promotion, given that circulatory diseases and cancer are the main causes of mortality and morbidity, obesity at all ages is the main heath threat and diabetes is highly prevalent, the authorities have introduced a total smoking ban, are planning a national alcohol strategy to curb alcohol consumption especially by those under 16 and will set up a national platform to tackle obesity including through the promotion of a healthy diet and exercise. The education sector is seen by the authorities as a crucial partner in adapting the curricula of health staff and young people to focus on PHC and preventive care and healthy life-styles.

5.2. Long-Term Care

Description of the system: Services are provided by the State, the church and private/voluntary organisations. Complementing PHC and rehabilitation, the Department for the Care of the Elderly runs residential homes for the elderly (who pay a part of their annual income), a geriatric hospital, a home help service (e.g. household activities and shopping, meals-on-wheels, household maintenance) for a nominal charge but free for low income individuals, and the telecare/telephone system. The system is funded through taxation and income-linked co-payments. The church provides free residential care for the disabled. The private sector also provides home care and support. Government policy focuses on keeping people at home and in the community for as long as possible and on ensuring a healthier and more active elderly population.

Accessibility: The report recognises that an increasing demand for services and limited availability of institutional care in the public and church sectors have resulted in long waiting lists, whilst the private sector is only affordable to a segment of the population. Initiatives to enhance provision include increasing the numbers of public sector beds and contracting private beds. Authorities are focusing on enhancing the provision of community services such as day centres and adult learning centres. A legal framework for voluntary organisations will soon be enacted, supporting the role of NGOs in this field. A needs assessment for non-elderly people is planned.

Quality: Legislation on quality standards is deemed rudimentary and is to be updated, and licensing and monitoring will be strengthened. Better coordination between levels of government and the church, the private sector and NGOs is being sought. A step-down facility was created to facilitate transition from acute to long-term care.

Long-term Sustainability: The 2006 EPC/EC age-related projections foresee an increase in public long-term expenditure of 0.2 percentage points of GDP by 2050 (see footnote 1). Authorities expect that a number of initiatives such as privately managed, state funded homes and support to family carers that maintain people at home will help to control costs and ensure an efficient use of resources. Training of human resources ranges from basic care skills to specialised professional training and is considered fundamental by the authorities. Thus, a manpower plan will focus on requirements of staff and their skill mix, as well as training and retraining for staff and carers. Specific promotion and prevention campaigns for the elderly are planned.

6. Challenges ahead

To raise the employment rate, particularly that of women, in order to improve social cohesion and reduce inactivity and the consequent phenomenon of exclusion. Expanding active labour participation and increased labour market integration of the long-term unemployed, women, the 55+ age group and other groups at high risk of poverty and social exclusion remain the immediate challenge.

To increase efforts to improve education, vocational training and lifelong learning, to fight illiteracy and to reduce the number of early school leavers in order to improve employability, and to prevent marginalisation and social exclusion.

To ensure that the reform of the pension system strengthens incentives to work and to remain in the labour market, provides adequate pensions and strengthens the financial sustainability of the pension scheme;

To enhance equity of access, reduce waiting times and enhance the provision of home and community care.

To safeguard sustainability through improved management and a contract system, through promotion and prevention policies and by keeping staff in the sector.

MALTA: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.7	78.0	**2000**	54.2	75.0	33.1	52.8	28.5	**2000**	6.7	6.4	7.4	13.7
2002	1.9	74.9	**2002**	54,4	74.7	33.9	50.5	30.1	**2002**	7.5	6.6	9.3	17.1
2004	0.8	71.3	**2004**	54,0	75.1	32.7	46.2	31.5	**2004**	7.4	6.6	9.0	16.8
2006	2.3f	69.7f	**2005**	53,9	73.8	33.7	45.3	30.8	**2005**	7.3	6.5	9.0	16.4

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2002 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI** % of pop
	Male	Female	Male	Female	male	female							
1995	74.9	79.5	15.3	17.5	na	na	8.9	**1995**			-		
2000	76.2	80.3	15.2	18.5	na	na	6.0	**2000**	8	76.5	21.2		
2003	76.7	80.7	15.8	18.4	65.1	65.7	5.9	**2004**	9.2	78.2	19.7		

**THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	51.4	24.4	5	11.8	2.5	4.8
2000	16.3	51.8	25.6	6.2	7.9	2.5	5.9
2004	18.8	51.2	27	6.9	5.2	2.9	6.7

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio	expenditure (% of GDP) level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-Term care
2005	19	18.2	7.1	4.2	0.9
2010	20.4				
2030	36		1.7	1.3	0.2
2050	40.6		1.8	1.8	0.2

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate

SILC income 2004	Total	Children 0-17	18+	18-64	65+
Total	15b	21b	13b	12b	15b
male	14b	-	12b	11b	15b
femal	15b	-	14b	13b	15b

Poverty risk gap

Total	Children 0-17	18+	18-64	65+
18b	21b	17b	18b	14b
19b	-	18b	18b	16b
18b	-	17b	18b	13b

Income inequalities

	S80/S20
Total	4.2b
male	-
female	-

People living in jobless households

	Children	% of people aged 18-59*		
	Total	Total	Male	Female
1999	na	na	na	na
2004	9.2	8.6	6.8	10.4
2006	8.2	6.7	5.2	8.2

Long-term unemployment rate

	% of people aged 15-64		
	Total	Male	Female
1999	na	na	na
2004	3.4	3.7	3.0
2005	3.4	3.4	3.2

Early school-leavers

	% of people aged 18-24		
	Total	Male	Female
1999	na	na	na
2004	42.0b	44.2b	39.5b
2005	41.2	43	39.3

**: excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.866b	0.886b	0.855b	***Aggregate replacement ratio***	0.546b	0.557b	0.464b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or Social Security)	pensions Estimate of current (2002)	Assumption

**:(DB / NDC/ DC); ** (DB / DC)*

2.18. THE NETHERLANDS

1. Situation and key trends

The recovery of the Dutch economy seems to be more and more in line with the overall economic recovery of the EU. According to the forecast for 2006 it promises to even outperform the latter (3% for NL against 2.8% for EU), bringing the Netherlands more in line with their 2000 level. Unemployment is low compared to the EU average in 2005 (4.7% against an EU-average of 8.7%), but relatively high compared to the (historically low) Dutch level in the period 2000-2002 (average of 2.6%).

Although overall and female employment rates are above Lisbon targets (2005: 73.2% overall and 66.4% for women), the long term unemployment rate has increased from 0.7% in 2002 to 1.9% in 2005 (EU average remained at 3.9% over the period 2002-2004). Also, the unemployment rate gap of 13.9 percentage points between non-EU and EU nationals is above the EU-average of 8.1p.p. This gap is also visible in national data on employment rates (46.9% for ethnic minorities compared to 65.6% for the remaining population, 2005).

The national target on the overall unemployment rate for the age group 15-24 years (8.2%) has been met: it is not more than double the overall unemployment rate (4.7%). Also it is the lowest among the EU-25 and it is expected that, with the economic recovery, youth unemployment will decrease further. The overall employment rate for older workers is gradually increasing, from 42.3% in 2002 to 46.1% in 2005 towards the Lisbon target of 50%. Gross social expenditure on disability, old age and housing has declined by around 1 p.p. since 2000, balancing out the increase in expenditures on health care and unemployment.

The overall poverty risk[63] of 11% in 2004 remains one of the lowest in EU-25 (16%). The at-risk-of-poverty rate for children aged 0-17 years is 15% (19% for EU), but 5% for the population above 65 years (19% for EU). There is a strong ethnic dimension in poverty risk: ethnic minorities account for 23.4% of the total number of minimum-income households, whereas the remaining population make up only 6.2% of such households (national figures). Furthermore, single parents (especially women) are overly represented in the number of minimum-income households and these households also face the highest inactivity trap. The overall unemployment traps also remain high (83% in 2005).

The Netherlands will remain one of the Member States with the lowest old-age dependency ratio (65+ population as a share of 15-64). It currently lies at a relatively low level in comparison to the EU25 average (respectively 20.7 and 25 in 2005), and is projected to remain below the EU25 average (respectively 38.6 and 52 in 2050).

Life expectancy at birth (76.9 for males and 81.4 for females in 2004) is above the EU average[64], showing an increase of two years for men over the last decade (74.6 in 1995).

[63] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, year to year differences that can be noted (especially for some population sub-groups) are therefore not significant. During the transition to EU SILC (see methodological note) those estimates were based on the national Income Panel Survey that was not fully compatible with the SILC methodology based on detailed income data

[64] EU average of 75.1 and 81.2 for males and females in 2003

Healthy life expectancy at birth has remained at an average level slightly above 61 years for males since 1995 (64.5 years for EU15 in 2003), but for females it decreased from 62.1 years in 1995 to 58.8 years in 2003 (66 years for EU15 in 2003). The infant mortality rate (4.1 in 2004) is around the EU[65] average, though it has fallen significantly over recent decades (16.5 in 1960). Perinatal mortality (7.4 in 2003) is high, but has fallen consistently since 1960.

2. Overall strategic approach

The choice of priorities for the inclusion part of the NRS is based on the broad political consensus in the Netherlands that work is the best remedy against poverty. The second guiding principle is that people themselves are responsible for their own living conditions. The key emphasis in preventing long term poverty is therefore put on increasing participation through work acceptance and training. This means equipping people with the necessary skills and offering them possibilities to engage in paid work or, if not possible, in volunteer work. This should also increase the chances for disadvantaged groups to benefit from the economic recovery. To increase effectiveness, priority has been given to *preventative* measures in an early stage, for example through the new priority on preventing child poverty.

On the other hand, the NRS includes *curative* measures as well, because the issue of poverty has attracted a lot of political attention in the (past) period of recession. People at minimum income level faced economic setbacks and, combined with poor financial management, the number of minimum income households increased. The government invested in identifying the causes for this increase through consultations with local governments, NGOs and especially those organisations in daily contact with the high-poverty risk group, e.g. municipal credit banks (for people in debt), social housing corporations and providers of energy services. These consultations revealed the need to tackle the non-usage of income benefit schemes and to reduce problem debts.

The number of targets on these priorities is limited: except for the clear targets on measures concerning education and training, no other quantitative targets have been set.

Through the focus on increasing labour market participation there is a clear link between inclusion and employment policy: policy initiatives mentioned in the NRP aimed at increasing the overall education level, reducing early school leaving, and reactivation of partially disabled employees increase both employability and the overall chances for social inclusion.

3. Social Inclusion

3.1 Key trends

Overall employment rates are high and overall youth unemployment is low. On the other hand, key trends in two areas need attention: the low employment rate of ethnic minorities and developments in education.

The causes of the low employment rates for ethnic minorities are the large number of early school leavers and low education levels (only 61.9% of ethnic minorities complete upper secondary education as opposed to 74.0% of the remaining population). Although the youth unemployment rate is relatively low compared to other Member States (2005: 8.2% for NL

[65] EU average of 4.5 in 2004.

and 18.5% for EU25), early school leaving is 13.6% (2005) - still far above the national target of 8% set for 2010. The number of people with learning arrears also remains high in the under-18 age group, primarily consisting of ethnic minorities. Although the language gap is narrowing, the percentage of 15 year-olds who are low-achievers in reading literacy has increased (9.5% in 2000, and 11.5% in 2003). Inactivity traps for single earners with children nearly doubled in 2006 (-2.5% in 2005 and -4% in 2006, national figures showing percentage of income lost when benefit recipient accepts job at minimum income) and rose by 1 p.p. in 2006 for single parents (the level is -7.25%). Low-wage traps for single persons remain high as well (without children 47%, with children 60% - 2004).

3.2 Key Challenges and Priorities

The overall strategic approach in the prevention of poverty is characterised by the focus on reducing the distance to the labour market, especially in the early stages. Possibilities for people to escape poverty through work primarily depend on personal factors determining their future prospects on the labour market. The government considers the level of education, knowledge of the Dutch language, duration of benefit dependence and the person's health as key factors. The strategic focus is on shortening the distance to the labour market, preferably in an early stage, but attention is not focused on target groups as such. By focusing on the factors causing this distance, the government expects to reach disadvantaged groups, like minorities, benefit recipients who are difficult to place and the disabled.

Under the policy of decentralisation local governments are now primarily responsible for the (re-)integration and participation of these groups. While the number of benefit recipients has fallen slightly since 2004, even though this is in a period of recession, municipalities have focused primarily on those who are relatively easy to place (Evaluation of the Social Assistance Act, April 2006). The government expects that in the forthcoming period the people who are more difficult to place are next in line, based on the fact that municipalities have argued that it has taken them longer than expected to translate their new responsibilities on reintegration into policy.. Secondly, municipalities will have an additional reintegration instrument at their disposal in 2007. They can introduce so called "re-entry jobs" for benefit recipients to acquire job experience for a maximum of two years without losing their benefit. This should be an attractive instrument for reintegrating people at a distance from the labour market. However, a recent survey shows that municipalities also assume that around half of their current social benefit recipients will never get a regular job. Therefore it is very important to closely monitor developments in this area. Since the national government is not playing a central role here as part of a decentralising and deregulation operation, monitoring is limited to interactive benchmarking between municipalities and via the on-going evaluation of the 2004 Act on Work and Social Assistance. It is therefore to be welcomed that some municipalities have taken the initiative to monitor and assess their own policy themselves. These reports produce a basis for sharing of best practices. To what extend best practices will be shared by other municipalities remains to be seen but could be of great importance as the report does not mention any other instruments for stimulating progress in this area.

Given the strong emphasis on own responsibility and accepting work, it is disappointing that the NRS 2006 contains no new policies for tackling inactivity and low wage traps, apart from a relatively small increase for in-work benefits. Inactivity traps and low wage traps remain high, especially for single parents. In order to have effective strategies on decreasing the distance to the labour market, it is crucial to point the financial incentives in the right direction. With regard to the social inclusion of ethnic minorities, the NRS 2006 pays special attention to social participation by women from ethnic minorities. This is relevant, given their

disadvantaged status. Although it is difficult to forecast the take-up of these measures, concrete targets have been set and the actors responsible are mentioned, making the proposed measures transparent and easy to monitor.

Integration policy and guaranteeing an adequate knowledge of the Dutch language is a responsibility of the national government, whereas active inclusion is a local responsibility. The national integration policy, however, has mostly been developed through dialogue with social partners, NGOs and municipalities, resulting in agreements on reinforcing efforts in the areas of helping women of ethnic minority origin to enter the labour market, fighting discrimination and strengthening social cohesion. Safeguarding coherence between the broad range of national and local policy initiatives remains a challenge, in particular considering the fact that, for some of the objectives in integration policy, budgets are allocated through municipalities. Because of the thin line between active inclusion and integration, target groups may overlap and streamlining of policies is necessary.

The NRS 2006 includes a priority on combating child poverty in line with key policy priority of the European Union. Preventing of inheritance of poverty is mainly targeted through focus on education: combating early school leaving, prompt action on learning arrears risks and fighting youth unemployment. In order to halve the number of early school-leavers over the period 2000-2010, national policy focuses on the 17-23 age group. On the other hand, the number of those with learning arrears in the under-18 age group, consisting primarily of ethnic minorities, also remains high. Development of this group will need close monitoring in the coming period, to safeguard the downward trend in the number of early school leavers in the future.

The remaining two priorities concern the growing number of households at minimum income level. In particular, the number of households that cannot make ends meet has increased. Strategy focuses on the two identified causes of this increase: the non-utilisation of income benefits schemes and the increasing amount of debt. Policy focuses on increasing the consumer's awareness and own financial responsibility consistent with the principle of individual responsibility. However, in consultation rounds, municipalities and other stakeholders also argued the need to relax the criteria on income arrangements and for a generic increase in social assistance payments. Although the government has doubts about the effectiveness of generic income measures, the individual responsibility approach may prove to be too one-sided to bring down the number of minimum income households. Although societal responsibilities are not ignored in the NRS, they are considered as being too difficult to influence. However, the NRS also correctly states that it is likely that the increase in the number of households with difficulties making ends meet is explained not only by individual risks, but by a combination of individual and social risks.

Concerning the new programming period for the ESF, the NRS only refers to the fact that part of the programme will be linked to Lisbon targets through projects concerning vocational training for low-skilled workers.

3.3. Policy measures

The NRS largely focuses on the continuation of existing policy measures. With regard to the objectives on increasing participation, the key policy measure is taken in the area of reintegration with the introduction of the "re-entry jobs" for benefit recipients. In 2007 the Social Support Act will be implemented, making municipalities responsible for social support.

At this point, synergies between the latter and the Act on Work and Social Assistance are being explored by municipalities.

In the field of social inclusion of immigrants and ethnic minorities, policy measures focus on acquaintance with the Dutch language and culture and combating discrimination. To better prepare immigrants the Integration Act (entry into force in March 2006) obliges them to pass a basic exam in the Dutch language and culture as a requirement for immigration. Upon arrival, the integration course is extended. As of 2007 this latter course will also be obligatory for resident immigrants, who have been in the Netherlands longer and are in need of it. On fighting discrimination, both sides of industry will commit themselves to cooperate with the government in a new monitoring tool on labour market discrimination.

The key policy measures on child poverty are in the areas of early school leaving and youth unemployment. The compulsory upper age limit on participation in education has been raised from 17 to 18 years, for which a budget of €130 million per year has been reserved up to 2010. Youth unemployment is tackled through the creation of 40 000 jobs in the period 2003-2007 for the unemployed in the 15-to-22 age group by the Taskforce Youth Unemployment, consisting of schools (Regional Vocational Training Centres, ROCs), the Centre for Work and Income (responsible for vacancies), and local authorities. For young people without upper secondary education, on-the-job training is made available.

With regard to the lack of take-up of income benefit schemes, the government is trying to reach beneficiaries through advertising, merging the databases of different institutions and by simplifying application forms. Merging the databases of the Social Insurance Bank (SVB), responsible for statutory pensions, and of the municipalities, means that elderly people with insufficient pension rights due to a short labour history in the Netherlands could be traced more easily and offered additional income support.

Through a new Financial Law, rules on granting financial loans and responsibilities to check the financial liability of clients have been tightened to reduce the risk of debt accumulation in households. Furthermore, research will be conducted in 2007 on the level of financial liability of consumers.

3.4. Governance

Due to the decentralisation of responsibilities concerning priorities in the NRS, monitoring and evaluation is primarily performed by making policy facts and figures accessible to the public. Best practices are shared between municipalities through websites.

NRS consultation involves not only provinces, municipalities, social partners and NGOs, but also - especially - those organisations in daily contact with the high poverty risk group, e.g. municipal credit bank (for people in debt), social housing corporations and providers of energy services. Civil society dialogue between these parties has resulted in agreements on the scope of NRS-related topics, e.g. in the area of reintegration and education between the Association of Municipalities (VNG) and the Ministry of Social Affairs, in the area of social inclusion with the 31 largest municipalities (G31) and in merging the databases of different institutions.

4. Pensions

In 2004, older people enjoyed a living standard close to that of the general population (88%). The Dutch pension system is extremely efficient at coping with old age poverty, as shown by poverty rates of 5% for the population above 65, significantly lower than that of the 0-64 population. It is noteworthy that the poverty rate for the very old (75 and more) is also low.

The 2006 Sustainability report assessed the Netherlands as a low-risk Member State as regards the sustainability of public finances. According to the AWG 2005 projections, public spending on pensions is expected to increase by 3.5 p.p. to reach 11.2% of GDP in 2050. ISG projections for net replacement rate show replacement rates (including occupational pensions, for which actual coverage is about 90% and assuming a contribution rate of 12 %) remaining fairly constant, from 92% net in 2005 (71% gross) to 90% in 2050 (69% gross).

The 2006 Joint Report recognised that the Dutch system ensures adequacy and highlighted the challenges of ensuring that women are as well provided for within the occupational pension sphere. It also commented on strengthening incentives for older workers to remain in the labour force. To this end the updated report makes reference to the adaptation of tax law and regulations affecting early retirees.

As mentioned, the Dutch pension system performs well in terms of adequacy, as it is based on a universal flat-rate public pension and on earnings-related supplementary pensions which cover a very large share of the population. The Dutch strategy for the first pillar relies on an ambitious goal of achieving budgetary surpluses over a long period of time (though this strategy may be weakened by the risk of remaining public deficits), supported by intensified employment policies and reduced incentives to make an early exit from the labour market. Regarding second-pillar pensions, the strategy relies on conducting sound macroeconomic policies and reinforcing surveillance, in particular through safe funding margins. The employment rate for people aged 55-64 has increased significantly in the past decade. Changes have been made in the disability and unemployment benefits to prevent these schemes from being used as an early retirement route and are currently being implemented.

5. Healthcare and long-term care

5.1 Health care

Description of the system: January 2006 saw a major reform of the Dutch health insurance system. The previous dual-funded and partly mandatory system was replaced with a compulsory single universal scheme operated by private health insurance funds. Insurers are obliged to accept every resident in their area and, to accommodate this, a risk adjustment scheme operates. The basic insurance package is fixed by law and health insurers compete with each other on the nominal premium and on services' quality, as well as negotiating with care providers on the price, quality and volume of care to be provided. The new Netherlands Care Authority (NZA) will supervise costs, prices, quality, contractual terms and health market developments from 2007. Provision is decentralized and of a private nature, with public limiting conditions. Service providers are independent and operate on the basis of contracts negotiated with the insurance funds. Primary health care (PHC) is delivered mainly by general practitioners (GPs). These (providing general medicine and promotion and prevention services) perform a gate-keeping role for specialist and hospital care. Specialised care is provided in outpatient and inpatient hospital departments. More than 90% of the hospitals are private while university hospitals are publicly funded owned. GPs are paid both on a capitation basis and a consultation fee. Specialists are paid either a salary or a service fee or a mixture of both. The basic and compulsory health insurance is financed primarily through

the nominal and income related premiums. The latter is redistributed according to a risk adjustment scheme for insurers. Each insured individual can obtain a refund of the basic rate premium up to a standard fixed amount in the absence of claims for care. Co-payments apply to certain services but are limited and for supplementary insurance the ban on premium differentiation does not apply. Recognising changes in the demand for care and continuous technological and medical developments, the authorities aim to create a system that guarantees access while increasing efficiency and maintaining and improving service quality.

Accessibility: The services available within the compulsory basic insurance package are fixed by law and encompass essential curative care. The insurer may not differentiate according to risks between patients in the premiums charged and the government pays the nominal premium for children up to the age of 18. The report highlights the existence of some regional disparities regarding health insurance funds in that not all of them offer the elementary care to the same level in every region. But the authorities expect the recent reform to result in improved access due to new incentives for providers organising care as efficiently as possible without any quality impairment. Although adverse selection is prevented by the legal obligation to take out basic health insurance, people are no longer automatically insured as was the case for participants in the former system. Hence, although authorities expect the new insurance system to provide universal coverage, during an initial transition period there may be a non-negligible number of individuals that are not insured owing to a lack of information or unwillingness to register. Waiting lists, seen as an unsatisfactory feature of the previous system, continue to exist, albeit at significantly reduced levels.

Quality: The government safeguards quality requirements for providers through supervision by the Health Inspectorate. As of 2007, all health care institutions will have to publish an annual public accountability report to ensure transparency and make performance indicators publicly available for insurers and patients. A greater use of ICT and e-health solutions and a nationwide system for the electronic exchange of medical data is expected to reduce medical errors, enhance cost-efficiency and improve access. Patients can choose their health insurer and due to the new incentives they are expected to switch insurer on the basis of price/quality ratio. Patients can also choose and change their GPs at any time. Governmental programmes to improve quality have been launched (e.g. *Better Quicker* programme).

Long-term sustainability: Total health care expenditure (9.8% of GDP and 3056 per capita PPP$ in 2004) was above the EU average and is one of the highest in per capita terms[66]. Since 1990 it has increased by 1.8 percentage points of GDP. The annual growth rate of per capita expenditure is also high compared to the EU average (7.2% in 2002/2003). The report pinpoints several challenges to long-term sustainability. The total costs of care have increased on average by 4.4% a year during the 2001-2006 period and projections predict a 5.5% per annum growth in the period 2008-2011[67] and the 2006 EPC/EC age-related projections show an increase in public health care expenditure of 1.3 percentage points of GDP by 2050. Authorities expect the reforms – notably the liberalisation of the health care purchasing market – to address these challenges by creating new incentives for the efficient use of resources. The aim is to contain health care costs by encouraging competition between care insurers and to obtain more efficient health care through better negotiated contracts between care insurers and health care providers. Increasing the supply of personnel and improving the attractiveness of working in the care sector is also a government ambition. A new broader

[66] 8.87% and 2376.33 per capita PPP$ in 2004.
[67] National Strategy Report on Social Protection and Inclusion in the Netherlands 2006-2008

strategy of prevention is currently in preparation. It should be noted that the conditions for market competition (leading to greater efficiency) are not always fully satisfied due to large information asymmetries, technical complexity, supply side limitations and the high level of uncertainty about future needs. When conditions are not met, regimes stay less liberalised and stricter regulations will apply.

5.2 Long-term care

Description of the system: Long-term care involves primary, home and day care (nursing activities, hygiene, meals-on-wheels, washing, leisure activities, and rehabilitation), assisted housing, residential services (pensioner's homes and boarding houses for pensioners) and sheltered housing. Long-term care medical or high-cost treatments are provided under the Exceptional Medical Expenses Act (AWBZ, financed through an earmarked payroll tax on employees and government grants) while the Social Support Act (Wmo) will enter into force in 2007 and will transfer several responsibilities to municipalities. The authorities' aim is to create stronger local social support. In order to tackle the challenges of ageing and societal changes the authorities aim to increase the provision of home care services and to shift from institutional to primary and individualised, needs-based care in the home environment.

Accessibility: A valid statement of need from the Care Needs Assessment Centre is needed to receive care under AWBZ. The care administration offices direct the process of long-term care at regional level, but their position in implementing the AWBZ is also under discussion. The report underlines that home services still need improvement and expansion, and coordination between regions and municipalities must be enhanced.

Quality: Arrangements have been made with all sectors in long-term care on methods of measuring responsible care. Standards for long-term care have been set. Indeed, the government intends to develop instruments to measure the standard of the care provided by nursing homes and homes for the elderly and how that care is perceived by patients. Additionally care organisations are themselves responsible for carrying out the assessments and reporting the results. Under the new Accreditation of Care Institutions Act care institutions will gradually be given more freedom and greater responsibility. The Making it Better programme supports quality development (e.g. prevention of bedsores and falls) concerning the care provided in seven AWBZ functions, such as residential care, personal care, treatment and counselling.

Long-term sustainability: The national action plan mentions a review of AWBZ in order to control expenditure growth limiting it to the financial ceilings set out in the government agreement. Care providers have committed to helping 1.25% more clients each year up to 2007 on the basis of available funds. Through the AWBZ new financing system function-specific financing will be introduced. It will affect the decisions on the assessed need for care, personal budgets and registration of care. The report also states that long term care providers have few financial incentives to work efficiently under AWBZ.

6. Challenges ahead

To promote active inclusion for the groups furthest from the labour market, in particular by further promoting the labour market integration of ethnic minorities, single parents and older workers, tackling inactivity, addressing low wage traps and increasing take-up of minimum income benefits.

To continue to develop an adequate evaluation and monitoring framework for assessing the participation of, and outcomes for, at risk groups in mainstream employment and social measures, also with an eye to reducing the number of minimum income households.

Increasing the participation of women and part time workers within the occupational pensions sphere, to ensure adequate pensions in retirement for all.

To monitor the medical, social and financial effects of the reform and the competitive changes which must enhance value and efficiency in purchasing health care.

To safeguard the functioning of the newly formed health insurance market – consolidation of the market is expected if insurers are to survive and build up bargaining power in negotiations with providers and tackle potential administrative problems faced by providers (e.g. reimbursement of GPs) and insurers (e.g. huge numbers of patient have changed their insurer);

To monitor the effects of the new AWBZ financing system through a number of pilot projects.

The Netherlands: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.9	124,0	**2000**	72.9	82.1	63.5	68.7	38.2	**2000**	2.8	2.2	3.6	5.7
2002	0.1	125.3	**2002**	74.4	82.4	66.2	70,0	42.3	**2002**	2.8	2.5	3.1	5,0
2004	2,0	124.7	**2004**	73.1	80.2	65.8	65.9	45.2	**2004**	4.6	4.3	4.8	8,0
2006	3.0f	126.1f	**2005**	73.2	79.9	66.4	65.2	46.1	**2005**	4.7	4.4	5.1	8.2

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	74.6	80.4	14.7	19,0	61.1	62.1e	5.5	**1995**	8.4	71	-		
2000	75.5	80.5	15.3	19.2	61.4	60.2	5.1	**2000**	8.3	63.1	9	75.6	92
2004	76.9sp	81.4sp	16.2sp	19.8sp	61.7e	58.8e	4.1	**2004**	9.8	61.2	7.8		

s: Eurostat estimate; p:provisional; e: estimate **THE: Total health expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	30.6	38	28.5	9.9	4.6	6.5	12.6
2000	26.4	42.4	29.3	5.1	4.6	6.8	11.8
2004	28.5	41.6	30.4	6.3	4.8	6	10.9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
2005	20.7				
2010	22.2	-0.3			
2030	36.7	3.8			
2050	38.6	4.9			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	11b	15b	9b	10b	5b	21b	21b	22b	22b	12b	**Total**	4.0b
Male	11b	-	9b	10b	5b	22b	-	23b	26b	11b	**Male**	-
femal	11b	-	10b	10b	6b	20b	-	20b	20b	12b	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	6.9	7.8	6.3	9.4	**1999**	1.2	0.9	1.5		**1999**	16.2	17.5	14.9
2004	7,0	8,0	6.7	9.3	**2004**	1.6	1.5	1.6		**2004**	14,0	16.1	11.9
2006	6.2	7.4	6.2	8.6	**2005**	1.9	1.9	1.9		**2005**	13.6	15.8	11.2

**: excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.879b	0.882b	0.879b	***Aggregate replacement ratio***	0.426b	0.475b	0.517b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Current estimate (2002)	Assumption
	-2	0	DB	-2	DB	100	91	7	9.8	11.5-12.5

**:(DB / NDC/ DC); ** (DB / DC)*

2.19. AUSTRIA

1. Situation and key trends

GDP growth increased from 2.4% in 2004 to 3.1% according to the forecast for 2006. The total employment rate stood at 68.6% in 2005 (75.4% for men and 62% for women), well above EU average. In spite of recent increases, the employment rate of older workers at 31.8% in 2005 (41.3% for men and 22.9% for women) remains among the lowest in the EU, far below the Lisbon target of 50%. The unemployment rate, while remaining below EU average, increased for the fourth consecutive year to reach 5.2% in 2005 (4.9% for men and 5.5% for women), affecting young people in particular (10.3%). In 2006, unemployment fell slightly. The long-term unemployment rate stood at 1.3% in 2005, well below the EU average. The at-risk-of-poverty rate was 12% in 2004, with a higher risk for women, elderly people, children, people with disabilities and immigrants. People aged 65+ have a living standard, as measured by average income, close to that of the 0-64 population. In 2004, the social protection systems (including old-age pensions) substantially reduced the overall at-risk-of-poverty (from 43% to 12%). Austria is projected to face similar demographic trends to most EU Member States in coming decades: the old age-dependency ratio will steadily increase from 22% in 2004 to 41% by 2030 (EU25 average of 25% and 40 % respectively). Social protection expenditure, as a percentage of GDP, has increased since 2000 reaching 29.1% in 2004 (old age and survivors' pensions 48.2%, health 25%). Life expectancy at birth (76.4 years for men and 82.2 years for women in 2004) is above the EU average[68]. It increased by 3.1 and 2.3 years in the last decade (from 73.3 and 79.9 in 1995). Healthy life expectancy (66.2 for men and 69.6 for women – Eurostat estimates for 2003) is also above the EU average. Infant mortality (4.5 in 2004) is in line with the 2004 EU average of 4.5. It has seen a substantial decrease since 1960 (37.5) and a continued decrease in the last decade (from 5.4 in 1995). Perinatal mortality is moderate (6.4 in 2002) and has steadily declined since 1960 (34.9).

2. Overall strategic approach

The key challenges identified in the National Strategic Report are the intergenerational transmission of poverty and social exclusion, difficult access to the labour market for disadvantaged groups, social and economic inclusion of people with disabilities, and the adaptation of social protection schemes to demographic changes. Austria's priorities for action address these four challenges. The planned measures should ensure the sustainability of welfare transfers, including pensions, and of social and health services, improve their efficiency and effectiveness and adjust them to demographic, social and economic developments. Promotion of equal opportunities for all, an increase of employment and reforms in the health and long-term care systems have been identified as the main policy instruments.

Some cross references between social inclusion policies and reforms in the pension and health systems are made. In particular, measures to enhance educational attainment and employment opportunities for disadvantaged groups are mentioned, which should contribute both to better social cohesion, a higher employment rate and sustainable financing of social protection schemes. Overall, the aims seem ambitious, although quantified targets and indications on

[68] The EU average was 75.8 for men and 81.9 years for women in 2004.

implementation, time frame and budgets are not consistently presented. Quantified targets are defined for the reduction of child poverty and for some aspects related to childcare, employment and social inclusion of the disabled. Coherence with the Lisbon reform programme should be ensured through close cooperation between the respective ministries. The social protection and social inclusion policies support the Lisbon reform programme insofar as they contribute to enhancing employment of disadvantaged groups, to ensuring the financial sustainability of the social protection systems and to exploiting the employment potential in the care and health sector.

Good governance is promoted by an enhanced involvement of a number of stakeholders including ministries, Länder, local communities, social partners and NGO umbrella organisations in the preparation and monitoring of the strategy.

Gender equality has been given limited attention overall, although gender mainstreaming and gender specific measures are mentioned within some policy areas, in particular with regards to labour market measures, the disabled, reconciliation of family and work. Youth policy is mainstreamed in different policy areas tackling issues like health, indebtedness and the re-socialisation of young delinquents.

3. Social inclusion

3.1 Key trends

Inequality of income and the risk of poverty remained below the EU average in 2004. The at-risk-of-poverty rate stood at 12% in 2004, with a higher risk for women (13%) than for men (11%). Unemployment, in particular long-term unemployment, increases the risk of poverty significantly. Moreover, 7% of people in gainful employment above the age of 18 have incomes below the poverty threshold, i.e. can be considered 'working poor'. For children under 18, the rate stood at 15% and is concentrated mainly on households where parents are not sufficiently integrated into the labour market. With rising unemployment, the number of children (aged 0-17) in jobless households increased from 5.6% in 2004 to 6.4% in 2005. Immigrants from non-EU/EFTA countries face a particular high risk of poverty, at 30% in 2004, as compared with those born in Austria at 11%. People with disabilities are also at above-average risk with a rate of 18% in 2004, which is mainly due to the low employment rate (36% in 2004) and low pensions. The increase in unemployment in recent years (from 3.6% in 2000 to 5.2% in 2005) has gone in hand with a significant increase in the number of people receiving social assistance.

Low educational attainment increases the risk of poverty to 18%. It is particularly high amongst women (24.9% in the age group 25-64 years vs. 14.9% for men in 2005). The percentage of early school leavers stood at 9% in 2005, well below the EU average. Among young immigrants, it is as high as 25% according to national data. While the rate of participation in continuous lifelong learning is above EU average at 14% (Eurostat 2005), that of individuals with no more than compulsory schooling is two thirds below the average (4%).

The increase in unemployment has affected disadvantaged groups in particular. The unemployment rate gap between non-EU and EU nationals has almost doubled since 2001, reaching 9.5% points in 2005. People aged 55+ are also particularly threatened by unemployment.

The situation of women continues to be generally less favourable than that of men. The gender pay gap is above the EU average (18% points in 2004). The risk of poverty is higher among lone parents (25%), of whom 90% are female, and women aged 65+ (20% vs. 13% for men of the same age group).For single women whose main income is a pension the risk is as high as 24%, due to the fact that the minimum pension is slightly below the poverty threshold. Households with female main bread-winners face a risk of poverty almost double that of households with male bread-winners.

3.2 Key challenges and priorities

Austria's main priorities for social inclusion policies are the prevention of poverty and social exclusion among children and young people, the promotion of more labour market opportunities for at-risk groups, in particular the long-term unemployed, older workers, women, migrants and the low qualified, and enhanced participation of people with disabilities. For all three priorities the approach is centred on access to employment and employability with the primary labour market while measures to facilitate access for all to the resources, rights and services needed for participation in society are covered to a lesser extent. The strategy focuses on continuing current policies rather than introducing new measures. The time horizon is generally limited to 2006/mid-2007. The 2006 Joint Report on Social Protection and Social Inclusion identified the increasing risk of social exclusion for the major at-risk-groups against the background of rising unemployment and the low participation in lifelong learning of the less qualified as main challenges for Austria. While the short-term increase in spending on active labour market measures for at-risk-groups has helped to counteract the negative trend in unemployment, continued efforts will be necessary. The low participation of the less qualified in lifelong learning remains a concern.

In view of the higher poverty risk for women (in particular single parents and elderly people) more determined action seems needed. Gender mainstreaming and gender specific action, although mentioned for some areas of intervention, are not strongly emphasised within the strategy. The disadvantaged position of women on the labour market, in particular with regards to atypical employments with limited security and the gender pay gap, is not directly addressed.

The European Social Fund 2007-13, although reduced by around one third as compared to the present period, will continue to make a contribution to the Austrian social inclusion policy, in particular through supporting active labour market policies.

3.3 Policy measures

Policy measures targeting children and young people aim at reducing child poverty to 10% in the next ten years, from the current 15%. Monetary transfers, such as the childcare and family allowances, and tax reductions, are already in place. As the impact of the childcare allowance scheme on social inclusion has been controversial, it would warrant close monitoring and potential adjustment. It is intended to enhance employment opportunities for parents by helping to reconcile family and work, in particular by improving the availability of childcare facilities. The identified additional need of 18.000 places seems, however, to be an underestimate, and the resulting target not ambitious enough to make a decisive improvement regarding in the prospects of parents, in particular women, on the labour market. Investments in the development potential of children focus on promoting reading skills in elementary schools, and early German language learning for children with another mother tongue. Further stepping up efforts to increase the qualifications of young persons with a migration

background, could be warranted given their high drop-out rate from school. The integration of young people into the labour market is supported by active labour market measures with substantial additional expenditures until 2006/07. Since 2004, there has been a legally binding target of offering a qualification or reinsertion measure to all unemployed young people under 25 within three months. Subsidies for apprenticeship places have helped to reduce, but not to eliminate, the demand/supply gap. A number of important instruments other than active labour market measures are planned, such as health prevention in schools, support measures for young people in crisis, and re-socialisation of juvenile delinquents. However, the respective aims and plans for implementation remain vague.

With regards to the integration of disadvantaged groups into the labour market, the strategy aims at contributing to reaching the EU target of a 70% employment rate before 2010, (68,6% in 2005), and in particular at further increasing the employment rate of older workers. Another aim is to reduce unemployment. One target is that 97% of the unemployed should not become long-term unemployed. The problem of working poor is, however, not addressed. A number of active labour market measures are in place for the long-term unemployed, older persons, women, migrants and the low qualified, which are a main pillar of the employment policies defined also in the National reform programme. These measures have been substantially reinforced for 2006/mid-2007, offering qualifications or employment to an additional 60.000 persons. The effectiveness of some of the qualification measures could be improved by better targeting them to individual needs. While some measures aiming at reducing the gender-specific segregation of the labour market are proposed, the increase of mini-jobs and non-standard employment without full social security for women is not addressed. The foreign nationals law package, which entered into force in 2006, will facilitate migrants' access to the labour market, as will professional orientation and qualification measures.

Policies to enhance participation of disabled people aim at creating conditions that provide opportunities comparable to those of people without disabilities**.** This entails integration in regular schools and in the primary labour market, as far as possible, and barrier-free infrastructure. Measures include extending early learning support for children, expanding integrative schools (common schools for disabled and non-disabled), increasing specific active labour market measures for this target group for 2006/mid-07 and enhancing support for occupational therapies, alternative forms of housing, and personal assistance. Equal opportunities will be promoted by recently adopted legal provisions to fight discrimination. Financial incentives will be offered to medium sized companies to invest in barrier-free access.

The use of the European Social Fund 2007-13 in Austria will focus strongly on the inclusion of disadvantaged groups in society, in particular older persons, the low-skilled, disabled people, and people at the margins of the labour market.

3.4 Governance

The section on inclusion of the Strategic Report was drafted in consultation with the major players at national, regional and local levels, including social partners and umbrella NGOs. The tight timetable, however, did not allow extensive discussion of the underlying strategic decisions. Efforts have been made to enhance the involvement of NGOs by inviting the two main umbrella organisations to carry out a survey of existing reform needs, which will be used for future policy planning. It is envisaged to set up a group of independent experts to

continuously monitor and evaluate implementation. The results of this work should serve as a basis for the development of the next strategy report.

4. Pensions

In 2004, older people had a living standard very close to that of the general population (95%), while the poverty risk among older people at 14% (gender differences are high, 10% for men and 17% for women) is slightly higher than for the population below 65. In spite of recent increases, the employment rate of older workers remains low at 31.8% in 2005.

The 2006 Sustainability Report assessed Austria as a low-risk Member States as regards sustainability of public finances. According to the AWG 2005 projections, Austria is expected to face low pressure on its public finances from an ageing population. From a spending level of 13.4% of GDP in 2004, an increase of 0.6 p.p. of GDP is expected between 2004 and 2030, while thereafter a decrease of 1.7 percentage points by 2050 is projected, resulting in a level of public pension spending in 2050 1.2 p.p. lower overall than in 2004. According to projections drafted in the framework of the ISG, before the 2004 pension reform the theoretical pension replacement rate was to decrease smoothly for a worker retiring at 65 after 40 years of contributions at the average wage from a level of 74% to 67% (2050), due in particular to the introduction of a loss limit of 10% for pension entitlements gained from the unreformed system. Following that reform, despite a decreasing accrual rate, Austria expects the theoretical gross replacement rate to decrease to 69% (84% net) by 2050.

The 2006 Joint Report on Social Protection and Social Inclusion underlined that the 2004 reform was a major step towards modernised and more sustainable pensions and stressed that a significant increase in the employment of older workers was needed to ensure both the adequacy and sustainability of future pensions, and that it was important to monitor adequacy of pensions and review policy options if necessary. With that reform, Austria harmonised the pension systems by introducing a uniform pension law for all professions for persons aged less than 50. This pension reform leads to a much stronger link between contributions and benefits, including a “bonus malus” system for deferred and earlier retirement, and a switch in the indexation of pensions to consumer prices as of 2006.

Although minimum pensions were increased slightly in 2006, they remain below the poverty threshold, which strongly influences current poverty among women. The retirement age for women will remain lower than for men for a long time and will be raised from 60 to 65 years between 2024 and 2033. However, the risk of poverty for female pensioners could increase in future if the participation of women in the labour market is not further enhanced.

5. Health and long-term care

5.1 Health care

Description of the system: The federal government is responsible for the health care system, except for hospital care, for which the federal government is only responsible for general legislation while the provinces (*Länder*) legislate on implementation of policies. Therefore, the federal and provincial governments conclude agreements to ensure the health care. Some 50% of health care expenditure is financed by compulsory social health insurances, 20% by tax revenue and 30% by private households (including financing by supplementary private health insurance). Self-employed health professionals provide most primary and secondary outpatient care. Outpatient clinics, owned by hospital providers or statutory health insurance

funds, deliver secondary outpatient and dental care. General practitioners coordinate care and referrals, serving as formal gatekeepers to inpatient care except in emergency cases. However, patients often access outpatient clinics directly. Public health authorities deliver child health care and screening services, often financed by statutory health insurance. Acute secondary and tertiary inpatient care is provided by 'fund hospitals', owned by municipalities, *Länder*, religious and other not-for-profit organisations, or by private for-profit hospitals.[69]

Accessibility: The social health insurance system is mandatory for the vast majority of the population. It covers around 98% of the Austrian population, including some social assistance recipients for whom the *Länder* pay contributions. Social health insurance covers all services linked with the treatment of an illness. All individuals covered by social health insurance are entitled to the social health insurance services and benefits laid down by law. Eligibility is not subject to means-testing. When using certain health care services, the insured have to make co-payments or take account of patient deductibles. There are exceptions for low-income earners and for people who provide proof of above average expenses due to illness. Supplementary private health insurance is mainly used to obtain better hospital accommodation and the doctor of one's choice at private hospitals. However, there are still around 2% of the Austrian population who are not covered by health insurance. Social assistance schemes, for which the *Länder* are responsible, pay the treatment costs for some non-insured persons. New legal provisions open access to health care further, in particular granting social insurance coverage to asylum seekers in need of assistance. While Austria has no nationwide data on waiting lists, there seem to be no major issues concerning waiting lists.

Quality: At federal level a large number of laws and regulations have been adopted in recent years that partly contain quality specifications (currently approx. 50 standards). In addition, a variety of standards have been set at *Länder* level. The framework for mandatory quality work has been strengthened by legal standards especially the Federal Act on the Quality of Health Care Services. Future challenges will lie in their implementation. The federal government has supported and financed a large number of quality-related (project) activities, on issues such as interface management, quality reporting, patient guidance, use of antibiotics and prevention of adverse events.

Long-term sustainability: Total health care expenditure (at 7.5% of GDP and 2365 PPP$ per capita in 2004) was recorded to be slightly below the EU average in GDP terms. Public healthcare expenditure as a share of total health expenditure was about 67.6% and mostly constant from 1998 to 2004.[70] According to the 2006 EPC/EC projections public health care expenditure is projected to increase by 1.6 percentage points of GDP by 2050 due to population ageing, whereas a national projection is 1.2% of GDP. Improving the use and impact of the available financial funds in health care is a continuous challenge to ensure financial sustainability, making it necessary to exploit rationalisation and efficiency improvement potentials. There are continuous policy talks and agreements with doctors' and pharmacists' associations and the pharmaceutical companies to achieve a sustainable dampening of the rising costs of pharmaceuticals. These changes, e.g. a revised reimbursement scheme for pharmaceutical innovations and generics, reduced average cost increases from 7-9% earlier to some 3% in 2005. Demographic developments and patients' increased demands on the services provided are confronting the health and social care sector

[69] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005

[70] Revised expenditure calculations, with the OECD System of Health Accounts, were recently introduced and resulted in increased figures that place Austria in the upper middle bracket among Member States.

with major challenges. Nursing and long-term care is becoming increasingly complex and raises both the quantity of staff needed and the quality standards expected of well-trained nursing staff.

5.2 Long-term care

Description of the system: The Austrian system for long-term care has two main components. Firstly, a universal allowance system for long-term care accessible to all those in need of long-term care was introduced in 1993. These benefits are entirely financed from taxes. They are granted to about 4% of the population on the basis of seven categories of need that depend on the hours of nursing care required per month.[71] The allowances provide flat-rate cash benefits that contribute to paying for additional expenses incurred because of a person's need for care, giving the individuals concerned a better chance of managing their own lives, e.g. staying in their own homes. Secondly, the *Länder* are responsible for providing social services for long-term care. In 1993, an agreement between the federal government and the *Länder* was concluded, with a catalogue of services and quality standards. The federal government has undertaken to provide social insurance cover for informal caregivers. 80% of all people in need of long-term care are cared for by family members at home.

Accessibility: The federal and corresponding provincial long-term care allowance programmes cover all persons in need of care, irrespective of age.[72] Persons not entitled to benefits under the federal scheme will receive long-term care benefits from the *Länder* at the same rates and in accordance with the same rules as in the federal scheme. Persons in need of care are legally entitled to this benefit irrespective of their income or wealth, and irrespective of the reason for requiring such care. However, income and assets, as well as care allowance, are taken into account in calculating the beneficiaries' financial contributions to social services. If the household does not have the income or assets to pay for the services, the social assistance service can provide funding in addition to the care allowance. Institutional care is predominantly provided by provinces and municipalities, or by religious and other non-profit organisations. Home care services are provided by non-profit organisations. Informal care traditionally plays a major role in Austrian long-term care. The formal home care sector is still expanding and there are marked regional differences in the availability of services, in particular of services to support informal care giving (such as counselling and respite care).[73]

Quality: There are several efforts made to enhance quality in long-term care. Creating uniform and binding quality standards together with quality assurance procedures for social services is one challenge. A first step in this direction is the agreement concluded between the federal government and the *Länder* on social care occupations, in force from July 2005, which introduced uniform standards for social care training and work. Particular emphasis is placed on standards for ambulatory care, including free choice between available services as well as quality assurance and monitoring by the *Länder*. The agreement concluded in 1993 also defines minimum standards for institutional care, including e.g. priority for small care facilities integrated in the local community and free choice of doctor. All *Länder* have now adopted rules for supervising old-age and nursing homes, including provisions that ensure the legal protection of residents. The policy of "Quality assurance in home care" is increasingly important to both receivers and providers of care. Home visits by certified care workers are a

[71] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005
[72] Long-term care for older people – ISBN 92-64-00848-9 – © OECD 2005
[73] Long-term care for older people – ISBN 92-64-00848-9 – © OECD 2005

key tool to check, inform and counsel all those involved in a home care situation. Providing support to caring family members is considered a top priority within long-term care, as the work of informal carers is very valuable to society as a whole but frequently associated with great physical and psychological stress.

Long-term sustainability: In 2005 the federal government spent € 1566 million on long-term care benefits. The *Länder*'s expenses under provincial long-term care benefit legislation amounted to some €282 million in 2004. Expenses on benefits in kind for social services totalled €1423 million in 2004, mainly financed by the *Länder*'s budgets (social assistance) and partly by municipalities, while the users of such services have to contribute towards these costs with socially graduated co-financing amounts. According to the 2006 EPC/EC projections public long-term care expenditure is projected to increase by 0.9 percentage points of GDP by 2050 due to population ageing (from 0.6% of GDP in 2004), while a national projection is 0.7 percentage points of GDP. (These projections only refer to expenditure under the Federal Long-term Care Allowance Act.) A major challenge for the financial sustainability of long-term care lies in demographic developments that might require more social services and therefore lead to increased financial requirements, which are expected to be balanced by significant employment effects. One immediate challenge, and an important point in the drafting of the new government's agenda, concerns the current availability of professional nursing and care staff, including the recruitment of migrant workers.

6. Challenges ahead

Further reinforce efforts to break the intergenerational transmission of poverty; in this context to develop stronger links between lifelong learning and social inclusion policies, in particular for young immigrants.

Adopt stronger steps to enhance active inclusion of women, especially of single mothers, older female workers and pensioners.

Ensure both the adequacy and sustainability of future pensions by significantly increasing the employment of older workers. It will be important to monitor the poverty risk for pensioners, as well as replacement rates, and review policy options if necessary.

To strengthen control of health care expenditure increases through continuous work to counteract various cost-raising factors, such as pharmaceuticals, and to improve the overall efficiency of the health care system.

To continue to improve support functions for informal (family) carers and to recruit, train and keep the professional care workers needed for future long-term care, especially with respect to changing family conditions.

To implement in practice the new legal framework of quality standards and procedures for health care and long-term care services.

AUSTRIA

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.4	125.5	**2000**	68.5	77.3	59.6	52.4	28.8	**2000**	3.6	3.1	4.3	5.3
2002	0.9	120.0	**2002**	68.7	76.4	61.3	51.7	29.1	**2002**	4.2	4.0	4.4	6.7
2004	2.4	123.4	**2004**	67.8b	74.9b	60.7b	51.9b	28.8b	**2004**	4.8	4.4	5.3	9.4
2006	3.1f	123.3f	**2005**	68.6	75.4	62.0	53.1	31.8	**2005**	5.2	4.9	5.5	10.3

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop.covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	73.3	79.9	14.9	18.6	60.0	na	5.4	**1995**	8.5	69.7	-		0.1
2000	75.1	81.1	16.0	19.4	64.6	68.0	4.8	**2000**	7.5	68.1	20.4	99	
2004	76.4sp	82.2sp	16.9sp	20.3sp	66.2e	69.6e	4.5	**2004**	7.5	67.6	19.2	98	31.8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	28.7	46.9	25.6	5.8	11.3	1.3	9.1
2000	28.2	48.4	25.4	5	10.7	1.4	9.1
2004	29.1	48.2	25	6	10.7	1.8	8.3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	23.6	25.4	13.4	5.3	0.6
2010	26.3	-1			
2030	40.8	0.8	0.6	1	0.3
2050	53.2	0.1	-1.2	1.6	0.9

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12	15	12	11	14	15	14	15	18	14	**Total**	3.8
male	11	-	11	11	10	15	-	17	19	12	**male**	-
femal	13	-	13	11	17	15	-	15	17	15	**female**	-

	People living in jobless households				***Long Term unemployment rate***			***Early school-leavers***		
	Children	% of people aged 18-59*			% of people aged 15-64			% of people aged 18-24		
	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female
1999	4.2	8.2	6.5	9.8	1.2	0.9	1.5	10.7	9.6	11.9
2004	5.6i	8.8i	7.6i	10.0i	1.3 b	1.3b	1.4b	8.7i	9.5i	7.9i
2006	7.2	8.8	7.8	9.8	1.3	1.2	1.4	9.0	9.4	8.5

**: excluding students; i: change in methodology; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.95	1.02	0.91	***Aggregate replacement ratio***	0.67	0.67	0.67

Change in theoretical replacement rates (2005-2050) - source ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Estimate of current (2002)	Assumption
4	5	5	DB	/	/	100	/		22.8		/	/

**:(DB / NDC/ DC); ** (DB / DC)*

2.20. POLAND

1. Situation and key trends

In recent years Poland has enjoyed sustained economic growth (3.2% in 2005 and according to forecasts: 5.2% in 2006), but this has not generated many new jobs. Even though the employment rate increased by 1 percentage point to 52.8% in 2005, it is still the lowest in EU, particularly for women (46.8%) and older workers (27.2%). The unemployment rate declined by over 1 percentage point and reached 17.7% in 2005 (16.6% for men and 19.1% for women). The long-term unemployment rate, at 10.2%, is the second highest in the EU. The at-risk-of-poverty rate[74] stood at 21% in 2004, significantly above the EU average. The main group facing poverty was children. Total social expenditure, as a percentage of GDP, reached 20% in 2004, with 60.1% of expenditure related to pensions, 19.5% to healthcare, and 11.5% to disability. Only 0.8% was spent on housing and tackling social exclusion.

Poland is projected to face similar demographic trends to most EU Member States in the coming decades: the elderly dependency ratio will grow from a current level of 19% to 33% by 2025 and to 51% by 2050 (close to the EU-25 average of 52%). Life expectancy (70.6 and 79.2 years for males and females in 2004) is below EU average, but has been consistently increasing over the last decade (67.6 and 76.4 in 1995) following a decrease in 1989-1991. Poland is facing a rapidly decreasing total fertility rate: from 2.0 in 1999 to 1.2 in 2004. Although the infant mortality rate is considerably and steadily decreasing (from 56.1 in 1960 to 13.6 in 1995, 7.0 in 2003 and 6.8 in 2004), it is amongst the highest in the EU.[75] Healthy life expectancy (62.5 years for men and 68.9 years for women) is below the EU-15 average (64.3) for men but quite high and above the EU-15 average (65.8) for women. Perinatal mortality is also high at 7.5 in 2003.

2. Overall strategic approach

The National Strategic Report (NSR) sets as the main policy objective the creation of integrated systems for delivering state policy leading to greater social cohesion, supported by mutually reinforcing social and economic policies, increasing employment, good governance and the involvement of various stakeholders in policy design, implementation and monitoring. To achieve this, the NSR identifies a broad range of priorities and specific measures in the area of social inclusion, social protection, and health care, without, however, systematically assessing their impact on social cohesion and equal opportunities for all. The synergy and the links between the three policy fields should be better developed in a common drive to achieve the strategic policy objective.

The policy approach presented in the NSR is interlinked with the National Reform Programme (NRP) in the area of macroeconomic and employment policies. The NRP is intended to complement the NSR by reforming various social assistance schemes, leading to

[74] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the large year to year differences that can be noted are therefore not significant. During the transition to EU SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.

[75] The EU average was 4.5 in 2004.

early withdrawal from the labour market, improving farmers' social insurance system, continuing health care reform, and vocational activation of vulnerable groups, including the disabled.

A separate priority for governance is envisaged, aimed at improving policy coordination, increased the involvement of all stakeholders and mainstreaming social policy in overall state policy. Although a considerable effort has been made to define indicators in the social inclusion part of the NSR, the absence of quantified targets is regrettable. The gender dimension is included, but with limited visibility. A consistent gender mainstreaming approach, and indications as to how the specific problems of disadvantaged women will be addressed, are outlined in general terms, but need more attention.

3. Social inclusion

3.1 Key trends

Despite sustained economic growth, Poland still has the worst employment and unemployment indicators in the EU. The risk-of-poverty rate was 21% for men and 20% for women. Poverty and exclusion are mainly associated with being out of work. In 2004, the rate of extreme poverty (which, in national statistics, refers to a "market basket" of goods including those needs, whose satisfaction cannot be postponed in time and consumption lower than defined by this level leads to biological deterioration) in households with at least one unemployed person was 26%, whereas in households where no one was unemployed the rate was only 7%. The "working poor" phenomenon affected 14% of people at work, and among them mainly the self-employed. The groups particularly affected by poverty and social exclusion are children (29%), young people, the long-term unemployed, and people living in rural and deprived areas. There is also a high correlation between the risk of poverty and a large number of children in the household.

Social transfers have a significant impact on poverty reduction. Poland has the highest poverty rate prior to social transfers in the EU (51% in 2004). The strongest effect of social transfers on poverty reduction is observed among people over 64 (mainly due to pensions). Although unemployment benefits themselves do not provide a high replacement ratio (65%), when combined with other social transfers, they generate a substantial unemployment trap (83%).

The education level of the Polish population has been improving and educational attainment at 22 years old is one of the highest in the EU (90%). In 2005, early school leavers accounted for only 5.5%. The education system nonetheless contains many inequalities, especially between urban and rural areas. The highest youth unemployment rate in the EU at 36.9% reveals a mismatch between the education system and the needs of the economy.

3.2 Key challenges and priorities

Poland set up three priorities for social inclusion: support for families with children aimed at equalising access to goods and services, ensuring economic security and facilitating reconciliation of work and family life; inclusion by activation, mainly through developing the social economy, reforming tools and instruments for active integration and supporting public-private partnership; and mobilisation and partnership by reinforcing social assistance institutions, strengthening their cooperation with labour market institutions. The above actions will be supplemented by the priority relating to the common objective of better governance,

aiming greater policy coordination and at increasing ownership of the social inclusion process.

The strategic approach presented is consistent with the common objectives for fighting poverty and social exclusion. It also responds to the country-specific challenges identified for Poland in the 2006 Joint Report on Social Protection and Social Inclusion. However, the NSR needs a more operational outline of how to achieve these strategic objectives. The strategy combines a continuation of current policies with new initiatives. Some long-term measures, which could have a significant preventive effect on social exclusion (i.e. affordable housing, development of care services), are still being planned. The integration of various education policy measures, and their contribution to policy goals, should be better recognised. There is a certain amount of confusion between objectives and challenges, and some instruments cited under the various priorities seem to overlap. In addition, the links between each measure and the corresponding objective are not always explicit. Lastly, the list of policy measures could be extended to fully ensure their long-term influence on poverty reduction and social exclusion.

3.3 Policy measures

Regarding families with children, the proposed measures focus on developing integrated systems of assistance through supporting incomes, and facilitating reconciliation of work and family life (developing care services and promoting flexible forms of employment). Although the high level of poverty among children fully justifies these measures, the priority does not address the risk of poverty and exclusion faced by single parents. Nor does it refer to prevention and treatment of various addictions, or prevention and treatment of family violence, which often lead to child poverty and exclusion. It is also necessary to level out the quality of the education system at different stages and to provide the necessary financial means, particularly for pupils and students from the poorest families.

Groups threatened by social exclusion will be integrated mainly through improving their access to the labour market, developing the social economy and reinforcing the links between the guaranteed minimum income and activation instruments. Special emphasis was put on people with disabilities. Poland still has to deal fully with reforms in the disability benefit system (i.e. re-evaluate existing disability rights), but the first steps towards improving the low activity rate of the disabled have already been taken. Other groups of instruments will be focused on developing public-social partnerships, by strengthening cooperation between public entities and NGOs operating in the field of social services. The social economy will be supported by developing advisory services, setting up local loan funds and conducting a promotion campaign. The implementation of these measures will depend, however, on local circumstances, such as the organisational and financial strength of the social assistance institutions and their ability to mobilise all partners.

Therefore, in order to strengthen the social assistance system and to involve all relevant stakeholders, a priority for mobilisation and partnership is envisaged. Further development of social services and social assistance institutions will be achieved through increasing the number of social workers, and facilitating cooperation between public employment services and social assistance centres. Complementary actions, planned under the better governance priority, are aimed at improving policy coordination, involving all partners and mainstreaming social integration policy in overall state policy. Although Poland notes some progress in strengthening the administrative capacity of social assistance institutions, the complicated

power structure and poor coordination between programmes implemented at various levels remain a concern.

The document contains some statistical data disaggregated by gender, but this is not consistent across the strategy. Reconciling family and working life is recognised as important to increase the fertility rate and to prevent intergenerational transfer of poverty, but promoting gender equality per se is not an explicit goal. A gender breakdown of target populations (provided in tables and annexes) is not discussed in the strategic part. NSR acknowledges the role of the ESF in carrying out the measures planned, but does not give any information on the planned financial allocations.

3.4 Governance

The drafting and consultation process for the NSR involved the representatives of relevant ministries, social partners, NGOs, and higher education entities. Although an effort was made to encourage major actors to engage in active discussion, it seems that the NSR is still not a matter of wide public debate. The situation may improve slightly, especially at local level, once the planned promotion campaign is implemented. Work is under way to establish a monitoring system for social inclusion at national and regional levels. The monitoring indicators devised contain both the main outcome indicators to monitor progress in social inclusion, and input indicators to evaluate implementation of the respective policies. Regrettably, the NSR neither includes any quantified targets, nor contains any analysis of the budgetary implications of the planned activities and policies (although the sources of financing are indicated).

4. Pensions

In 2004, older people had a living standard relatively higher than that of the general population (109%), while the poverty risk among older people (7%) is significantly lower than that of the population below the age of 65. In spite of recent increases, the employment rate of older workers remains very low.

The 2006 Sustainability Report assessed Poland as a low risk Member States as regards sustainability of public finances. The AWG's 2005 projections show a considerable drop in public pension expenditure from 13.9% to 8.0% of GDP over the period 2004-2050 (pension expenditures decrease to 9.3% of GDP in 2050 when the mandatory funded tier is taken into account). Nevertheless, the pay-as-you-go tier is projected to remain in deficit until the mid-2030s due to transition costs. According to ISG projections, the net replacement rate would gradually decline from 2005 to 2050 from 78% (63% gross) to 44% (36% gross) unless the balance between the years in employment and retirement is improved (the decrease is lower for people retiring at 67 after 42 years of contributions).[76]

Poland has introduced significant reforms in its old-age pension system, the new system being in place since 1999. It has, however, created high transition costs, the financing of which will require a major effort over the coming decades. The reform also introduced options for voluntary pension insurance, subsidised by moderate tax incentives. A major challenge is to increase the currently low level of employment (partly linked to undeclared work and a high

76 These calculations are based on wage growth in line with relatively strong productivity growth and with a uniform interest rate for the EU. Any departure from these assumptions may result in a less marked decline in replacement rates.

level of unemployment). Whether incentives in the new pension system translate into higher employment and hence improved financial sustainability will, however, depend on the employability of older workers and overall demand for labour. The planned reform of early retirement schemes has been delayed by one year and the rules for the miners' pension scheme have been changed back to the old system. Such delays in reform weaken the message that change is necessary. Further initiatives translating into a return to the old system (for instance for people working in so-called special conditions) would erode the pension reform.

Following the projected decline in the replacement rate, the adequacy of pensions may become an issue in the future, notably for those with short careers, predominantly women. Moreover, equalising the legal retirement age for men and women would help reduce the gender gap in pension entitlements and would contribute to increased employment rates. Other major issues that remain to be addressed are a comprehensive reform of the farmers' pension scheme and of disability pensions, which have become a major route to early labour market exit. The preparation of legislation for the payout phase of the funded tier of the statutory scheme (annuities) should be concluded soon, as the first pensions will have to be provided in 2009.

5. Health and long-term care

5.1 Health care

Description of the system: The compulsory health insurance scheme administered by the National Health Fund (NHF) and its regional branches (16) provides universal coverage with a defined benefit package to insured persons (with a list of excluded services). Provision is decentralised (there are three tiers: central, regional and communal) and paid out by the decentralised NHF branches. Primary health care (PHC) is provided in outpatient clinics and at home (with doctors obliged to provide home services when required for medical reasons). Family doctors act as gate-keepers for specialist and hospital care. Specialist outpatient care (about 80%) is based on private medical practices or specialised health centres. Doctors (PHC) are paid on a capitation basis. Inpatient hospital care is provided in predominantly public hospitals. The system is financed mostly by insurance contributions with state, regional, county and local budgets financing some population groups (e.g. unemployed people) and capital investment. Private voluntary (supplementary) insurance is negligible. Some companies offer accident and health insurance packages (mostly outpatient care) to their workers. Co-payments apply to food, drugs, medical devices and transport. The national strategy aims at enhancing health promotion and healthy living, increasing the effectiveness of services, achieving better value for money and reducing the health status gap in relation to the EU average.

Accessibility: Though population and service coverage is high there are significant regional discrepancies in care availability (lack of certain specialists) and thus access to health care. Moreover, patients' out-of-pocket payments are high (26.2% in 2004 of total health spending plus informal payments) due to co-payments and the use of private sector hospitals, adversely affecting vulnerable groups. Waiting lists and times for some impatient services are extensive. This results in limited access and forces patients to opt for the private sector, where they have to pay the full cost of care. Waiting data is collected and is to be better monitored, however. The waiting list management system is being improved. The number of GPs is rather low (11.9 per 100 000 inhabitants) by EU standards and can be an obstacle to ensuring access and developing a functioning PHC system. Additional investment in infrastructure is planned, together with a 24-hour info-line and special electronic services (e-health). The authorities are

considering reducing patients' financial input by changing the system for reimbursing pharmaceuticals. As well as compiling a list of guaranteed health services, covered by the public health insurance scheme, the authorities are to extend its scope by introducing new schemes of health insurance. This will result in increased coverage and additional resources for the healthcare system. The authorities are improving the functioning of the national medical emergency system and aim to develop a hospital network, to avoid duplication of provision and strengthen the PHC system so that it becomes the first pillar to the system guaranteeing access. The main concern for the authorities in terms of access is extending the scope of insurance to achieve better and wider coverage of the population. A package of Health Care System Acts will introduce a defined 'basket' of guaranteed health services covered by the public health insurance scheme.

Quality: The Centre for Health Care Quality Monitoring (CHQM) provides independent accreditation on the basis of a published set of standards. Quality requirements, national guidelines and standards are to be developed based on independent expertise. Authorities are developing a health information system and systematic monitoring of quality indicators at different levels. An accreditation system for service providers is being developed on an ongoing basis. The use of technology assessment will increase, leading to evidence-based contracting of services. The authorities aim to publish a Patient's Guide to services, setting out patients' rights. Additionally the planned Health Care System Acts will define the rights and responsibilities of patients.

Long-term sustainability: Total health care expenditure (6.4% of GDP and per capita PPP$810 in 2004) is below the EU average[77]. Per capita expenditure has increased over time and in real terms. Public health expenditure represented 70% of total health expenditure in 2004, with private health expenditure standing at 30% of total health expenditure. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.4 percentage points of GDP by 2050 due to population ageing. The cost of drugs in relation to total health expenditure is one of the highest in Europe (30.3% in 2003). Increased demand for care is straining the financial sustainability of the system with a high, albeit declining, degree of indebtedness of care providers. To ensure extra funding, the NHF contribution rate is increasing annually by 0.25% from 7.5% in 2000 to 9% in 2007. Additionally, efforts to improve the effectiveness and efficiency of provided services, such as new rules for the accreditation and establishment of healthcare providers and the increase of public funding towards healthcare entities, are underway. The number of acute hospital beds has decreased and is about the EU average (463.2 acute beds per 100.000 inhabitants in 2003). Average length of stay has also decreased. Further restructuring is necessary: PHC needs to be strengthened and outpatient contacts need to increase vis-à-vis unnecessary and expensive specialist and hospital inpatient care. Agreed drug prices, reference prices and electronic prescription have been introduced to control pharmaceutical expenditure. The system of national health accounts is constantly being improved. Improving care coordination is to bring efficiency gains. With regard to staff, the number of medical professionals is low[78] in EU terms. The structure is imbalanced, with too many specialists. Wages are low and the authorities plan to progressively increase them in order to tackle staff migration. In order to improve health status and productivity, promotion and prevention is emphasised through various programmes (e.g. the National Programme for Cardiovascular Diseases).

[77] EU average was 8.87% and 2376.33 PPP$ in 2004

[78] 243.3 practicing physicians and 548.8 nursing staff per 100.000 inhabitants in 2003

5.2 Long-term care

Description of the system: The long-term care (LTC) system operates within both the health and social care sectors. Local bodies are responsible for the provision of long-term care. Under universal insurance coverage, long-term care can be provided in residential or nursing units and care units (hospitals) or as home care (but less so) and is complemented with PHC visits. Care services for lower-income groups can also be provided in social welfare centres. While care is funded by the NHF, food and accommodation is funded through the central budget for vulnerable groups, people with severe problems and chronic diseases, on a means-tested basis.

Accessibility: Social assistance is provided in welfare houses which pay additional costs that are not covered by the NHF. Local authorities test the conditionality for receipt of social assistance. They means-test according to household size and income, comparing that level to healthcare costs. New facilities have been set up, grants for service providers have been awarded and special training programmes for nursing staff pursued. Transforming acute care capacity into nursing capacity is a priority for the authorities. In the light of growing demands for LTC, the scope and availability of services are deemed insufficient. There is little state provision of community care services and too few nursing beds. Distribution across the country is uneven and coordination between different stakeholders is unsatisfactory, hampering access in smaller and rural areas.

Quality: The Health Care System Acts will cover the scope of PHC and specialist care (e.g. geriatrics) and the development of the hospital network, defining the competences and responsibilities of LTC entities. They will also enhance coordination between medical branches, competent authorities and social partners. The authorities have identified support for training of staff and nurses as a priority, both to improve quality and retain staff.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.1 percentage points of GDP by 2050 due to population ageing. Integrating health and social care services and developing the social infrastructure in rural areas remains a challenge. This will be partly addressed by the compulsory nursing insurance to be introduced, which will provide additional resources for financing the system by increasing the share of NHF funding.

6. Challenges ahead

To promote active inclusion by decreasing inequalities in the education system, further developing active labour market instruments, particularly for young people, women and older workers, implementing policies to make work pay for recipients of various forms of social transfers, and providing the social services needed to support integration in employment, especially for large families.

To pursue action to strengthen the administrative capacity of social assistance and labour market institutions, supported by mechanisms improving coordination of policies at various levels.To ensure that sufficient resources for adequate pensions are available until the funded schemes have matured, while monitoring future adequacy and raising the employment rate of older workers and people with disabilities.

To continue the pension reform process, by reforming the farmers' and disability pension scheme and organising the conversion of funded pension savings into safe annuities.

To ensure equal and better access to healthcare and LTC services by reducing regional discrepancies in supply (notably PHC), patients' direct financial burden of care and long waiting times, by increasing public health expenditure to address under-financing, and improve care purchasing and the administration of purchasing entities.

To improve system efficiency by strengthening PHC, outpatient care and day-case surgery vis-à-vis inpatient care and implementing pharmaceutical reimbursement reform.

Poland: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.2	46.7	**2000**	55,0	61.2	48.9	24.5	28.4	**2000**	16.1	14.4	18.1	35.1
2002	1.4	46.3	**2002**	51.5	56.9	46.2	21.7	26.1	**2002**	19.9	19.1	20.9	42.5
2004	5.3	48.7	**2004**	51.7	57.2	46.2	21.7	26.2	**2004**	19,0	18.2	19.9	39.6
2006	5.2f	51.1f	**2005**	52.8	58.9	46.8	22.5	27.2	**2005**	17.7	16.6	19.1	36.9

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (data for 1996 and 2002)		Infant mortality rate	WHO	Total health exp. %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	67.6	76.4	12.9	16.6	n.a.	n.a.	13.6	**1995**	5.6	72.9	-	n.a.	n.a.
2000	69.7	77.9	13.6	17.3	59.9	66.8	8.1	**2000**	5.7	70.0	30.0	n.a.	n.a.
2004	70.6sp	79.2sp	14.2sp	18.4sp	62.5	68.9	6.8	**2004**	6.4	70.0	26.2	n.a.	n.a.

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	19.5	55.8	19.8	4.6	5,0	0.6	14.1
2004	20.0	60.1	19.5	3.5	4.6	0.8	11.5

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2004	18.7	23.7	13.9	4.1	0.1
2010	18.8	20.2	n.a.	n.a.	n.a.
2030	35.7	14.4	9.2	5.1	0.1
2050	51.0	13.7	8.9	5.5	0.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	21b	29b	18b	20b	7b	30b	33b	29b	30b	17b	**Total**	6.6b
male	21b	-	19b	21b	5b	31b	-	30b	31b	19b	**male**	-
femal	20b	-	17b	20b	9b	30b	-	28b	30b	16b	**female**	-

	People living in jobless households					***Long-term Unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 16-54				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	n.a.	n.a.	n.a.	n.a.	**1999**	5.8	4.5	7.4	**1999**	n.a.	n.a.	n.a.
2004	n.a.	15.8	14.8	16.8	**2004**	10.3	9.6	11.0	**2004**	5.7b	7.7b	3.7b
2006	11.2	13.5	12.3	14.6	**2005**	10.2	9.3	11.4	**2005**	5.5	6.9	4.0

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	1.089b	1.204b	1.022b	***Aggregate replacement ratio***	0.585b	0.658b	0.573b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									Pensions (or social security)	pensions	
Total	Total	Statutory Pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory Pensions	Occupational and voluntary pensions			Current estimate (2002)	Assumption
-33	-27	-27	NDC and DC		n.a.	77	n.a.	n.a.	36.9	n.a.	n.a.

**:(DB / NDC/ DC); ** (DB / DC)*

2.21. PORTUGAL

1. Situation and key trends

Underlining the structural weaknesses of the economy, average GDP growth rate in the period 2001-2006 was below 1% per year (0.4% in 2005). The overall employment rate decreased from 68.4% in 2000 to 67.5% in 2005. However, the overall Lisbon target is still within reach and the intermediate targets for women and older workers were achieved in 2005 (61.7% and 50.5% respectively). Unemployment increased from 4% in 2000 to 7.6% in 2005, with a significant impact in youth and long-term unemployment. In 2005, the proportion of early school leavers remained extremely high at 38.6%, and the youth educational attainment level very low (48.4%). These two education indicators are very far below the EU averages. The at-risk-of-poverty rate after social transfers (20% in 2004) and inequality of income distribution (ratio 8.2 in 2004) are among the highest in the EU. Children and the elderly are most at risk of poverty.

Portugal is expected to face faster ageing than most EU Member States in the next decades. The old-age dependency ratio is projected to increase from 25.2% in 2004 to 58.1% in 2050. Public pension expenditure was 11.1% of GDP in 2004, and is projected to increase by 9.7 p.p. until 2050. Life expectancy at birth (74.9 for males and 81.5 for females in 2004) is slightly below the EU average,[79] showing a significant increase since 1995 (71.6 and 78.7) and a consistent increase over time (63.8 and 70.3 in 1971). Healthy life expectancy (59.8 and 61.8 in 2003) is below the 2003 EU average[80] and has remained stable since 1995 for men, with a small reduction for women. Infant mortality (4 in 2004) is around the 2004 EU average of 4.5, a reduction from 77.5 in 1960 and 7.5 in 1995. Perinatal mortality (5.1 in 2003 and 4.4 in 2004) is about EU average, a substantial reduction from 41.1 in 1960.

2. Overall strategic approach

To address structural weaknesses and promote social cohesion, Portugal has identified five key challenges: (i) to pursue economic development, improved competitiveness and budgetary consolidation, while making the necessary changes to structural factors that lead to greater social cohesion; (ii) to significantly reduce poverty levels by focusing on extreme and persistent situations of poverty and social exclusion, while preventing the reproduction of inequalities; (iii) to reform the social protection system to ensure its efficiency, adequacy and financial sustainability; (iv) to improve access to social services, in particular to health and long-term care, and to quality social infrastructure, as a means of promoting healthy working lives and reconciliation of work and family life; (v) to improve the effectiveness of governance in drafting, implementing and assessing policy.

Portugal has significantly improved its strategic approach, and focused on a small set of core priorities that address the key challenges in a fairly comprehensive manner. Although not covering the multitude of existing problems, the strategy has the potential to produce a significant impact on social cohesion, if strongly pursued and sustained by all stakeholders, over the long term. Most of the social inclusion measures have identified the necessary financial resources, set quantified targets, and monitoring indicators. Setting clear overall targets for the main political priorities would give the strategy further credibility.

[79] EU average of 75.8 and 81.9 for males and females in 2004.
[80] EU average of 64.5 and 66 for males and females in 2003.

Social cohesion is one of the key challenges in the Lisbon National Reform Programme (NRP). The 2006 NRP Implementation Report shows substantial progress in incorporating some of the priorities and measures of the Open Method of Coordination (OMC) on Social Inclusion. The "Employment" chapter now identifies shared priorities as raising the qualification levels of the population, reconciling work and family life, and developing activation policies for those excluded from the labour market. The "Macro" chapter includes the reform of the health and social protection systems to ensure their sustainability and adequacy, while the "Micro" chapter sets out action on the structural factors that strongly contribute to reproduce patterns of social exclusion.

Governance of the strategy has been improved by increasing policy coordination mechanisms, and increasing the involvement of the main stakeholders. Through the Non-governmental Forum for Social Inclusion, stakeholders were given a real opportunity to contribute to the process from the conception stage. The potential contribution of Local Social Networks (LSN) has not been fully exploited to profit from their knowledge of local realities and experience. The report could have provided more strategic gender guidelines in close coordination with existing national structures responsible for gender issues. The collection of gender-related data has scope for improvement and the report could be more specific on identifying measures to assess the gender impact of the proposed policies.

3. Social inclusion

3.1 Key trends

The economy remains structurally weak, with a development model based on unskilled and labour intensive activities that offer low wages and poor quality jobs, resulting in low levels of productivity and a high number of working poor (11.4% in 2003). The difficult budgetary situation, with a general government deficit of 6% of GDP in 2005, a large external deficit, and high private sector indebtedness, has strongly conditioned economic recovery.

Youth employment decreased from 42.2% in 2000 to 36.1% in 2005 (40.5% for men and 31.4% for women). However, the employment rate of women continued to increase, from 60.5% in 2000 to 61.7 in 2005.

Unemployment has increased significantly, from 4% in 2000 to 7.6% in 2005, with long-term unemployment now accounting for almost 50% of that total. The youth unemployment rate was 8.8% in 2000, but increased significantly to 16.1 in 2005 (13.6% for men and 19.1% for women). The labour market continues to be highly segmented, with almost 40% of all those employed being either on fixed-term contracts or self-employed. The gender gaps in employment and unemployment favour men, but have decreased slightly since 2000. The gender pay gap in the private sector remained at almost 25% in 2005.

Despite falling since 2000 (when it was 42.6%) the proportion of early school leavers continues to be extremely high and was still 38.6% in 2005 (46.7 for men and 30.1 for women). The educational attainment of young people has improved, from 42.8 in 2000 to 48.4 in 2005 (40.4 for men and 56.6 for women). These two indicators are still very far below the EU averages and the situation is particularly serious for men, with the gender gaps increasing since 2000.

The at-risk-of-poverty rate after social transfers (20% in 2004) and inequality of income distribution (ratio 8.2 in 2004) are among the highest in the EU. Older people (in particular

women) and children are most affected by poverty. In 2004, social protection expenditure was 24.9% of GDP, far below the EU average of 27.3%.

3.2 Key challenges and priorities

The report identifies six multidimensional and systemic risks that strongly affect social inclusion in Portugal: (i) child and elderly poverty; (ii) school failure and early school leaving; (iii) low qualification levels; (iv) low participation in life-long learning; (v) info-exclusion; (vi) inequality and discrimination in the access to rights of people with disabilities and immigrants. These risks have been substantiated with statistics and detailed analysis.

To address these risks, three key priorities have been established: (i) fight child and elderly poverty, through measures ensuring basic rights of citizenship; (ii) correct the disadvantages in qualification levels, as a means of preventing exclusion and interrupting poverty cycles; (iii) overcome discrimination by including the disabled and the immigrants.

The overall strategic approach seems adequate and focused on a clear set of non-exhaustive priorities, while paying increasing attention to operational aspects. However, the complementarities between existing and proposed actions are unclear (e.g. links between the Critical Neighbourhoods Programme and Social Development Contracts, and the existing work done by the LSN). The synergies between the three strands of the OMC could have been further developed. The specific needs of the most vulnerable (e.g. immigrants and the homeless), for example that of health care access, are not adequately addressed. Moreover, social transfers are known to have little impact on reducing poverty in Portugal. The report could have further elaborated on how the social security reform will address this serious weakness.

Portugal has responded positively to the challenges identified in the 2006 Joint Report, by setting up mechanisms to mainstream social inclusion in relevant policy initiatives and establishing closer links with the reforms being conducted under the Lisbon Process. Furthermore, there has been a strong effort to streamline the extensive list of sometimes overlapping and redundant measures, while increasing their clarity, attributing responsibilities, establishing schedules for implementation and allocating financial resources. These efforts need to be further pursued and improved, for example by setting precise deadlines and clear measurable monitoring and impact indicators for the various priorities. Measures to tackle inequality in income distribution are not sufficiently detailed. The report does not elaborate on how the Structural Funds are going to support the proposed measures.

3.3 Policy measures

Reducing child and elderly poverty is a major policy priority with cross-cutting measures such as the activation instruments in the Social Integration Income scheme and the Social Development Contracts, as well as specific measures designed for each of these target groups. Targets for reducing child poverty include 200 000 family allowances to support single parents, and the achievement of the Barcelona commitments for child care. For the elderly, the measures include a "solidarity supplement" to increase income to a minimum of EUR 4200 a year. Although the measures and targets are very positive developments that clearly contribute to the objectives, they are not sufficient to reduce poverty significantly.

To correct disadvantages with regard to educational attainment**,** strong links have been established with the measures provided for in the National Reform Programme and in

particular with the *Novas Oportunidades* initiative. Targets include reducing the proportion of early school leavers to 25% by 2009, reducing school failure by 50% by 2009, and training one million working-age adults by 2010. The measures and the very ambitious targets seem adequate to address the structurally low educational attainment of the population, but they do not focus on those most subject to exclusion. Furthermore, they do not include operational information such as the quality control and evaluation mechanisms proposed to ensure that the stated social integration and employability objectives are achieved.

People with disabilities and immigrants have been identified as particular target groups for tackling discrimination. For the disabled, measures focus on increasing access to goods and services and fostering integration in the labour market to increase their social and professional participation and economic independence. Targets include assigning 4 000 special education teachers to support 26 000 young people, and education/training courses for 46 000 people with disabilities. For immigrants, the legalisation process has been simplified and the network of centres providing integrated support is to be further improved. Targets include giving schools the autonomy to cater for the 80 000 foreign students and provide active employment measures for 38 500 unemployed immigrants by 2008. Although specific measures for both these target groups are necessary and justified, the report does not explain the criteria for selecting them rather than others (e.g. the homeless, people in debt, ex-offenders, Roma, etc.). It is not clear how the proposed measures are expected to produce a lasting impact on these target groups.

A significant improvement on previous National Action Plans (NAPs) is the fact that for most measures the necessary financial resources have been identified, and that quantified targets are linked to concrete objectives. However, some targets lack any preceding diagnosis or contextual framework, which makes it difficult to understand the reasoning for the quantification being proposed. Most indicators allow only quantitative achievements to be monitored, which makes it difficult to assess whether the measures achieve their expected impacts. For some measures, there is also a clear need for operational objectives which would explain how they will be put into practice.

In spite of the effort made to collect gender-related data and the explicit concern for gender mainstreaming, the measures and targets do not translate this concern into operational action.

3.4 Governance

The Ministry of Labour and Social Solidarity is ultimately responsible for coordinating and drafting the Social Inclusion Strategy. A National Coordinator supported by a Technical Team has been appointed to coordinate, draft, monitor and evaluate the strategy. An Inter-Ministerial Commission, established by the Council of Ministers, includes representatives from the various national ministries, from the Autonomous Regions of Azores and Madeira, and from the Non-Governmental Forum for Social Inclusion. This Commission is also responsible for monitoring the whole process. The LSN are expected to have a major operational role in implementing the Social Inclusion Strategy.

For the first time since the launch of the OMC on Social Inclusion, civil society (namely the NGOs), had a real chance to actively participate in the first stage of the preparation of the NAP. The Inter-Ministerial Commission, which was rather ineffective in the past, has created the conditions to enhance its role in the process. The quality of stakeholder involvement could be further improved by developing adequate and effective coordination mechanisms with the LSN. During the planning phase, the meetings conducted with the LSN had essentially an

informative role, which meant losing out on all their operational experience and field knowledge.

The setting up of Focal Points within each Ministry clearly adds value to the strategy, and reinforces the organisational and institutional mechanisms. While important, these Focal Points will need strong support, because mainstreaming social inclusion demands an active approach in different governmental departments. With the growing number of participatory mechanisms and contributions from different sectors and different levels of governance, there is an increased risk of conflict, competition and unnecessary overlapping. Therefore, it is vital that the strategic coordinating role of the NAP be reinforced.

The monitoring and evaluation mechanisms provide for a new model of coordination based on national and local information systems. This is a challenging task due to the huge variety within the different LSNs, and in their capacity to contribute effectively. It will be a long process, which needs a clear strategic and participatory approach in close cooperation with the local structures to build on existing work, while adapting it to new challenges.

4. Pensions

In 2004, older people had a relative living standard relatively close to that of the general population (77%). The poverty risk among older people (28%) is estimated to be higher than that of the population below the age of 65.

The 2006 Sustainability Report assessed Portugal as a high-risk Member State as regards sustainability of public finances, notably due to the high projected increase in age-related expenditure. Portugal is expected to face significant pressure on its public finance system resulting from ageing populations. According to the AWG's 2005 projections, public spending on pensions is set to rise from 11.1% of GDP to 20.8% between 2004 and 2050. This increase in pension spending is one of the highest in the EU, resulting in a serious risk to the long-term sustainability of public finances. According to ISG projections, theoretical replacement rates are set to remain stable overall. In the case of a worker retiring at 65 after 40 years of a career at the average wage, the net replacement rate would be stable at 91% in 2005 to 92% in 2050 (gross replacement rate declines from 75% to 70%).

The 2006 Joint Report stressed progress as regards adequacy of pensions and highlighted the importance of further reforms, in particular regarding measures to strengthen the incentives for active ageing and defining a framework to support supplementary individual savings.

The Government and social partners signed an agreement on the reform of social security in the second half of 2006. Detailed proposals will now have to be approved by Parliament. The changes introduced by the current reform (the Framework Law on Social Security is already enacted, the specific legal framework on pensions benefit formula, currently under public discussion, is expected to be passed into law on the short term) are expected to enter into effect as from early 2007, and be gradually phased in until 2016. The proposal introduces significant changes in the calculation of pension benefits (e.g. introducing a mechanism that adjusts benefits to changes in life expectancy) and introduces a new indexation mechanism for calculating adjustments to pension benefits (replacing the national minimum wage as a reference). It is essential that reform leads to a strengthening of incentives to work longer and contributes to more equitable treatment of members of different schemes. The progressive convergence of the various public social security sub-systems (private and public sectors) will not only contribute to greater equity among beneficiaries but also to future sustainability.

Future generations with complete insurance careers in better-paid employment will receive higher pensions than most current pensioners who had on average shorter contribution records. In this respect it remains to be seen whether the modernisation of occupational pension schemes will enable an appropriate contribution to be made to future adequacy, notably as regards gender differences. To help alleviate current poverty risks, a major priority has been the establishment of a minimum level of income for old-age pensioners, which could particularly benefit women. The new tax-financed social benefit Solidarity Supplement for the Elderly, launched in 2006, will progressively be extended to all those above 65 years.

5. Health and long-term care

5.1. Health care

Description of the system: A National Health Service (NHS) provides coverage to all. NHS primary health care – PHC (general and family medicine, promotion and prevention) – is provided through a network of health centres and outreach services and private profit and non-profit entities that provide care for NHS users. In the NHS general practitioners (GPs) refer patients for specialist care, operating as gate-keepers. Specialist care is provided in hospital outpatient departments and by private entities with established Ministry of Health contracts. The NHS provides most hospital inpatient care (74% of all inpatient beds). Private provision consists of: a) diagnostic, dental and therapeutic care, often contracted by the NHS and b) specialists' private practice, in private facilities for private users. NHS doctors are salaried while private doctors are paid a fee for service. The NHS is mainly funded by general taxation. Co-payments apply to pharmaceuticals, consultations, hospital care and home visits. A number of social health insurance schemes based on employer and employees' contributions fund health care for 25% of the population (e.g. civil servants and the banking sector), who directly access any specialist or hospital allowed by their scheme. 14.8% of the population has voluntary health insurance (duplicate, supplementary or complementary). Despite the large health improvement since the 1970s, the authorities point to the need to improve health status further through promotion and prevention activities. Moreover, recognising the need to improve access and quality, they propose to reform PHC, to reinforce it as the central pillar of the system and to ensure (preventive and curative) care for all including to those who are more vulnerable or at greater risk. Reinforcing resource planning and management and attaining better value for money are other goals of current policy.

Accessibility: High private expenditure (out-of-pocket payments were 29% of total health expenditure in 2004), high reliance on indirect taxes and the various social insurance systems lead to regressive financing and a pro-rich use of care. The lack of GPs and certain specialists in rural areas and certain regions, the concentration of resources in hospitals, big cities and the coast and NHS lack of coverage of certain services (e.g. dental care) are highlighted as obstacles to access. This also interferes with the running of a PHC-led NHS and leads to unnecessary use of expensive hospital and emergency care. Increased social inequality and access inequities have lead to a greater prevalence of less healthy lifestyles, ill-health conditions (e.g. tuberculosis) and health inequalities. The authorities are setting up a contact centre that provides information and help on how to access and find one's way around the NHS. They are restructuring PHC to create small family units (multidisciplinary and autonomous, providing a common basket of services under an NHS contract) that are closer to the home or workplace and are better matched with hospitals and long-term care units. A range of ehealth mechanisms (health portal, electronic health records, tele-appointments, electronic prescription, information networks between health care entities) and direct phone

lines (e.g. a paediatric line, an influenza line) are to improve access to care. To better manage waiting times and lists an integrated waiting list management system is to be extended to the whole country. Over-the-counter medicines can now be sold in a variety of places.

Quality: The state ensures quality standards in public and private institutions. An independent quality authority has been established. Quality measures include: audits, inspections, national accreditation and qualification for facilities, a national safety programme to prevent hospital infections, national clinical guidelines and national staff safety guidelines. Investment has been made in developing information systems to improve the monitoring and evaluation of processes and outcomes. Legislation has established patient rights and choice (seen as informed choice, compatible with referral networks and respecting rational resource use). The government plans for the participation of beneficiaries in services management as a means to identify problems and search for solutions and patient satisfaction is to be closely monitored. Ethic commissions and an ethics charter are to promote professionalism, good practice and respect for users. The authorities also wish to improve coordination between services (notably via ehealth solutions), ensuring that primary, hospital and long-term care act as a network. The report refers to several screening schemes.

Long-term sustainability: Total health care expenditure (9.8% of GDP and 1903 per capita PPP$ in 2004) is above the EU average[81] in GDP terms. Public expenditure as a share of total expenditure (69.7% in 2004) is below the EU average but increasing. The 2006 EPC/EC age-related projections suggest an increase in public expenditure of 0.5 percentage points of GDP by 2050. In this context, slightly more public funding could be used to improve access and ensure effective prevention and promotion policies. The authorities identify the ineffective referral system and care coordination, high patient expectations and specialists' perverse behaviour as notable challenges. These have resulted in a doubling of diagnostic procedures and overuse of (expensive and unnecessary) specialist, hospital and emergency care. The authorities stress that the pharmaceutical industry's influence and the fact that pharmacies act monopolistically has resulted in overprescribing and excessive cost. They propose to use generics, reference prices, a rational use of medication, electronic prescription and protocols with the industry to lower pharmaceutical expenditure. The authorities are introducing a purchaser-provider split and establishing contracts (partly based on DRGs) with all hospitals (more autonomous but regularly evaluated) for the provision of care. They want to promote complementarities between hospitals and avoid duplication in each region. Joint procurement of goods is to be introduced. With regards to staff, medical training has increased and the number of doctors and nurses is close to the EU average. However, the number of GPs is still imbalanced with respect to specialists: GPs are 29.5% of the total number of doctors. Furthermore, there was a reduction in numbers of GPs from 70.1 per 100 000 inhabitants in 1990 to 55 in 2002. The authorities are strongly focusing on human resource planning and continuous training. They expect that promotion in different sectors and settings can help reduce premature mortality.

5.2. Long-term care

Description of the system: The "Misericordias" and other non-profit organisations operate facilities for rehabilitation, long-term care and residential care. Day care centres provide activities, meals, laundry services, bathing, assistance with medication and attendance at health centres. There are a number of private nursing and residential homes. A joint venture

[81] EU average of 8.87% of GDP and 2376.33 per capita PPP$ in 2004.

between the Ministry of Health and Ministry of Labour & Social Solidarity has been established to define a long-term care plan for dependent individuals and patients with progressive chronic pathologies. It is a partnership of health authorities, municipalities and public and private/ third sector providers. The system will include convalescence units integrated in acute hospitals and other institutions, medical medium-stay units, rehabilitation units, long-term care institutions, palliative care units, day care, hospital teams preparing patient discharge to other settings, mixed teams providing PHC and social support in health centres, social security centres and at home and mixed teams in hospitals and in the community providing support and counselling for palliative care. Simultaneously, the authorities are promoting responses adjusted to the needs of the elderly with dependency in different moments of the evolution of the illness and possible social complications.

Accessibility: The government recognises the weaknesses of long-term care. There is little state provision of community and home services and care is concentrated in large cities. Private nursing homes are very expensive and most have no means to pay for them. The new plan aims to improve access (with full implementation at national level by 2016), launch information campaigns and strengthen the use of ICT (e.g. telemedicine and call centres).

Quality: The authorities see public sector residential care as being of poor quality and lacking resources. The National Network of Integrated Continuous Care is to monitor, both health care and organisational quality. The Network units and teams are subject to regular (self and external) evaluation by the regional coordination team. The use of contracts will clarify the responsibility of providers.

Long-term sustainability: There is a political guarantee of: specific funding; centralised control of management and financial allocation; payment models to providers, adapted to the nature of the services; and permanent economic and financial evaluation.

6. Challenges ahead

To closely monitor and evaluate the impact of measures relating to the minimum income scheme, ensuring effective social integration of groups at risk.

To ensure that the groups furthest from the labour market benefit from mainstream measures to raise the qualification levels of the population, with a particular focus on the large numbers of unskilled working poor and early school leavers.

To implement the pension reform, with the aim of improving financial sustainability and ensuring that sufficient resources for adequate pensions are available, notably through the promotion of longer working lives and establishment of a comprehensive active ageing strategy that promotes longer healthy working lives in quality jobs.

To tackle regressive financing in healthcare, reduce the financial costs of care for disadvantaged groups, reduce geographical disparities of supply and enhance the provision of long-term care.

To improve efficiency (notably through reinforcing primary care, adjusting hospital capacity and controlling pharmaceutical expenditure) and implement comprehensive all-ages promotion policies to improve health status and reduce health inequalities.

PORTUGAL: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,9	80,3	**2000**	68,4	76,5	60,5	42,2	50,7	**2000**	4,0	3,2	4,9	8,8
2002	0,8	79,5	**2002**	68,8	76,5	61,4	42,2	51,4	**2002**	5,0	4,1	6,0	11,6
2004	1,2	71,8	**2004**	67,8	74,2	61,7	37,1	50,3	**2004**	6,7	5,8	7,6	15,3
2006	1.2f	69.8f	**2005**	67,5	73,4	61,7	36,1	50,5	**2005**	7,6	6,7	8,7	16,1

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health exp.% of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	71,6	78,7	14,6	17,8	59,6	63,1	7,5	**1995**	8,2	62,6	-		
2000	73,2	80,0	15,3	18,7	60,2	62,2	5,5	**2000**	9,2	69,5	29,2	100,0	14,8
2004	74,9sp	81,5sp	16,2sp	19,7sp	59.8e	61.8e	4,0	**2004**	9,8	69,7	29,0		

s: Eurostat estimate; p: provisional **THE: Total health exp.enditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old-age and survivors	Sickness and Health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	21,0	41,1	36,2	5,3	5,2	0,4	11,8
2000	21,7	44,7	32,0	3,7	5,4	1,4	12,7
2004	24,9	47,2	30,4	5,7	5,3	1,0	10,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes sinc			
		Total social expend.	Public pensions	Health care	Long-term care
B 2004	25,2	23,8	11,1	6,7	
2010	26,5	0,4			
2030	39,0	4,2	4,9	-0,1	
2050	58,1	9,8	9,7	0,5	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	24	19	18	28	27	28	26	29	17	**Total**	8,2
Male	20	-	19	17	28	27	-	26	30	16	**Male**	-
femal	21	-	20	18	28	27	-	26	29	19	**Female**	-

	People living in jobless households					***Long-term Unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 16-54				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	4,5	4,7	4,1	5,3	**1999**	1,8	1,5	2,1		**1999**	44,9	50,8	38,9
2004	4,3	5,3	5,0	5,7	**2004**	3,0	2,6	3,4		**2004**	39.4b	47.9b	30.6b
2006	4,7	5,8	5,3	6,4	**2005**	3,7	3,2	4,2		**2005**	38,6	46,7	30,1

** excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0,775	0,785	0,763	***Aggregate replacement ratio***	0,628	0,612	0,678

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Current estimate (2002)	Assumption
1	-5	-5	DB			82			32.6 g		

**:(DB / NDC/ DC); ** (DB / DC)*

2.22. ROMANIA

1. Situation and key trends

Since 2000, Romania has seen its GDP grow by around 5% per annum in real terms. GDP growth in real terms in 2005 was 4.1%, and the forecast for 2006 is for 7.2.1% [sic]. However, per capita GDP in PPS[82] is only around one third of the average for the EU25. Although the GDP growth figures are encouraging, the employment rate has been fairly constant since 2002 — in 2005, it was 57.6%, with employment in subsistence agriculture still quite high, despite the fall recorded recently (from 41.4% in 2000 to 31.7% in 2004)[83]. In general, this type of employment yields very little monetary income and is a major source of poverty. Its important role, as well as emigration of working-age persons, may explain how the number of employees has fallen without a corresponding increase in the unemployment rate. According to the NSI[84], the activity rate in 2005 was 62.4% (69.5% for men and 55.3% for women). The female employment rate (51.5%) is still below the European average. The employment rate for young people has been falling steadily since 2000[85] (from 33.1% in 2000 to 24.9% in 2005), and the same trend can be seen among older workers, with a recovery in 2004, when the employment rate rose from 36.9% (2004) to 39.4% (2005). The unemployment rate is 7.2%, lower than the European average, although the rate for young people is still a cause for concern (20.2%, 2005).

The at-risk-of-poverty rate[86] was 18% in 2004, with higher rates for rural areas, Roma people, children and elderly women. The total population has fallen recently, from 22.8 to 21.7 million, because of a low fertility rate (1.3), one of the highest stillbirth rates in Europe (16.8 in 2004), a life expectancy at birth also one of the lowest in the EU (68.3 years for men and 75.6 years for women in 2004), and high emigration between 1990 and 2002. Social expenditure rose during this transition period, but it is still one of the lowest in Europe (a national source quoted a figure of 19.4% of GDP in 2005[87]).

2. Overall strategic approach

The challenges to be met in the area of social protection and social inclusion include: population shrinkage and ageing, the extent of the informal economy and high rates of employment in subsistence agriculture, the quality of human resources, the insufficient development of social services in terms of their territorial coverage, quality and diversification, the continuing low level of social benefits, obstacles for vulnerable groups trying to gain access to the labour market, services and resources.

For the period 2006/2008, the strategic objective chosen by Romania is "creating an inclusive society" able to provide the resources and means to ensure that all citizens have a decent life. The strategic approach presented is ambitious and poses significant challenges for Romanian

[82] Purchasing Power Standards (PPS)

[83] Data from the National Statistical Institute (NSI), processed by Catalin Ghinararu

[84] National Statistical Institute (NSI)

[85] In 2002, the definitions were revised, which means that the indicators are not always compatible with the series of data from previous years.

[86] Data for all income-based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc.) are based on the national household budget survey that is adjusted ex-post to the EU harmonised SILC methodology but is not fully compatible with the SILC detailed definition of income.

[87] NSI data processed by Zamfir, 2005

society. However, subsequent progress evaluations could benefit from a choice of quantified indicators appropriate for the country's situation. Developing a coherent framework for the sectoral strategies and a shared vision and understanding of social inclusion would be appropriate at this stage. The strategy identifies and encourages an integrated approach based on partnership, with roles for all those with responsibilities in this area. The gender dimension is another priority, and clearer references would be desirable as far as women's work/home life balance, the lack of services in this sector and the serious problems affecting some women (e.g. the trafficking of women, domestic violence, insufficient and ineffective family planning services, etc.) are concerned.

3. Social inclusion

3.1 Key trends

The groups most at risk of poverty include the rural population (70% of poor people live in rural areas), the Roma (three times poorer than the average), elderly women, single-parent familes, households with three children or more and the long-term unemployed. Certain children and young people can also be identified as the next generation of poor people. The level of poverty quoted in the strategy is 18.2% in 2005, slightly down on the previous year. The available Eurostat data indicate a falling risk-of-poverty rate both before social transfers (from 23% in 2002 to 22% in 2003) and after them (17% in 2003, compared to 18% in 2002). The number of children living in households where no one has a job has fallen (from 11.1% in 2004 to 10% in 2006). The same trend can be seen for persons aged 18-59 years. The long-term unemployment rate has stayed relatively constant at 4.4% in 2005 (4.7% for men and 3.9% for women). However, this indicator does not reflect the true situation, because many inactive persons claiming social benefits are capable of working but are considered "inactive" because of a lack of alternatives to work. Out of all inactive persons in Romania, 27% are young people and 51.8% are pensioners and persons on social benefits. One worrying phenomenon is youth unemployment (20.2% in 2005). As far as school drop-out is concerned, a fall has been recorded from 23.6% in 2004 to 20.8% in 2005, but it still remains high. The situation is worrying for Roma children, 17.3% of whom aged between 7 and 16 years have no formal education. More than a third (38.6%) of the Roma population is functionally illiterate.

3.2 Main challenges and priorities

Romania's concerns in the field of social inclusion for the coming period are in line with the main challenges identified in part 2. above. They focus on facilitating access and return to employment for persons furthest from the labour market, increasing the level of benefits and implementing a national social services strategy and sectoral strategies.

3.3 Political measures

In order to create an inclusive society for all, the three priorities are: i) to increase the population's standard of living by increasing income from work, stimulating employment and promoting inclusive policies; ii) to facilitate access to resources, rights and services**;** iii) to improve living conditions for the Roma population.

As regards the first objective, the Romanian Government has proposed continuing with existing measures to stimulate employment in general (e.g. new employment promotion programmes, increasing the budget for active measures, improving the legislative framework

in order to encourage employers to recruit persons at risk of social marginalisation, stimulating job creation in rural areas, raising the gross minimum wage, etc.). Increasing employment will certainly have a positive impact on reducing poverty and social exclusion, but specific measures and policies for the active integration of vulnerable groups and those living in disadvantaged areas (rural areas in particular) should also be stepped up.

The second objective, "to facilitate access to resources, rights and services", is very ambitious and corresponds to the priorities identified in the Joint Inclusion Memorandum (JIM). The introduction of quantified objectives would be useful in order to give a precise idea of what is expected. Improving access to health services is one of the priorities identified in the JIM and should be one of the priorities listed under this objective. Measures to prevent discrimination against vulnerable groups should also be considered a priority.

The measures planned for the priority concerning the improvement of living conditions for the Roma population are designed to improve the social and educational integration of Roma people (improved access to education, to the labour market and to housing, solving the problem of persons without identity papers, etc.) and to improve interinstitutional dialogue and cooperation. A large proportion of the Roma population work in the informal economy. Measures to combat this phenomenon, with a serious impact on the social protection system, should be stepped up over the coming period. Particular attention should be paid to measures targeting Roma women.

These three objectives are ambitious, in line with the priorities in the Joint Inclusion Memorandum (JIM). In order to achieve them, there must be a clear and sufficient budget, a description of the content and phases of the planned programmes and quantifiable indicators for each objective.

3.4 Governance

The strategy was drawn up by the Ministry of Labour, Social Solidarity and the Family, with contributions from the other ministries and agencies directly involved. The drafting of the strategy would have benefited from the greater participation of all those with responsibilities in this area (local authorities, NGOs, providers of social services, etc.), as the mobilisation of all those involved is both an instrument and a goal, in order to achieve social inclusion and protection objectives.

The strategy identifies, for each priority objective, the institutions responsible for implementing them. Particular attention should be paid to stepping up the capacity of local authorities. Evaluation and monitoring will be performed using a management information system to allow the collection and analysis of data at central, regional and local levels. A national mechanism to promote social inclusion, with the aim of broadening the institutional consultation at territorial level, is being drawn up. The social monitoring centre, a new institution currently being established (Act 47/2006), will monitor the impact of social policies.

4. Pensions

Like all EU Member States, Romania faces significant demographic challenges, with projections for Romania's future old-age dependency ratio being close to the EU average: 21.1% in 2005, rising to 51.1% in 2050.

Eurostat's figures for Romania's pensioner poverty for 2003 show a poverty rate of 17% for those over the age of 65 (with a significant gender gap: 24% for women and 14% for men). This is higher than the EU average, although slightly lower than that of the 0-64 population in Romania, which was 18.4%. Poverty levels have remained stable in recent years, decreasing by a couple of percentage points in the last year. Attention should be paid to the large gender discrepancies at risk of poverty.

According to national sources, public expenditure on pensions remained stable at 6.5% of GDP between 1995 and 2005. In 1995, the pension system registered deficits that were covered by transfers from the State budget, while for 2006 forecasts suggest that there will be a surplus (mainly due to the cut in spending as a result of the externalisation of short-term benefits and the removal of liabilities relating to the pensions of independent farmers). The average pension in Romania is 38.8% of the average wage (national sources, including those with incomplete contributory histories, early retirement pensions and invalidity pensions).

Romania's pension system has undergone substantial reform in the last decade, resulting in a system that aims to offer more equity and sustainability in the long term. The system itself, with the reforms of the pay-as-you-go component and the development of new funded provisions (both mandatory and voluntary), mirrors similar reform packages undertaken across Europe, especially in the new Member States. A notable difference in the development of funded provision is the lack of involvement of employers (through collective agreements) in the new system. This may have a considerable impact on the success of including significant proportions of the employed workforce in voluntary saving for retirement.

The recent reforms to the pay-as-you-go system, and measures designed to increase the levels of pensions for those outside the p-a-y-g system (most notably independent farmers), have resulted in increases to all pensions and subsequently in poverty levels for the current generation of older people being lower than that of the general population.

However, Romania faces a real risk of high levels of old-age poverty for future cohorts due to a significant proportion of current workers not contributing to the pay-as-you-go system, as in the case of current independent farmers with insufficient contributory records to qualify for specific assistance. With only a third of current workers contributing to the State pension system, both long-term sustainability and adequacy could be a serious challenge. Romania must step up its efforts to increase employment while ensuring a corresponding increase in contributions to the pension system (notably as regards the collection of contributions). Consideration should also be given to the position of women and carers, to ensure that the pension system does not penalise them for their caring roles. Failure to do so may result in the development of a two-tier system, where those who have contributed in their working lives have adequate retirement pensions, but a large proportion of elderly individuals will be reliant on means-tested assistance, leading to the need for large and unpredictable transfers of revenue to the elderly in the future.

5. Health and long-term care

5.1 Health care

Description of the system: Major reforms in health care have transformed the centralised, tax-based system into a decentralised and pluralistic social health insurance system with contractual relationships between health insurance funds as purchasers and healthcare providers. The system covers the whole population through public and private facilities. It is

insurance-based with mandatory, employment-linked, membership and contributions are a percentage of income paid in equal proportions by the employer and the insured. Primary health care (PHC) has been reformed and GPs are independent practitioners, contracted by the insurance funds, operating in private practices. They act as gatekeepers, with outpatient treatment requiring a referral. Ambulatory services are provided by outpatient hospital departments and specialised centres. Private practice is allowed, although hospitals are mainly publicly owned. The District Health Insurance Funds (DHIF) collect insurance contributions, contract healthcare providers and ensure payment and reimbursement. The National Health Insurance Fund (NHIF) can reallocate up to 25% of the collected funds to under-financed districts. 5% of the funds collected must be set aside for reserves. The NHIF negotiates contracts with the College of Physicians. The State budget (taxes) has retained responsibility for public health services funding, capital investment and preventive policies. Formal co-payments are required for drugs expenditure, out-of-pocket payments are considerable and there are significant under-the-table payments to public providers. Hospitals are financed according to hospital activities and their ownership is to be transferred to the local councils. All physicians' income is provided by the DHIFs on a contractual basis. In PHC, their payment is a mix of weighted capitation (70%) and fees for services (30% for preventive services). Ambulatory secondary care physicians are paid on a fee-for-service basis. Hospital staff are salaried. The national strategy prioritises increased access for disadvantaged groups and improving the quality of the services provided.

Accessibility: Children, dependants, war veterans and the disabled have free access to health insurance. The high proportion of private out-of-pocket payments (33.5% of total health expenditure in 2003) and the non-affordability of health services effectively hinder access. Despite the reforms and integration of PHC, a large proportion of the population are not registered on a family doctor's list. Recent increases in the numbers of medical staff have not resolved accessibility issues in rural areas that are isolated, lacking specialised services and far away from health units or hospitals. This is of particular importance for the Roma population. Although pilot programmes and the legal framework for developing a network of community nurses have been initiated (starting in 2002), the process of implementation needs to be further intensified and extended to reach the most vulnerable and isolated communities. In 2002, a national system of Roma mediators was developed. Their role is to improve the health status of the Roma communities and their number has been increasing. Differentiated access is also due to heterogeneous territorial distribution of hospitals, hospital beds and medical staff. Another important problem is that care is provided, after referral, to persons covered by health insurance, thereby disqualifying the non-covered. This is a dual problem of lack of GPs and non-registering on GP lists. Ambulatory services are materially limited and need to be improved. In addressing accessibility issues, medical assistance has to be provided, whether on a GP list or not, on the basis of a minimum medical package which has been introduced (emergency) and is legally enacted.

Quality: For PHC, there is a free patient choice of GP and hospital. Legal regulations are often misinterpreted by the DHIFs, creating confusion about patients' rights. Insured persons are often misinformed about their rights and obligations within a wider setting, there being a lack of evaluative and controlling mechanisms. One option for quality improvement through increased funding is expanding private provision. With the exception of capital investment, redistributive mechanisms are in place without, however, showing any immediate quality improvements. The main difficulty for quality improvement is the misdistribution and low pay of specialised medical staff, requiring renewed training investment and retraining. Efforts have been made to concentrate resources on the best-performing health institutions and

eliminate poor-quality hospitals and specialised centres. The resulting decrease in hospital beds has not been matched by the corresponding development and quality improvement of ambulatory services. Equipment acquisition is problematic with important regional disparities.

Long-term sustainability: In 2004, total health care expenditure was estimated to be 5.7% of GDP. In 2004, the share of public health expenditure was 59.6% of total health expenditure, whereas out-of-pocket payments were on the increase and accounted for 36.3% of total health expenditure. In ambulatory care, the payment of physicians based on a fee for service with a points system can cause low reimbursement and payment values due to the single closed budget for those services. The authorities aim to develop a unique information system (ICT), which would increase the system's efficiency and performance through informed access to a patient's health files and tackling of informal and unregulated pharmaceutical provision. Although total health care expenditure appears to be on the decline, the measures announced to integrate PHC can be beneficial for the long-term sustainability of the system, and make for more rational and efficient use of resources and medical staff. This is important, as the referral system is often bypassed. In an effort to tackle high private expenditure, co-payments for specialised care will be introduced, addressing hospital overuse and informal payments.

5.2. Long-term care

Description of the system: There is no comprehensive community-based social care network. External assistance and support is still very important to the future development of the LTC sector. One problem is that it is impossible to discharge persons in need of LTC from acute hospital beds due to the lack of suitable alternatives. The reforms in LTC have shifted responsibilities from the central budget to local authorities and districts. Old people's and nursing homes are under the responsibility of the DHIFs. LTC recipients are asked to pay a fee, which is deducted from their pension or income and then passed on to the central budget. People with no income come under the responsibility of the district budget. Although some free LTC services are available to vulnerable groups, the financing of the system is mixed, with a combination from the State and local (district) budgets. The system remains poorly developed and NGOs play an important organisational and financial role. Specific efforts have been made with additional allocated funds for mental health patients and drug users. Pilot programmes and new psychiatric centres have been created, coupled with legal developments to ensure that mental health patients' needs are met. A new law aims to set up a dependency benefit for financing LTC in a residential and home setting. The benefit will be entirely means-tested (depending on degree of dependency and place of service). The same law proposes a compulsory insurance contribution for LTC, with the funds collected being used to finance the dependency benefit. The implementation target is 2007.

Accessibility: The number of institutions providing LTC needs to be increased in order to improve access to LTC services, particularly in isolated and rural areas. The aim is to switch from residential care to the promotion of home care. However, addressing acute bed use and their shortages for LTC recipients appears to be a prerequisite.

Quality: Improving the quality of LTC and living standards in residential homes of LTC recipients is a priority for the authorities. Similarly, developing a social workers' network and enhancing facilities with appropriate training of LTC medical staff is another priority for the authorities.

Long-term sustainability: The new law sets out to address the long-term sustainability of the LTC system, with the introduction of a financing method based on means-testing and

targeting LTC recipients and compulsory LTC insurance participation. Although the new Agency for Child Protection has been created, local authorities are still underfunded and LTC is still underdeveloped.

6. Challenges

To step up measures needed to break the cycle of poverty, by targeting income in particular and access to services by groups at high risk, be they rural populations, Roma people, elderly women, single-parent families or families with many children.

To promote an approach based on active inclusion, in particular the creation of high-quality jobs that make work pay. In this context, to target vulnerable groups (in particular, young people) and people living in disadvantaged areas (especially rural areas) by way of reinforced measures and specific policies.

To pay particular attention to empowering local authorities, so that they can better identify and implement priorities and ensure that the implementation of measures, actions and projects uses the funding allocated in a consistent and effective way and effectively meets the objectives set.

To conclude the implementation of the government strategy to improve the situation of the Roma population (issue identity papers for all Roma people, combat any form of discrimination, increase access to education, to the labour market, to housing, etc.).

To strengthen the functioning of the pension system by greatly increasing the proportion of those in work to declare all paid work and ensuring that appropriate contributions to the social security system are made and also to improve general employment rates and in particular to increase numbers of older workers.

To continue with the ongoing reforms to ensure both increased adequacy for today's and more importantly future older people and future sustainability.

To continue efforts to achieve a fully-fledged, decentralised, social health insurance-based system that can address the limited coverage of the system and its long-term financial sustainability.

To extend resource allocation to health care and LTC systems in order to tackle accessibility issues (geographical discrepancies and lack of specialised services), improve the quality of the services provided and coordinate the central and local funding authorities better to make for a well-functioning PHC, referral and gatekeeping systems and to tackle high private expenditure in health care and pharmaceutical use.

Romania: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	2.1	24.9	**2000**	63.0	68.6	57.5	33.1	49.5	**2000**	7.2	7.8	6.4	20.0
2002	5.1	28.1	**2002**	57.6b	63.6b	51.8b	28.7b	37.3b	**2002**	8.4	9.1	7.7	23.2
2004	8.4	32.6	**2004**	57.7	63.4	52.1	27.9	36.9	**2004**	8.1	9.1	6.9	21.9
2006	7.2f	35.8f	**2005**	57.6	63.7	51.5	24.9	39.4	**2005**	7.2	7.8	6.4	20.2

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	65.3	73.1	12.6	15.1	n.a	n.a	21.2	**1995**	n.a	n.a	n.a		
2000	67.7	74.6	13.4	15.7	n.a	n.a	18.6	**2000**	5.4	65.5	31.7		
2004	68.3sp	75.6sp	13.3sp	16.2sp	n.a	n.a	16.8	**2004**	5.7	59.6	36.3		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a	n.a	n.a	n.a	n.a	n.a	n.a
2000	n.a	n.a	n.a	n.a	n.a	n.a	n.a
2004	n.a	n.a	n.a	n.a	n.a	n.a	n.a

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since2004: Total social expend.	Public pensions	Health care	Long-term care
2005	21.1	n.a	n.a	n.a	n.a
2010	21.2	n.a	n.a	n.a	n.a
2030	29.6	n.a	n.a	n.a	n.a
2050	51.1	n.a	n.a	n.a	n.a

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
HBS income 2004	Total	Children 0-15	16+	16-64	65+	Total	Children 0-15	16+	16-64	65+		S80/S20
Total	18	25	16	16	17	23	24	22	23	19	**Total**	4,8
Male	18	-	16	17	11	23	-	23	23	18	**Male**	-
Female	18	-	17	16	21	23	-	22	23	19	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	7.3	7.8	7.0	8.6	**1999**	2.8	2.8	2.7		**1999**	21.5	23.0	20.0
2004	11.1	11.1	10.4	11.7	**2004**	4.5	5.2	3.6		**2004**	23.6b	24.9b	22.4b
2006	10.0	9.7	8.8	10.6	**2005**	4.4	4.7	3.9		**2005**	20.8	21.4	20.1

**: excluding students; b: break in series*

HBS income 2004	Total	Male	Female	HBS income 2004	Total	Male	Female
Relative income of 65+	0.91	0.99	0.86	***Aggregate replacement ratio***	n.a	n.a	n.a

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									Pensions (or social security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions			Current estimate (2002)	Assumption
n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a

**:(DB / NDC/ DC); ** (DB / DC)*

2.23. SLOVENIA

1. Situation and key trends

The Slovene economy has experienced robust GDP growth, averaging almost 4.0% p.a. over the last decade. GDP per capita reached 83.6% of the EU average in 2006. While the employment rate is slightly above the EU average (66.0% in 2005), and the unemployment rate is one of the lowest (6.5%), the labour market is characterised by low employment of older workers (30.7%), especially older women (18.5%). Youth unemployment stands at 15.9% in 2005 and is higher for young women (17.8%). Regional disparities are considerable, with Eastern Slovenia significantly lagging behind. A fairly high level of total expenditure on social protection (24.3% of GDP in 2004) helps achieve a relatively low at-risk-of-poverty rate[88] (12% in 2004; below the EU average). Within social protection expenditure (expressed as percentage of total benefits), the highest share was spent on old-age and survivors (44.7 %), followed by sickness and health care (32.7 %), while 2.8% was spent on housing and social exclusion. Due to the projected rapid ageing of the population in the coming decades – life expectancy is increasing and the fertility rate is low (1.26 in 2005) –age-related public social expenditure is expected to rise by 9.6 percentage points by 2050 and the old-age dependency ratio (21.7% in 2005) to more than double (55.6% in 2050). Life expectancy (73.7 and 80.6 years for males and females in 2004) is below the EU average, but one of the highest among the new Member States. Infant mortality (3.7 in 2004) is below the EU of 4.5 average and has fallen considerably from 35.1 in 1960. Perinatal mortality is 7.7, down from 29.6 in 1960.

2. Overall strategic approach

The National Strategic Report recognises that globalisation and the ageing of Slovenian society require changes in social protection systems in order to promote a just and sustainable social state, which will at the same time motivate people to be more active. Consequently, the overall Slovenian strategy for social protection and social inclusion focuses on improving flexibility in the labour market, modernising the system of social transfers, promoting longer working lives through sustainable pension systems, and maintaining the standard of public health care achieved.

The strategy for promoting social inclusion focuses on activation of those furthest away from the labour market, providing housing for the most vulnerable groups, fighting discrimination and promoting integration of immigrants into society as well as ensuring care for elderly. These priorities address the main challenges Slovenia is facing in the field of social inclusion. However, the measures on activation and fighting discrimination might prove to be insufficient, and the targets not ambitious enough, to tackle the existing challenges, in terms of strengthening labour market flexibility and competitiveness and prolonging working lives.

[88] SILC(2005) income year 2004: Provisional data. Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.

Gender mainstreaming is not systematically applied in policies and measures; however, some positive measures for women are reported.

The National Strategic Report is strongly interrelated with the Lisbon National Reform Programme, especially in the fields of active inclusion and modernisation of social protection systems. However, ensuring a proper level of security within the planned reforms is a challenge, which should be addressed.

Good governance is promoted by the involvement of relevant stakeholders in drafting the national report, and in monitoring and evaluating its implementation. Transparency was ensured through discussions on the report on different occasions (public debates, consultation of social partners, etc.).

3. Social inclusion

3.1 Key trends

The key trends in the field of social inclusion are generally favourable. The at-risk-of- poverty rate[89] (12% in 2004) and income inequalities (3.4 in 2004) are among the lowest in the EU. However, the at-risk-of-poverty rate is high among certain population groups, such as older people living in one-person households (45%), the unemployed (25%), one-person households with at least one child (22.4%) and women over the age of 65 (26%). The at-risk-of-poverty rate of these groups and the population in general would be even higher (42%) without social transfers and pensions.

According to the National Strategic Report, the number of welfare recipients is growing. 41% of recipients are younger than 27, 15% are long-term unemployed. Although the indicators for education and skills are good (the educational attainment of 22-year-olds is 90.6% and the proportion of early school-leavers is low at 4.3%), 41% of welfare recipients have a low educational attainment level (national data).

According to the 2002 population census, 83.5% of the population own their homes. Nevertheless, access to housing is a challenge for certain groups of population due to the scarcity of housing in highly urban areas and the high prices of housing.

3.2 Key challenges and priorities

In line with the key challenges recognised by the National Strategic Report, the social inclusion strand of the report concentrates on four priorities: increasing the activity of social assistance beneficiaries by raising their level of education and offering more employment possibilities; providing accommodation to vulnerable groups; combating discrimination and integrating immigrants in society; and ensuring care for elderly people. These reflect the challenges identified for Slovenia in the Joint Social Protection and Social Inclusion Report 2006. The first priority of the Slovene report concentrates on active social inclusion for all; the others focus on access for all to the resources, rights and services needed for participation in society.

According to the report, progress has already been achieved in recent years in addressing some of the Slovenian priorities. New measures for bringing people, who depend on benefits,

[89] SILC(2005) income year 2004: Provisional data

back to the labour market were introduced and existing measures were further developed. The new active inclusion measures focused on introducing conditions for social benefits and subsidies for employers employing long-term unemployed people. The recent tax reforms should provide additional incentives for work. It is important to monitor the impact of these reforms on the income security and effective inclusion of the people concerned. Progress has also been achieved in increasing access to accommodation, especially for the most vulnerable groups. Nevertheless, several challenges have not been sufficiently tackled so far. There is a lack of systematic focus on gender-related issues. The report recognises that discrimination exists, but is vague in terms of types and scope of discrimination. Within the priorities defined, the strategy does not take into account regional differences.

The social inclusion policies are coordinated and mainstreamed into relevant public policies to a certain extent, through several strategic documents prepared recent years. The role of the Structural Funds, particularly the ESF, is very important in supporting the National Strategic Report objectives, since it is planned that the ESF will co-finance the majority of the labour-market-related measures.

3.3 Policy measures

The National Strategic Report identifies different measures such as legislative amendments, active labour market policy/inclusion activities and concrete projects, to address each of the priorities. Under each priority, targets and indicators are set and corresponding financial resources indicated.

The first priority, increasing the activity of social assistance beneficiaries by raising their level of education and offering more employment opportunities, focuses on increasing employment among older people, activation of the recipients of social assistance and reforming social transfers. Higher employment among older people will be achieved by a combination of activation policies (e.g. subsidies to employers and innovative measures supported by the ESF) and amendments to legislation (broadening the scope of part-time employment for older people and incentives for later exit from the labour market). The main measures taken to increase activity of social assistance beneficiaries are increasing conditionality in access to benefits and subsidies to employers hiring long-term unemployed people. These measures could be more ambitious, especially in light of plans for increasing labour market flexibility and prolonging working lives. Especially the most vulnerable groups, such as older women and people living in one-person households with at least one child, should receive further attention. In addition, this priority should concentrate more on young unemployed people as they are over-represented among long-term unemployed people on social benefits, especially given the European Council's call to ensure that each unemployed young person gets a job or training offer within six months. Mechanisms need to be introduced to evaluate the impact of the measures.

The second priority, providing accommodation to vulnerable groups, focuses on the one hand on temporary housing for the most vulnerable groups, and on the other hand on problems related to the general lack of housing and its high costs. Accommodation for the most vulnerable groups, such as single mothers, people with mental or physical disabilities, drug users and homeless people, is guaranteed by the National Programme for Social Protection 2006-2010, which sets clear targets for providing additional housing up to 2008. The issues of housing supply, and its financing, will be tackled by the National Housing Strategy, which is under preparation. These measures will be complemented by reducing administrative and other barriers in spatial planning and tax legislation, and by ensuring financial incentives to

municipalities to support additional supply of housing. The priority covers key aspects of to housing issues; nevertheless, it is not clear whether these measures are sufficient to help vulnerable groups to leave temporary housing and move into permanent housing arrangements.

The third priority, fighting against discrimination and integrating immigrants in society, is the least focused and clear. Stronger evidence to underpin this priority is needed, together with an overall strategy taking into consideration the needs of all disadvantaged groups. The work of the Council for the Implementation of the Principle of Equal Treatment and the implementation of the National Programme for Equal Opportunities for women and men 2005-2013 are mentioned, but clear objectives and targets are not provided The National Strategic Report does not pay enough attention to other problems related to discrimination, such as including ethnic minorities and ethnic groups (Roma) in all spheres of life. Additional emphasis should also be given to support for single mothers, who face a high risk of poverty, especially in relation to reconciling work and private life. The measures on integration of immigrants (drafting and implementation of an integration plan for each immigrant, housing, special attention to vulnerable groups of immigrants, consulting and psychosocial assistance) concentrate on refugees and asylum seekers, while other groups of immigrants are not mentioned. Targets and financial allocation (partly funded by the ESF) are set in relation to some aspects of the integration of immigrants.

The fourth priority, ensuring care for elderly, combines the objectives of all three strands of the streamlined open method of coordination in the fields of social protection and social inclusion. The measures will be achieved as part of the implementation of the Strategy for Protection of Elderly up to 2010, which is being drafted. It will cover activation of older workers, ensuring socially adequate and sustainable pensions, and a variety of measures in the field of health and long-term-care for the elderly. In addition, the National Programme for Social Protection 2006-2010 covers maintaining and developing the existing services for social protection of the elderly (institutional care, network of daily care, domestic help services, sheltered housing, etc.).

3.4 Governance

The social inclusion strand of the National Strategic Report was drafted by the Ministry of Labour, Family and Social Affairs and sent for consultation to a working group involving representatives of governmental services, research institutions, local communities, NGOs and social partners. The report was also presented and discussed at a seminar organised for the general public, although the report as such had not yet been made available at that time. The final document will be distributed among all stakeholders, which is important for raising awareness. An effort has been made in the report to identify, as far as possible, quantified targets to improve monitoring of outputs and impacts. In addition, a special evaluation group, involving all relevant stakeholders, will be established and at least one evaluation report will be drafted. However, more could be done to involve those who actually implement the proposed policies and measures (centres for social work, NGOs, etc.) in the process of drafting, implementing and evaluating the report. According to some actors involved in implementing of policies and measures, they are aware neither of the existence of the report not of its added value.

4. Pensions

In 2004, older people had a relative living standard close to that of the general population (87%)[90], while the poverty risk among older people at 20% (gender differences are high, 11% for men and 26% for women) is estimated to be significantly higher than of the population below the age of 65 (11%). The employment rate of older workers remains low in spite of recent increases and, at 30.7% in 2005, contrasts with the Lisbon target of 50%.

The 2006 Sustainability Report assessed Slovenia as a high-risk Member State as regards sustainability of public finances, notably due to the high projected increase in age-related expenditure. Slovenia is facing significantly stronger budgetary pressures due to ageing populations than most other Member States. According to 2005 AWG projections, public pension expenditure is set to increase to 18.3% GDP in 2050, a rise of 7.3 p.p. of GDP from 2004. According to ISG projections of theoretical replacement rates for a worker retiring at 65 after 40 years of employment at the average wage, the net replacement rate in the statutory scheme is expected to decrease significantly from 82% in 2004 to 60% in 2050 (declining from 64% to 39% in gross terms).

The 2006 Joint Report stated that the 2000 reform constitutes an important step towards ensuring adequate and sustainable pensions, but stressed that pressures on the pension system are strong in Slovenia and that further measures are needed to strengthen incentives to work longer.

While the gradual increase in pension age will be effective in 2008 for men (63) and in 2023 for women (61), both after 20 years of contributions, this transition period appears long and faster reduction of the gender gap in retirement age would also contribute to ensuring future adequacy. Furthermore, improving financial incentives to work longer is urgently needed as the employment rate among older workers is very low. Furthermore, reducing early exit from the labour market (before the standard retirement age) is a major challenge and would contribute to ensuring future adequacy (through further accrual of pension rights which are otherwise planned to decrease) and sustainability.

Following the introduction of strong incentives to participate in voluntary provision, the share of actively insured persons covered by voluntary supplementary pension schemes is increasing (51% in 2004, 56% in 2005), highlighting the importance of adequate portability as well as risk-sharing rules.

5. Health and long-term care

5.1 Health Care

Description of the system: A compulsory health insurance system, operated through the Health Insurance Institute of Slovenia (HIIS) and its branches, provides comprehensive coverage to all residents. The citizens of Croatia and Macedonia are provided care on the basis of bilateral treaties. Provision is mostly public although there are a growing number of private practitioners. Local governments finance primary healthcare (PHC) facilities. PHC is provided via general practitioners (GPs) and their teams in public healthcare centres or private practices with an HIIS contract. These operate as "gatekeepers". Specialist and hospital care is performed in hospitals (75%), spas or private health facilities. Hospitals are mostly state owned. PHC centres are paid a combination of capitation and fee for service by the HIIS.

[90] SILC(2005) income year 2004: Provisional data

Public sector doctors are salaried and there are bonus payments in place. Private non-HIIS contracted doctors are paid a fee-for-service. Financing is mainly employment-based (with equal contribution rates by employees and employers). Pensioners, the self-employed, farmers and craft workers also pay contributions. The state pays for the unemployed and non-insured and capital investment. Co-payments are paid for a range of services. Voluntary supplementary health insurance (to cover co-payments) covers 1.4 million people (70% of the population). Recognising important access challenges, the authorities wish to improve countrywide availability of care, tackle the financial burden of care, reduce waiting times and improve the equity of financing. Recognising the potential efficiency gains, authorities are focusing further on PHC, referral systems, outpatient care and day surgery. Highlighting the benefits of a healthy population for sustainability and economic growth promotion and prevention activities are strongly emphasised.

Accessibility: About 20 000 people, mostly from the other former republics of Yugoslavia, do not have health insurance because they have no settled residence or citizenship, although they can receive free emergency care. According to the authorities, though insurance covers all costs of certain groups (children, students, persons with disabilities) and of many services (preventive, emergency, cancer, diabetes and reproductive/family care), out-of-pocket payments (9.8% of total expenditure in 2004) and insurance premiums paid for voluntary insurance (13% of total expenditure) may pose a financial burden to low-income groups. Hence, they want to define a basic care package for which there are no co-payments. Some services are directed at the population groups most at-risk (e.g. new-borns, children). It is reported that a general shortage of PHC doctors (16.3 per 100 000 inhabitants) may pose difficulties to a PHC-led system, whilst regional differences exist in relation to specialist outpatient care, as trained personnel and facilities are concentrated in major urban centres. The authorities have thus established regional targets for staff and plan additional incentives for staff to work in deficit areas. They also express the concern that albeit decreasing, waiting times for certain non-urgent procedures can be very long causing public dissatisfaction. The report claims that waiting times are due to: a) restricted resources not allocated on the basis of needs and b) population ageing, which results in needs greater than capacity. Additional funding and co-payments to staff in specialties where waiting times are long thus aim at increasing activity and reducing the wait.

Quality: To improve quality, the authorities are introducing standards, clinical guidelines and clinical paths. EU law has been implemented in relation to quality control, the registration and the sale of pharmaceuticals. As the report indicates, alongside a free choice of PHC doctor (although registration is to last for one year), there is a free choice of hospital or specialist clinic after referral. A law on patient rights is to be adopted. Service users are represented in the Assembly of the HIIS and participate in the management of health institutes. The authorities expect that users' involvement will raise awareness of financial issues and contributes to the sustainability of the system. Slovenia is developing an extensive ICT and health infrastructure (electronic data exchange, health insurance card system with patient information, electronic insurance applications, advice, and communication between actors in the field) which will provide information for policy and bring services closer to users and providers. The authorities are focusing strongly on reinforcing free preventive services (five-yearly check-ups and counselling for cardiovascular diseases, screening for cervix and breast cancer, vaccination, and preventive examinations of newborns, children and women).

Long-term sustainability: Total expenditure on health (8.7% of GDP and 1760 per capita $PPP in 2004) is at the EU average in GDP terms[91]. It has consistently increased over time. Public health expenditure comprises 77.2% of total health expenditure and though relatively high in EU terms has showed a significant decrease from 100% in 1990. This decrease has been compensated by voluntary private insurance and service co-payments (to add funds and control unnecessary demand). The authorities identify ageing and growing pharmaceutical expenditure as financial pressures. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 1.6 percentage points of GDP by 2050. Moreover, the report underlines that current contribution evasion can be detrimental to the sector's funding, with some groups (e.g. the self-employed) not paying a high enough proportion of their income (16% less than they ought to). To eliminate these deficiencies and enhance the system's solidarity, the authorities plan changes in the law regulating health insurance. According to the report measures to improve efficiency include: reinforcing the referral system and redirecting resources and responsibilities to PHC and outpatient specialist care, further decreasing the number of acute inpatient beds and increasing occupancy rates, further increasing the use of day case surgery vis-à-vis inpatient care, and reducing hospital length of stay. Moreover, the introduction of new health interventions is to be based on evidence-based medicine. With regard to staff, a shortage of PHC doctors and nurses is identified, so more professional training is planned. Strong emphasis is placed on promotion programmes including awareness campaigns on world days (exercise, tobacco, suicide, breastfeeding, aids, and mental health) and in coordination with different levels of government and NGOs.

5.2 Long-term care

Description of the system: Long-term care includes PHC and PHC home visits (GPs and nurses), institutional medical care provide in hospital in nursing departments and non-acute wards, home domestic help, home assistance, sheltered housing, homes for elderly people and disabled people and a widespread network of health resort treatment, which provides physiotherapy and rehabilitation services. Those needing care can also receive cash benefits which can be used to buy non-formal care. Services are financed partly from taxes, partly from social security contributions and partly from co-payments but a new compulsory long-term care insurance is to be implemented.

Accessibility: The state pays for those who are unable to pay for services. The authorities are expanding network capacity (increasing the number of providers), with a focus on home and community services. Options include domestic help and mobile help services, day care centres, care in another family, sheltered housing and non-acute hospitalisation in all hospitals to transfer patients from acute care to the community and home. Better coordination (through co-ordination offices) between local and regionally provided services is expected to allow better and faster access to services as well as quality. Access to palliative care is low as this is only provided by voluntary organisations.

Quality: The report suggests that national quality policy applies to this field.

Long-term sustainability: The 2006 EPC/EC age-related projections forecast an increase in public expenditure of 1.2 percentage points of GDP by 2050. As pinpointed in the report additional funding will be sought through new compulsory long-term care insurance. The authorities highlight the need for sufficient trained staff in the areas of geriatric care,

[91] 8.87% of GDP and 2376.33 per capita PPP$ in 2004

gerontology, psychiatry, palliative care, communication and coordination. Several promotion programmes are planned (diet, exercise, social contacts).

6. Challenges ahead

To strengthen the active inclusion of people depending on social assistance, especially young long-term unemployed persons, by ensuring proper accompanying measures and adequate incomes to ensure that those furthest from the labour market are not marginalised further. Gender and regional difference should be systematically taken into account in this context.

To undertake with all relevant stakeholders, a thorough analysis of the extent and nature of discriminations and adapt the strategy as appropriate.

To address the financial sustainability and ensure the adequacy of pensions, notably by considering strengthening pension reform and by taking complementary measures to increase the employment rate of older workers.

To extend coverage, increase PHC staff numbers and enhance long-term care provision.

To improve efficiency (notably through a stronger focus on PHC, outpatient and day-case surgery) and improving health by focusing on promotion and reinforcing free preventive services.

Slovenia: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.1	72.7	**2000**	62.8	67.2	58.4	32.8	22.7	**2000**	6.7	6.5	7.0	16.3
2002	3.5	74.5	**2002**	63.4	68.2	58.6	30.6	24.5	**2002**	6.3	5.9	6.8	16.5
2004	4.4	79.9	**2004**	65.3	70.0	60.5	33.8	29.0	**2004**	6.3	5.8	6.8	16.1
2006	4.8f	83.6f	**2005**	66.0	70.4	61.3	34.1	30.7	**2005**	6.5	6.1	7.0	15.9

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	70.3	77.8	13.5	17.1	n.a.	n.a.	5.5	**1995**	7.8	89.7	:	:	:
2000	72.3	79.7	14.2	18.5	n.a.	n.a.	4.9	**2000**	8.6	77.7	8.6	:	:
2004	73.7sp	80.6sp	14.9sp	19sp	n.a.	n.a.	3.7	**2004**	8.7	77.2	9.8	:	:

s: Eurostat estimate; p: provisional **THE: Total health expenditure* ***PHI: Private health insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old-age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	24.9	45.2	30.7	4.3	9.2	1.6	9
2004	24.3	44.7	32.7	3.1	8.6	2.8	8.1

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	21.7	24.2	11	6.4	0.9
2010	23.6	-0.2	:	:	:
2030	40.4	4.4	3.4	1.2	0.5
2050	55.6	9.6	7.3	1.6	1.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12bp	12bp	12bp	10bp	20bp	19bp	17bp	20bp	19bp	20bp	**Total**	3.4bp
Male	11bp	-	10bp	10bp	11bp	20bp	-	21bp	22bp	17bp	**Male**	-
Female	14bp	-	14bp	10bp	26bp	19bp	-	19bp	17bp	20bp	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	4.1	9.6	8.7	10.5	**1999**	3.3	3.5	3.1	**1999**	na	na	na
2004	3.8	7.5	7.0	8.0	**2004**	3.2	3.1	3.4	**2004**	4.2u	5.8u	2.6u
2006	3.6	7.2	6.6	7.8	**2005**	3.1	2.9	3.3	**2005**	4.3u	5.7u	2.8u

** excluding students; b: break in series; p: provisional* *u: unreliable*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.865bp	0.943bp	0.804bp	***Aggregate replacement ratio***	0.424bp	0.515bp	0.376bp

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or social security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Current estimate (2002)	Assumption
-22	-25	-25	DB	/	/	100	/	24.35	/	/

** (DB / NDC/ DC); ** (DB / DC)*

2.24. SLOVAKIA

1. Situation and key trends

Slovakia continued in its positive trend of high GDP growth rate; the fourth highest in the EU at 6.1 % in 2005 (6.7 % forecast for 2006). GDP per capita, however, stood at 55 % of the EU average, with a forecast at 59.4% in 2006. Strong growth was only partially reflected in better labour market performance in 2005, with total employment increasing by 0.7 percentage points to 57.7%. Employment rates for both young people (15-24 years), at 25.6%, and older people (55-64 years) at 30.3% in 2005 are among the lowest in the EU. However, while youth employment has fallen continuously since 2000 (29 %), that of older workers has steadily risen from 21.3 % in 2000. The unemployment rate decreased by 2.5 percentage points to 16.3 % since 2000, but remained the second highest in the EU, particularly hitting young people at 30.1%. The activity rate of the population aged 15-64 was almost stable throughout the years 1998 – 2005, standing at 68.9 % for the whole population (76.5 for males and 61.5 for females) in 2005 (EU-25: 70.2%). Significant regional employment disparities persist (9% total registered unemployment and over 28 % in the weakest region).

The at-risk of a poverty rate[92] after social transfers was 13 %[93] in 2004, with a higher risk for children at 19%. By contrast, people over 65 faced a significantly lower risk at 7%. Life expectancy in 2004 has increased by almost 2 years since 1995 to 70.3 years for males and 78.0 years for females however it is bellow the EU average[94]. The trend in the fertility rate has been marginally positive since 2002 when it hit an all-time-low of 1.18 (in 2004: 1.25). Infant mortality (6.8 in 2004) is the third highest in the EU[95] though it has improved considerably over the years (28.6 in 1960 and 11.0 in 1995). Perinatal mortality is high (7.6 in 2003) but has constantly fallen since 1960 (21). The current and projected old-age dependency ratio 65+ is well below the EU average: it is set to increase quickly from the present 16.3% to 28% in 2025 and 50.6% in 2050 (just below the EU25 52%). Total gross social protection expenditure in 2004 slightly decreased compared with 2000 (by 2.1 percentage points) and represented 17.2 % of GDP (EU average: 27.3%). Health and pensions represented the majority of expenditure in 2004 (30.1% and 40.1% respectively) with social inclusion somewhat behind (29.8%).

2. Overall strategic approach

Main strategic messages identified by Slovakia and addressed in the submitted National Strategic Report for years 2006-2008 are described as 1) ensuring financial sustainability, adequacy and accessibility of social protection systems and social inclusion policies with strengthened principle of solidarity, 2) ensuring integrated multidimensional approach to tackling poverty and social exclusion based on prevention, active inclusion, and creating conditions for decent life, and 3) improving management, implementation and monitoring of

[92] Following the implementation of EU-SILC in 2005, the values of all indicators related to income and living condition (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years, the large year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were extrapolations based on the national micro-census survey that was not fully compatible with the SILC methodology based on detailed income data.

[93] EU average of 16 % in 2005.

[94] EU average of 75.8 and 81.9 years for males and females in 2004.

[95] EU average of 4.5 in 2004.

political measures at national, regional, and local levels and strengthening human resources development.

Social cohesion will apply the principles of activation and protection, emphasising prevention and effective social assistance in order to achieve its objectives. In the area of health-care the principle of solidarity[96] will be preserved. Introducing the voluntary option and ensuring a financial stability will be priorities for the pension system. The National strategy report is broadly in line with the Lisbon strategy and National Reform programme. Systems of social protection and social inclusion started to be interconnected with measures for increasing employment in recent years. The governance objective will be pursued in particular through the creation of partnerships at a horizontal and vertical level, human resources development, and social inclusion mainstreaming.

Activities to tackle children poverty and the inter-generational transmission of poverty are good examples of synergies between social and employment policy. Children from low-earning families are motivated to school attendance through school grants and social scholarships from pre-school education to University, by granting child allowances, school expenses, fiscal bonuses, etc.

The Slovak government is promoting gender equality as a significant aspect of the approach to addressing social exclusion. In the last years, gender equality legislation started to be adopted; however mechanisms for its implementation still need to be regulated, including a regular monitoring and the introduction of institutional structures.

3. Social inclusion

3.1 Key trends

At-risk-of-poverty rate in 2004 was almost identical for males and females in all age groups except for adults over 65, where 10 % of women compared to 3 % of men were at risk.

The percentage of adults living in jobless households has slightly decreased during the last years, reaching 9.6 % in 2006 (EU average 9.8%). However, larger proportion of children live in jobless households (11.8 % in 2006 compared with 9.5 % in the EU).

The youth unemployment rate (15-24) which rose considerably in 2000 (to 36.9 % compared with 25.3 % in 1998), has decreased to reach 30.1% in 2005 (EU-25: 18 %). Young males tend to have higher unemployment rates than females.

With respect to early school-leavers (18-24 years) SK is among the most successful MS. The rate was further reduced to 5.8% in 2005 (EU: 15.2%). In the last three years, life-long learning in Slovakia represented approximately half of the EU average (SK: 4.8 %, 4.6%, and 5.0% respectively).

The gender pay gap is a specific issue in Slovakia (24% in 2004, compared to the EU average of 15 %), which found itself among 3 countries with the biggest gap in 2004.

3.2 Key challenges and priorities

[96] Ensuring efficient performance, accessibility, and quality of health care for all inhabitants, with preservation of their economically and socially sustainable financial participation for selected types of health care.

The National action plan on social inclusion develops the principles and measures set out in the National Reform Programme 2006-2008, in particular those connected with an inclusive labour market and an inclusive society. The ambition of the plan is to be a strategic umbrella document in the area of inclusion which defines the priority objectives and reflects a long-term vision. In its National report, Slovakia established as its four priority political objectives (1) reduction of child poverty and inter-generational reproduction of poverty, (2) increasing inclusion and fighting against discrimination of vulnerable groups through the public services, local solutions, and increased participation of excluded groups, (3) improved access to the labour market and increasing employment and employability of vulnerable groups, (4) and finally strengthening management, implementation, and monitoring of policy measures.

As highlighted in the 2006 Joint Report on social protection and social inclusion, the main social inclusion challenges Slovakia is facing are increasing the overall employment rate and the one of elderly in particular, monitoring and assessing an impact and an implementation of the reforms with regard to vulnerable groups including Roma, and tackling housing shortage. Slovakia partially succeeded in addressing all three challenges: (1) the overall employment rate has slightly increased from 57 % in '04 to 57.7 % in '05, while the one of older workers noted a more impressive increase from 26.8% in '04 to 30.3% in '05; (2) new flexible tailored services and measures in regions are going to be introduced based on the monitoring and assessing (social services, social-legal protection, and social curators), though the lack of detailed statistics still continues to be a problem; and (3) the NAP establishes the goal to increase the availability of housing for vulnerable groups of population through the State Fund of the Housing Development and other measures, however there has been no comprehensive approach yet.

The NAP also refers to the NSRF and programming documents prepared for the new programming period 2007-2013 and their compatibility with the intentions, objectives and priorities defined in the National strategy; however indicative reference to the amounts and contributions of Structural Funds or ESF was described only later in the draft NSRF.

3.3 Policy measures

All priorities except for the last one are intended in particular for vulnerable groups of population. In relation to the pursued policy priorities, the measures and partially also targets employed seem in general feasible and appropriate. Slovakia considers gender equality a significant aspect of tackling social exclusion, however new more effective mechanisms for implementation of gender legislation needs to be introduced. The objectives of capacity building and enhancement of local and community development are considered to be a core of the Slovak strategy.

3.3.1. To reduce poverty of children and to resolve the inter-generation reproduction of poverty by preventive measures and by support of families with children

Government considers educational policy and the provision of equal opportunities in access to quality education including support measures starting with pre-school education to be one of the key tools to fight intergenerational poverty. The new School Act on upbringing and education should be prepared by 2007. Changes in the system and increase of the level and structure of the support in the framework of state social benefits should be introduced in 2006 and 2007 in order to enhance solidarity for families with children. The composition of minimum subsistence will be revaluated, in order to better correspond to the actual fundamental living needs. Slovakia plans to concentrate on improving the implementation of

the new legal regulation on social-legal protection of children and social curatorship with emphasis on the prevention and package of measures. The need for intensive social work in the natural biological family environment and more and better public services for families is recognised.

3.3.2. To increase inclusion and to fight against discrimination of vulnerable population groups by supporting the availability of public services, developing local solutions and increasing the participation of excluded groups in the life of society

Slovakia will increase the availability, quality, modernize and ensure higher variability of social services provision (social-legal protection and social curatorship, social work on the spot, community work, and other integration activities) and measures of social and legal protection of children and social curatorship as a key tool for addressing this priority. The NAP intends to invest more massively in this area, also by adopting appropriate compatible operational programmes of Structural Funds in the new programming period. The new Act on Social Services should be prepared in 2007, with a view to creating conditions for the development of community work and improving the provision of social services. Some of the measures for increasing the accessibility of housing and apartments' construction for low-earning vulnerable groups of population have been adopted already. The system of cost-less legal aid and support of access to health care will be maintained. The integration process will be strengthened by culture mechanisms, information society measures and e-inclusion, and finally by systematic activities to prevent all forms of discrimination, racism, xenophobia, anti-Semitism, and other intolerances.

3.3.3. To improve access to the labour market and to increase employment and employability of the population groups threatened with exclusion

Key measures applied will be the support for the integration of disadvantaged groups and creation of equal opportunities in the access to the labour market, in particular of marginalised Roma communities. Despite measures used so far proved to be effective as concerns short-term unemployed, in the future mainly vulnerable groups will be tackled, which creates the need to provide higher intensity assistance in regions lagging behind, in order to decrease regional disparities and increase job creation, with the use of the Structural Funds, in particular ESF. Existing tools for support of employment would be further developed and sharply targeted. Key objectives include decreasing of long-term unemployment, youth unemployment, and increasing the share of persons with disabilities in the total number of employed.

3.3.4. To strengthen management, implementation and monitoring of political measures accepted at national, regional and local levels

The efforts for a comprehensive and effective approach to the policy and social inclusion measures' creation will continue to be strengthened by the coordination of policy creation in the framework of individual institutions, inter-service and vertical co-operation, and mainstreaming activities. Non-governmental sector would play an important role in this area including the awareness rising of the issue of poverty and social inclusion. Different types of partnerships for the needs of inclusive policies including local partnerships of social inclusion with action plans of social inclusion under the Social Development Fund would be pursued. Operational priority would cover the capacity building and enhancing the quality of public services and non-profit organisations in the area of management and creation of inclusive policies, building partnerships and networks. Obtaining good quality, reliable social statistics

has been a distinctive weak spot for the creation, implementation and evaluation of policies and measures until recently. The data collection and creation of indicators at regional and local levels are still problematic.

3.4 Governance

A working group has been established in order to draft the National report on the strategies of social protection and social inclusion 2006-2008. A seminar organised by the Ministry of Labour took place as part of the consultation process, with the intention to initiate the discussion and obtain new concrete proposals and recommendations from stakeholders from public and state institutions and non-governmental area.

Committee of Ministers for Children and Youth, Council of Government for Seniors, and institutional structures and monitoring systems for applying a gender-based approach will be established, in order to co-ordinate and build a more efficient system of protection of the mentioned subjects' rights.

However, arrangements for implementation, monitoring and evaluation of the inclusion part of the Report are not described into detail. Quantified objectives, indicators, financial sources, and institutions responsible for monitoring and management of priorities have been set, however amounts of financial resources assigned for priorities or key targets are missing.

4. Pensions

In 2004 the relative living standard of older people was around 85% of that of the population under 65. The risk of poverty of the 65+ age group is low, at 7% in 2004 (3% for men and 10% for women) and is significantly lower than that of the under-65 age group.

The projected increase in age-related spending in Slovakia is lower than the average in the EU, rising by 2.9 percentage points of GDP between 2004 and 2050. The increase in expenditure on pensions is projected to be relatively limited, rising by 1.8 percentage points of GDP as a result of a pension reform. According to calculations, replacement rates from the statutory scheme for a worker retiring at 65 after 40 years of average earnings will remain stable over the coming decades, with the net rate increasing slightly from its present level of 63% to 64% by 2050 and the total gross rate from 49% to 50% by 2050.

The 2006 report highlighted the extensive reform that the Slovak pension system has undergone and outlined the key challenges facing the reformed system, the main one being the improvement of overall employment levels, in particular that of older workers.

The 2005 reforms split the statutory old age pension scheme into pay-as-you-go financed and privately managed funded pension tiers. The introduction of the latter tier entails a significant loss of contribution revenues, creating a large deficit in the financing of the public PAYG scheme and thus also limiting the scope for improving current pensions. The Slovak Government has amended legislation recently to stop individuals continually changing pension fund providers within this system. The voluntary supplementary pension saving system consists of a variety of saving plans, privately managed by specialised pension managers and sponsored by employers. Individuals are also encouraged to use other pension-related and tax deductible products from other financial institutions.

A key challenge for the Slovak Republic is to raise its employment rates in general and those of older workers in particular and to lower unemployment, which would both strengthen the contribution base and allow people to accrue additional pension rights. The new system design also establishes a strong link between personal contributions to the system and benefits, which could lead to adequacy issues in the future for the lower income earners and people who have taken career breaks, notably women.

5. Health and long-term care

5.1. Health care

Description of the system: A compulsory social health insurance scheme, with multiple (currently not-for profit but in the future, for-profit) health insurance companies acting as purchasers of care, provides universal comprehensive coverage to all residents. The provision of healthcare is decentralised and based on a public-private mix. Service providers operate on the basis of contracts concluded with health insurance companies. Primary healthcare (PHC) is provided via general practitioners (GPs), gynaecologists-obstetricians and dentists, practising mainly independently with health insurance contracts. Specialist and hospital care is performed in polyclinics, medical centres and hospitals. Some specialist outpatient care facilities are also private. Most hospitals and polyclinics have been decentralised to municipalities. The 2004 reform led to the privatisation of state-owned hospitals and other facilities into for-profit, joint stock companies. GPs are paid a capitation income plus a fee for service for preventive services. Specialists and inpatient doctors are mostly salaried employees, although they receive a fee for services in the private sphere. GPs now have a gate-keeping role, though patients have direct access to some specialist care. The social insurance system is financed mainly by insurance contributions and by state contributions on behalf of certain groups. Co-payments exist for virtually all services. Voluntary health insurance has a limited but growing role and informal payments are common. The insurance system and care provision is regulated by the Health Care Surveillance Authority (HCSA). The complex reform package of six major laws launched in 2004 focus on ensuring universal coverage, solidarity and equity of access (notably through social insurance and the definition of minimum provision and a basic healthcare package), whilst enhancing efficiency in the delivery of services through the privatisation and decentralisation of provision. It also emphasises the control and supervision role of the state and ensuring financial sustainability (notably through explicit rationing and treatment prioritisation). The report highlights that the maintenance of quality and accessibility within limited financial resources requires the restructuring of the network of healthcare providers.

Accessibility: The minimum public network of providers is defined by law. Nevertheless inequity in access for some vulnerable groups (low-income households, Roma communities) is an important issue. Patients can freely select healthcare providers, but the selected providers can refuse patients in some cases. Increasing out-of-pocket payments (12% of total health expenditure in 2004) are also a cause for concern though the share of private expenditure is one of the lowest in the EU. Informal payments are also high but the data is ambiguous. The authorities have defined a set of fully reimbursed medical services related to priority diseases (a "solidarity package" with an increasing share of screening benefits) and specified the scope of co-payments. Those in material need, children under six, blood donors, the mentally ill and long-term care patients are exempt from co-payments. The authorities expect voluntary supplementary insurance to develop substantially and thereby decrease the burden of direct payments. Access to care in rural areas is more limited than in the cities due to regional

disparities. Hence, to improve regional accessibility the government plans to modernise the local infrastructure of health-related services and transport networks. The authorities also plan to organise an ambulance network that reaches the patient in 15 minutes.

Quality: All outpatient and inpatient service providers have a legal requirement to set up, maintain and improve quality assurance systems, which expressly gives them responsibility for the quality and efficiency of the services provided. The legislator has required all health insurance companies to evaluate the quality of healthcare providers according to specific quality indicators drafted annually by the Ministry of Public Health. Since 2004 providers and health insurance companies have been accredited and supervised by the HCSA. This authority is also responsible for the scope and quality of medical services purchased within the framework of the "solidarity package". Private health insurance companies must be accredited and supervised by the Financial Market Authority and patients can freely choose health insurers and change once a year. The modernisation of healthcare facilities, the development of advanced technologies, the informatisation of hospitals and eHealth are priorities identified by the authorities for the next decade to be co-financed by the European Social Fund. The report emphasises the importance of some existing preventive programmes (the oncology programme, the cardio-vascular programme, the mother and child programme and the care for seniors programme) along with other screening programmes.

Long-term sustainability: Total health expenditure (5.8% of GDP and 829 per capita PPP$ in 2004) is among the lowest in the EU and has been relatively constant in GDP terms. The share of public expenditure spent on health (88% of total expenditures in 2004) is one of the highest in the EU and has remained stable (91.6% in 1998). The 2006 EPC/EC age-related projections show an increase in public expenditure of 1.9 percentage points of GDP by 2050 due to population ageing. Expenditure on pharmaceuticals is particularly high by international standards (38.5% of total health expenditure in 2003). The report notes that the government strongly focuses on financial and organisational restructuring of the health system to stabilise its finances and stop debt rising. The government expects that co-payments (for all services and notably pharmaceuticals) and spending caps for drugs will limit excessive consumption. Prospective budgeting and DRGs were also introduced to render costs and finance more transparent. The authorities plan to increase the self-responsibility of service providers, to improve efficiency incentives through privatisation and competition, to free the state from settling the debts of providers, and to ensure better monitoring of providers by insurers. Restructuring the system of healthcare facilities, shifting activities into the outpatient sphere is also a government priority. Regarding staff, the low income of practising doctors and the decrease in the number of nurses due to migration is an area of concern. Regarding promotion and prevention, authorities are prioritising initiatives to combat major national diseases through enhanced screening benefits for targeted groups and disease-specific programmes.

5.2. Long-term care

Description of the system: The government declared its intention, in its programme declaration 2006-2010, to introduce legislative provision for the development of social services/long-term care. The integration of healthcare services and social services is an additional objective of the government. Residential and non-residential care is provided mostly by municipalities and self-governing regions in pensioners' homes, lodging houses, nursing service facilities, day or rehabilitation centres, at home (notably through nurses), in regional integration centres and in state-owned care facilities. The system is financed by a mix of public (state budget, public health insurance funds) and private funds (with co-payments based on income). The report points out that the main objective of the Slovak authorities is to

balance home and institutional provision, depending on patients' needs and preferences, and to provide adequate support for dependent individuals and their carers.

Accessibility: The provision of adequate long-term care is a priority of the Slovak authorities. The report highlights that at present the municipalities are insufficiently equipped in terms of personnel, expertise and technical outfitting. The network of social service facilities is insufficient with regional disparities. Waiting times for placement in public facilities (e.g. pensioners' homes) vary from several months to several years and regional inequalities in access to long-term care services (availability, waiting times, and financial costs) are high.

Quality: At present, there are no legal requirements or standards for the provision of social services, though the government aims to draft them in the form of an amendment to the Social Services Act. In 2005-2006 23 projects were supported by the European Development Bank under the heading of "Transformation of the existing social service facilities".

Long-term sustainability: According to the 2006 EPC/EC projections, public long-term care expenditure is set to increase by 0.6 percentage points of GDP by 2050 as a result of population ageing, from 0.7% of GDP in 2004. The authorities stress the need to support both the disabled and elderly people, and their families, and activities that enable them to return to their home environment.

6. Challenges ahead

– To increase the overall employment rate and in particular for young and older workers, to improve access to the labour market and to increase the employability of vulnerable groups of population.

– To promote the social inclusion of vulnerable groups of population in particular Marginalised Roma Communities through support of public services and addressing housing shortages, and to increase public awareness and fight against discrimination.

– To strengthen the management, implementation, and monitoring of policy measures at national, regional, and local level with the participation of all stakeholders.

To ensure that sufficient resources for adequate pensions are available in the long run, and ensure that the transition costs of the partial shift into private funded schemes can be met and the long-term sustainability of public finances maintained.

To monitor the medical, social and financial effects of the reforms in order to ensure universal access to high-quality health and long-term care services.

To restructure the network of healthcare facilities and to address the issue of human capital management.

To develop an adequate and financially sustainable long-term care system based on the integration of health and social care sectors into one comprehensive system.

SLOVAKIA: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	0.7	47.4	**2000**	56.8	62.2	51.5	29,0	21.3	**2000**	18.8	18.9	18.6	36.9
2002	4.1	51,0	**2002**	56.8	62.4	51.4	27,0	22.8	**2002**	18.7	18.6	18.7	37.7
2004	5.4	54.4	**2004**	57,0	63.2	50.9	26.3	26.8	**2004**	18.2	17.4	19.2	33.1
2006	6.7f	59.4f	**2005**	57.7	64.6	50.9	25.6	30.3	**2005**	16.3	15.5	17.2	30.1

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality	WHO	Total Health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI** % of pop
	male	female	male	female	male	female							
1995	68.4	76.3	12.7	16.1	n.a	n.a	11,0	**1995**	N	N	-		
2000	69.1	77.4	12.9	16.5	n.a	n.a	8.6	**2000**	5.5	89.4	10.6	100	Negligible
2004	70.3sp	78sp	13.4sp	17.1sp	n.a	n.a	6.8	**2004**	5.8	88	12		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	18.4	38.1	33	3.5	14	4.6	6.8
2000	19.3	37.2	34.9	4.8	9	6.5	7.6
2004	17.2	40.1	30.1	6.2	10.7	3.3	9.6

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	expenditure (% of GDP) level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health Care	Long Term care
2005	16.3	16.2	7.2	4.4	0.7
2010	16.9	0.8			
2030	31.7	0.3	0.5	1.3	0.2
2050	50.6	2.9	1.8	1.9	0.6

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13b	19b	12b	13b	7b	23b	24b	23b	25b	16b	**Total**	3.9b
male	13b	-	11b	13b	3b	25b	-	25b	26b	23b	**male**	-
femal	13b	-	12b	13b	10b	23b	-	23b	24b	16b	**female**	-

	People living in jobless households					Long Term Unemployment rate				Early school leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	10.6	9.8	8.8	10.9	**1999**	7.8	7.4	8.3	**1999**	na	na	na
2004	12.8	10.8	10.0	11.6	**2004**	11.8	11.3	12.4	**2004**	7.1	7.8	6.4
2006	11.8	9.6	9.0	10.2	**2005**	11.7	11.2	12.3	**2005**	5.8	6,0	5.7

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0.849b	0.904b	0.818b	***Aggregate replacement ratio***	0.549b	0.53b	0.557b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Estimate of current (2002)	Assumption
1	1	1	DB and DC	/	/	Nd	/		Nd	/		/

**:(DB / NDC/ DC); ** (DB / DC)*

2.25. FINLAND

1. Situation and key trends

Finland's GDP grew by 3.5% in 2004 (EU-15 2.2%), 2.9% in 2005 (EU-15 1.6%), and 4.5% in 2006. A slowdown to 3.0% is predicted for 2007. Employment continues to grow. In the short term, the unemployment rate will decrease due to the decline in labour supply as bigger cohorts retire and smaller ones enter the labour market. Long-term unemployment has decreased but remains a major cause for exclusion and is often connected with other risk factors. The youth unemployment ratio has slightly decreased since 1998, but was still relatively high (20.1%). The unemployment rate of foreigners is as high as 28%, but the trend is decreasing.

In 2004, 12% of Finns lived on an income of less than 60% of the median income (in 2003 11%) and the inequality ratio of 3,6 in 2004 is still low (EU-25 4,9).

At risk of poverty figures before social transfers are very high - 29% for the whole population (EU 26%) - but national data on relative poverty are more favourable - 12.0%. This indicator, however, is on the increase. Certain households have a higher than average risk of poverty: youth under 25 years of age (22.0%), many of them students and unemployed (40.1%).

Finland faces atypical demographic ageing: the increase in the dependency ratio will be faster than that for EU-25 until 2025 and then become slower. Indeed, it is expected to rise from current levels of 23% (25% for EU-25) in 2004 to 45% in 2030 (40% for EU-25), and then increase slowly to 47% by 2050 (while the EU average would be 52%). Life expectancy at birth (75.3 and 82.3 for males and females in 2004) is at the 2004 EU average, showing a consistent increase over time. Healthy life expectancy (57.3 and 56.5) is however below the EU average, especially for women (who spend 10 years more in disability). The infant mortality rate (3.3 in 2004) is one of the lowest in the EU, down from 21 in 1960. Perinatal mortality (4.9) is average, having decreased from 27.5 in 1960.

Finnish gross social protection expenditures were put at 26.7% of GDP (EU 27.3 %). The biggest items are pensions 35.8% (EU 43.9%), health care 24.3% (EU 27.2%) and disability 12.8% (EU 7.6%).

2. Overall strategic approach

Finland has a strong tradition in promoting social cohesion and social progress based on comprehensive social protection systems, and mutually reinforcing and complementary economic, employment, social and educational policies. As regards the financing of social policy programmes, the greatest threats are from the international rather than the national operating environment. Long-term unemployment is still a major challenge among certain young unemployed groups and those nearer old age.

The Finnish NRS recognises that gender equality and anti-discrimination policies are important requirements for social inclusion and economic growth. Finland has a century-long tradition of equal and universal suffrage and the right to stand for election, which has furthered women's participation in political decision-making. In terms of social exclusion, the report shows that most individual recipients of social assistance are men, while most of the

single parents receiving this form of support are women. Furthermore, the majority of people receiving the basic unemployment allowance, labour market subsidy and earnings-related allowance are men. The Strategy concludes that gender equality will have increased without any operational targets. The government is implementing the Action Plan for Gender Equality in 2004–2007. The revised equality law entered into force in summer 2005.

The Ministry of Social Affairs and Health revised its strategy up to 2015 in spring 2006. The four strategic lines of policy for social protection are: *The promotion of health and working capacity*; *Increasing the attraction of employment; Care about and prevention of social exclusion;* and *Well-functioning social and health services and adequate income protection.*

The overarching objectives of the OMC for social protection and social inclusion are addressed in the Finnish NRS. Reducing health and welfare differences will improve social cohesion. NGOs will be mobilised to support this objective. The social inclusion of migrants and ethnic minorities has received special attention in the NRS.

The plans for a national reform are in accordance with the integrated guidelines forming the key part of the Lisbon strategy. These two reports have been coordinated. The role of structural funds in pursuit of the Lisbon strategy will be specified and developed. A detailed description of the use of the structural funds was not included in the NRS.

3. Social inclusion

3.1 Key trends

Despite the overall positive developments, a number of negative ones are also evident, in particular high structural unemployment and the increasing difficulty of breaking the cycle of social exclusion. The gap between the demands of working life and the skills and functional capacity of the socially excluded is perceived to have widened.

The groups under high risk of exclusion are the long-term unemployed, poor families with children, the homeless, the over-indebted, people with chronic illnesses, the disabled, substance abusers, prisoners and certain groups of immigrants.

At present, the price and distribution of alcoholic beverages is a target of critical public discussion. The NRS highlights the importance of the prevention of alcohol and drug experimentation and drug use, especially among children and young people. The unemployment rate decreased from 9.8% in 2000 to 8.4% in 2005, but this positive development does not mitigate the negative influence of the misuse of alcohol and drugs. There is a vicious circle: misuse prevents employment and unemployment supports misuse.

The level of relative poverty in Finland is 12% in 2004, and is among the lowest in the EU. . This is the result of economic growth and improved employment rates, but also active measures aimed at improving the quality of coverage of social services; and active labour market policy measures have seen the number of the homeless and long-term unemployed fall and the need for social assistance reduced. High structural unemployment remains a problem, however, and makes it difficult to break the cycle of social exclusion because unemployment and income problems have become a long-term issue. Evidence based on national data show that the rate of relative poverty has increased since the mid 90's.

The risks of social exclusion among children and young people, as well as among substance abusers, have increased recently. The number of children and young people subject to child protection measures has risen alarmingly. For example, the number of children placed outside the home (59 100 in 2005) increased by 19.8% from 2000 to 2005. However, this is partly the result of more effective and systematic policies, and does not necessarily reflect only changes or increases in social exclusion.

The number of people with a persistently low income continues to rise, increasing the risk of social exclusion. Normally, prolonged poverty is connected to remaining permanently outside the labour market. The number of insolvent people has remained steady at around 300 000.

Overall, favourable labour market developments have not eased the problem of structural unemployment. Most of the structurally unemployable people, approximately 100 000 in number, are under 55 years of age and could still be employed, but the insufficient number of jobs suitable for the structurally unemployable and the geographical mismatch between jobs and unemployed will continue to hamper their prospects of employment even in the future.

3.2 Key challenges and priorities

In the 2006 joint report, Finland identified four main challenges: increase in employment, decrease in unemployment, safeguarding of the pension reform and improved health. These challenges are covered in the NSR.

Finland's goal for 2015 is to be a socially and economically sustainable, efficient and dynamic society. Well-being is rooted in the maintenance of working capacity and general functional capacity, adequate income protection, and independent initiative.

In terms of social inclusion, this means, among other things, that the general functional capacity and social welfare of the population will be improved. People will stay at work for, on average, two to three years longer than they do at present. Poverty and marginalisation will be reduced and the promotion of health and welfare will become established as a normal aspect of operations in social policy. The availability, quality and impact of services will be improved. Income transfers will provide a reasonable income while still offering an incentive to work and social protection will have a sustainable financing base rooted in collective responsibility supplemented by individual responsibility.

The goals are set high. Two major problems may hamper the attainment of the goals: the ageing of the population and the financial cost of the programme. However, the social expenditure forecasts that are available up to 2030 indicate that increases in social expenditure can be funded, assuming positive growth and employment rates.

The Finnish strategy addresses the social inclusion objectives and supports the Commission's key policy priorities. The Finnish strategy does not, however, make any exact references to the Structural Funds. The funds are mentioned as a source of support for local and national projects.

3.3 Policy measures

In Finland, action to curb poverty and social exclusion is based on the development of extensive social security benefits and services. The measures launched by the government to combat poverty and social exclusion are based on the 2003 government programme. The

strategic targets of the programme were presented in the national action plan against poverty and social exclusion for 2003–2005. The strategic outlines of the government programme are supplemented and specified by different administrative sectors' own strategies and sector-specific targets.

The implementation of measures launched during the current term of government and the monitoring of results continue in the main part in 2006 and 2007. The outlines of measures against poverty and social exclusion will be re-examined when the new government takes office after the parliamentary elections of 2007. Therefore, the targets and concrete measures of the Finnish policies against poverty and social exclusion will not be specified until preparations are made for the programme of the next government in 2007.

The NRS lists four objectives (priorities): guaranteeing work opportunities for as many as possible; prevention of social problems and social risks; safeguarding the continuity of measures to prevent and correct social exclusion and poverty; and ensuring the supply of skilled labour in services safeguarding the welfare of residents.

In terms of social inclusion, the main objectives are the prevention of social problems and the safeguarding of preventive and corrective measures. A preventive approach will be the primary operating model. Early intervention is needed in the problems of children, young people and families with children. A major problem can, however, be the ability to maintain the universal service model under the economic constraints.

As for young people, the new youth act which took effect in March 2006 includes a target on social empowerment of young people with measures to improve young people's skills and prevent social exclusion. A social guarantee for young people was also put into place to prevent prolonged unemployment of young people and the linked exclusion threat.

As regards the gender perspective, the NRS identifies equality as an important requirement for social inclusion and economic growth. The majority of the structurally and long-term unemployed are men. Most individual recipients of social assistance are men, while most of the single parents receiving this form of support are women. The majority of those receiving the basic unemployment allowance, labour market subsidy and earnings-related allowance are men. Gender differences of this kind should be further considered in social policy planning and in the implementation of social inclusion programmes.

3.4 Governance

The NRS was drawn up following the Finnish administrative procedure in cooperation with various ministries. In this context, organisations representing the poor and socially excluded, labour market organisations, research institutes, local government representatives, and social work representatives of the Evangelical Lutheran Church of Finland have been consulted.

As regards the arrangements for monitoring and evaluation, the results of actions will be assessed separately once updated statistics on changes in poverty and social exclusion are completed. Efforts will also be made to use the available qualitative descriptions on the development of Finnish welfare. The development of poverty and social exclusion is assessed in connection with the follow-up to the government programme and in the annual reviews of various administrative sectors.

4. Pensions

In 2004, older people acknowledge a living standard relatively close to that of the general population (75%), while the poverty risk among older people at 18% (gender differences are high, 11% for men and 23% for women) is estimated to be significantly higher than for the population below the age of 65.

The 2006 Sustainability report assessed Finland as a low-risk Member States as regards the sustainability of public finances. Finland is expected to face relatively strong pressure on its public finances due to an ageing population. According to projections made by the AWG in 2005, public spending on pensions is expected to increase by a further 3.0 percentage points of GDP by 2050. According to ISG projections, net replacement rate levels are projected to remain roughly stable for a worker retiring at 65 after 40 years on the average wage, at a level of 63% in 2005 (gross 57%) to 62% in 2050 (gross 52%).

The 2006 Joint Report highlighted the key steps embedded in the 2005 reform, while stressing the need to ensure an effective further increase in the employment rate of older workers. In 2005, Finland introduced a reform of the earnings-related scheme which aimed at dissuading people from early retirement and at encouraging them to remain in the labour market. With this reform, Finland has made significant progress in meeting the challenge of financial sustainability of its pension system, while ensuring adequate pensions and adjusting the system to changing social circumstances, in particular through a mechanism to adjust pensions to increases in life expectancy. In the long run, the latest reform is expected to entail raising the age of retirement by about two or three years between now and 2050.

Finland has developed a strategy of accumulation of surpluses both in the private and the public sector (in total, the assets of social security pension schemes accounted for 59% of GDP in 2004). However, it is expected that a further increase in the contribution rate will be needed in the statutory scheme for the private sector. The government also plans to reform funding and insolvency rules as well as stepping up supervision with the aim of increasing returns and the security of earnings-related pensions and possibly softening the projected increase in contribution rates. The occupational pension schemes reform of 2005 made family-related leave a period of accumulating credits towards occupational pensions. This policy is likely to increase gender equality.

5. Health and long-term care

5.1. Health care

Description of the system: Municipalities provide/ purchase care for all their residents regardless of social and financial position. Primary health care – PHC (a wide variety of services, including preventive care) is provided in public health centres. Patients need a referral from their PHC doctor to visit a specialist. Specialised care is provided in outpatient and inpatient hospital departments. Federations of municipalities form hospital districts and own public hospitals. Private provision is mostly outpatient specialist care in large cities. Private physicians can refer patients to public hospitals. Public sector doctors receive salaries whilst private doctors are paid a fee for service. It is a taxation-based system: municipalities' flat-rate taxes and state subsidies cover most of the costs. It is coupled with co-payments for various services (e.g. hospital care, drugs). A compulsory sickness insurance scheme covers all residents and is financed through employers, the state and the insured. It refunds approximately a third of the costs of doctors' fees, examinations and treatment in the private

sector, two thirds of the costs of medicines (2005) and 90% of transportation costs. Employers (and the self-employed), through employers' contributions, provide/ buy occupational health care for 1.8 million employees (2004). Voluntary private insurance covers approximately 11% of the population, mostly children (2005). Authorities recognise as policy goals the need to ensure nationwide availability of accessible and quality services, prolong healthy and active life and reduce health inequalities. Recognising that a healthy population improves sustainability, a public health policy has been formulated with actions in all sectors (e.g. impact assessment of all policies, environmental policy, education and occupational health).

Accessibility: The report notes that local decision-making and different geographical conditions, treatment practices and shortages of staff have in the past resulted in geographical disparities in provision (e.g. different types of care provided/covered, differences in waiting times). With nationwide harmonised legislation and guidelines, the geographic differences in supply and access criteria have been diminishing. The authorities plan a municipal and service structure reform that extends the population base and the co-operation of municipalities, thus ensuring better countrywide availability of services. To reduce disparities in and shorten waiting times, legislation establishes the right to immediate access to health centres by phone during working hours or visit within 3 working days. Treatment should be provided within 3 months and maximum 6 months. A referral must be assessed within 3 weeks and hospital treatment provided within 6 months. Otherwise patients can be treated in another hospital district or in the private sector at the municipality's expense. The government stresses that centralised phone and internet services have been improving access. Inequity in access exists in that free of charge occupational health care is available only to a part of the population. The state is allocating extra funding to health care to face an increased demand for services. Private financing especially co-payments (19% of total expenditure in 2004) are still rather high but have decreased in recent years (20.4% in 2000). Payment ceilings are in place to reduce patients' cost burden. Data show that health inequalities exist.

Quality: The report describes the use of quality recommendations (e.g. staff numbers) and national safety guidelines as a means of improving general quality and patient safety (e.g. reducing hospital infections). It stresses that Finland has an extensive information management and statistics system that can be used for informed policy. Evidence-based medicine guidelines based on scientific expertise are being developed and published (on-line, on CD ROM) to make for better evaluation of the introduction of health interventions. Patient rights are legislated, as is the non-fault patient injury compensation system. All providers contribute to the injury fund out of which compensation is paid. Cases are analysed free of charge. Whilst recognising that in most municipalities there is little choice of public hospital and PHC doctor, authorities highlight that patients can choose between public and private providers when available. The choice of place of treatment is planned to increase. Authorities expect that the use of patients' assessment of services enhances responsiveness and that a national electronic patient record can ensure a better care path. On prevention, municipalities are responsible for child, maternal and school health care. Occupational health (adjusting working conditions, assessing and monitoring health hazards and employees' health through medical check-ups and arranging health care) is seen by authorities as a way to ensure lasting health and working capabilities as well as the system's long-term sustainability.

Long-term sustainability: Total health care expenditure (7.5% of GDP and 2275 per capita PPP$ in 2004) is at the EU average. The share of public health care expenditure (76.8% of total expenditure in 2004) is at the EU average and has been constant throughout the decade. The 2006 EPC/EC age-related projections show an increase in public expenditure of 2.3 percentage points of GDP by 2050. The insufficient coordination between specialist care,

PHC and social welfare and the division of duties between them are identified by the authorities as challenges to sustainability. Concentrating certain services at regional level, increasing municipal joint provision of care, creating health districts and work division at health district level, implementing joint procurement of medicines and material and national electronic patient records are some of the ongoing/ proposed measures to improve efficiency. Generic use – pharmacies must offer the cheapest medicine available for each active substance – is also seen as helping to control the increase in pharmaceutical expenditure together with the promotion of a more rational prescription and use of medicines and growing use of technology assessment for reimbursement. A reform of the pharmacies system is also planned to control retail prices. Regarding staff, the number of medical students has increased, which the government hopes will help overcome staff shortages especially in certain medical (PHC, dentists) and regional areas. Finland wants to ensure that staff adapt to a changing technological and multicultural environment. Authorities expect that the implementation of various health promotion programmes will reduce the prevalence of non-communicable diseases and reduce health inequalities. Municipalities have seen their role in health promotion increase. A health in all policies approach is to ensure that healthy options are widely promoted.

5.2. Long-term care

Description of the system: Long-term care is part of the health and social care systems and the responsibility of municipalities. All are eligible. Municipalities provide long-term medical care in health centres and non-medical long-term care in institutions and they provide service vouchers to social welfare clients to buy for example home help services. These are coupled with home help and support services, home health care, day hospitals and day-care centres and comprehensive rehabilitation services. Cash benefits (e.g. care allowances) are provided to pensioners. Informal carers receive municipal financial support (minimum €300/month) and a combination of health and social services (e.g. respite care) in agreement with the municipality and based on a care plan. Services are funded through municipal and state taxation plus client fees (e.g. in the public sector long-term inpatient fees are means-tested, and can be up to 80 % of clients' net income but no more than the actual costs of production). The policy focus is to improve/ maintain the autonomy and health of older persons while increasing access to care when needed by supporting independent living at one's home for as long as possible. Healthy ageing, enhancing home care, reinforcing rights and autonomy, and ensuring sufficient funding for services and individual reasonable incomes are priorities.

Accessibility: According to the report, provision and access vary substantially across regions and only 11.4% of all 75+ received regular home help (social) services, whereas the target is 25%. Thus, the government expects that a guidance project and additional state subsidies to municipalities will help to establish home help services, home nursing, day hospitals, day-care centres and part-time nursing. This is to be coupled with service housing (i.e. people live in rented apartments tailored to their needs, and are provided with meals, nursing and other help) and intermittent care in residential homes (whereby clients have at least eight periods of care a year). Joint municipal provision and access legislation (equal treatment, non-discrimination) are being implemented as a means of improving supply and access to care. Authorities also see the routine needs assessment of each 80+ as a way to define a care plan for those in need.

Quality: National quality guidelines (e.g. number of staff), better monitoring and a good practice guide are in place to enhance quality in the area. Indicators are increasingly used to measure patients' needs and services quality. Authorities seek more flexible and client-oriented provision (e.g. vouchers, an individual care plan established by a multidisciplinary

team, mother tongue) to increase choice and provision. Legislation has strengthened the rights of clients. As local authorities provide both health and social services, the report highlights that there are opportunities for coordinated/ integrated care. Authorities are encouraging close cooperation between municipalities, and between municipalities and national authorities and with third sector organisations, voluntary workers and enterprises. Prevention and rehabilitation in old age are receiving particular attention.

Long-term sustainability: In view of ageing (the 2006 EPC/EC age-related projections foresee an increase in public long-term care expenditure of 1.8 percentage points of GDP by 2050) and with the aim of decreasing and postponing inpatient and institutional treatment authorities are implementing various healthy ageing programmes (e.g. the health fitness programme for older people) and promoting volunteer work in old age. Staff qualifications have been revised and further education and training have been mandatory since August 2005. A special focus is put on geriatric and multi-professionalism training. A challenge identified in the report is work-related fatigue among staff.

6. Challenges ahead:

To promote the active inclusion of the long-term unemployed and inactive, especially young and older people and immigrants, in order to break the cycle of deprivation and avoid the development of new exclusions.

To address exclusion and other social problems associated with the misuse of alcohol and drugs.

With an ageing population, to increase the employment rate at both ends at the age spectrum, and in particular to ensure that the recent pension reforms effectively translate into further increases in the employment rate of older workers, thus contributing to adequacy and sustainability.

To reduce regional differences in access, tackle waiting times and enhance the provision of home care.

To improve system efficiency through greater emphasis on primary and outpatient care and regional concentration of services and promote health through a health in all policies approach.

Finland: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.0	114.0	**2000**	67.2	70.1	64.2	41.1	41.6	**2000**	9.8	9.1	10.6	21.4
2002	1.6	114.7	**2002**	68.1	70,0	66.2	40.7	47.8	**2002**	9.1	9.1	9.1	21,0
2004	3.5	110.8	**2004**	67.6	69.7	65.6	39.4	50.9	**2004**	8.8	8.7	8.9	20.7
2006	4.9f	113.1f	**2005**	68.4	70.3	66.5	40.5	52.7	**2005**	8.4	8.2	8.6	20.1

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	72.8	80.2	14.5	18.6	na	na	3.9	**1995**	7.5	75.6	-		
2000	74.2	81,0	15.5	19.3	56.3	56.8e	3.8	**2000**	6.6	75.1	20.4		
2004	75.3sp	82.3sp	16.5sp	20.5sp	57.3e	56.5e	3.3	**2004**	7.5	76.8	19		

s:Eurostat etsimate; p: provisional **THE: Total health exp.* ** Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	31.4	32.8	20.9	14.4	13.4	3.6	15
2000	25.1	35.8	23.8	10.5	12.5	3.5	13.9
2004	26.7	36.9	25.5	9.8	11.5	3.1	13.2

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	23.7	25.4	10.7	5.6	1.7
2010	25.4	0.2			
2030	45	4.7	3.3	1.1	1.2
2050	46.7	5.2	3.1	1.4	1.8

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk- of- poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12	10	24	11	18	14	11	14	17	10	**Total**	3.6
Male	11	-	22	11	11	15	-	16	18	9	**Male**	-
femal	13	-	26	10	23	13	-	13	17	11	**Female**	-

	People living in jobless households					***Long-term Unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				people				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	na	na	na	**1999**	3,0	3.2	2.8	**1999**	9.9	12,0	7.9
2004	5.7	11,0	11.2	10.9	**2004**	2.1	2.3	2.0	**2004**	8.7	10.6	6.9
2006	6.6p	10.5p	11.0p	10.0p	**2005**	2.2	2.4	1.9	**2005**	9.3	11.3	7.3

**: excluding students; p: provisional*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.748	0.811	0.712	***Aggregate replacement ratio***	0.46	0.455	0.459

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or social security)	Current estimate (2002)	Assumption
	-4	-4	DB			100			21.6		

**(DB / NDC/ DC); ** (DB / DC)*

2.26. SWEDEN

The Swedish government reports that, following the general election on 17 September 2006, it intends to present an update of its National Report on Strategies for SPSI. This country paper is based on the Report presented on 15 of September 2006. As with other countries, this paper should be read in conjunction with the analysis presented with the Annual Progress Report under the Lisbon process.

1. Situation and key trends

The Swedish economy is performing well, with growth in GDP of 4.1% in 2004 and expected growth of 4.0% in 2006. After some years of jobless growth, it now seems that employment will start to rise. With an overall employment rate of 72.5% and a high employment rate among women (70.4%) and older workers (69.4), Sweden still has one of the highest employment rates in the EU. The unemployment rate is almost the EU average and is especially high among young people and immigrants. The long-term unemployment rate is still low (1.2%) and the high youth unemployment rate gives cause for concern (22.6%[97]). The early school leavers' rate is still lower in Sweden (11.7%) than the EU average (15.1%) but exceeds the target to be reached by 2010. Sweden has an overall low at risk of poverty rate (9% in 2004) and low income inequalities (3.3). Differences can however be found between groups. Young people aged 18-24 and women over 65 live at significantly higher risk of poverty (25% and 14% respectively). Sweden still has the highest gross expenditure on social protection in relation to GDP (32.9% in 2004). Life expectancy at birth (78.4 and 82.7 years for males and females in 2004) is relatively high.[98] It has increased by about 1.5 years in the last decade (76.2 and 81.4 in 1995). Life expectancy at 65 was 17.4 years for men and 20.6 years for women in 2004. Sweden is projected to face less challenging demographic trends in comparison to most EU Member States: the old age-dependency ratio will increase from 26% in 2004 to 41% by 2050 (while the EU25 average will increase from 25% to 52%). Perinatal mortality is also low (5.2 in 2003) and has constantly declined since 1960 (25.4). Although the general statistics are favourable, the Swedish National Strategy Report 2006 points to certain signs of deteriorations in the public health status, e.g. increasing obesity rates in all ages, increased alcohol-related deaths in some regions and less favourable self-perceptions of the psychological situation.

2. Overall strategic approach

To pursue social cohesion the Swedish welfare system continues to be built on the principle of general income maintenance, to ensure a decent standard of living during periods of illness, unemployment, parenthood or old age. The Swedish National Strategic Report identifies a range of social conditions where improvements are needed and a quite extensive list of policy measures for the coming two years. The priorities chosen in the report are in line with the challenges Sweden is facing, with a broad list of measures chosen from the spring budget bill 2006 and earlier bills, but without any prioritising among them. Therefore, it is difficult to know what the main priority is. The key challenges identified in the report, as in former reports are on combating poverty and social exclusion, and increasing labour supply and the number of hours worked. The overarching aim is to boost the employment rate to 80% (for

[97] Provisional data.
[98] EU average was 75.1 and 81.2 years for males and females in 2003.

people in the 20-64 age bracket) and to reduce the unemployment rate to 4%. The employment goal was initially meant to be reached by 2004, but now it is as soon as possible. Furthermore, the Government has set itself the target of halving the number of sick leave days between 2002 and 2008 and decreasing the number of new entrants into sickness- and activity schemes (former disability pensions). Progress has been made but the stock of people already on disability schemes is still increasing although expected to reach its peak this year.

The relationship with the Lisbon strategy is visible and complementary. Disadvantaged groups on the labour market mentioned in the NRP for Sweden last year are also given priority in the report for social protection and social inclusion. It is mentioned that the relationship between the revised Lisbon strategy and how the open method of co-ordination is applied in the social area must be mutual. The Swedish government, as usual, invited a large number of stakeholders to participate in the work on the strategic report. The Swedish Social Insurance Agency (Försäkringskassan) plays an important role in reducing sickness leave while the National Labour Market Board (AMS) is responsible for active labour market policy. Gender mainstreaming, gender equality and the adequacy of the policy approach for advancing gender equality are good. Gender mainstreaming is applied to women and men in general and to immigrant women and men, but less so to young persons and handicapped persons, which could be further expanded on.

3. Social inclusion

3.1 Key trends

Sweden has an overall low at risk of poverty rate (9% in 2004 against 16% in the EU). Looking at the poverty rate in more detail, it can be seen that single-adult households, as expected, have a higher poverty rate than two-adult households (19% and 5% respectively).

One of the main policies in recent years has been to increase the number of people that proceeds to university studies. However, the labour market situation for young people with an academic degree has worsened in recent years and the unemployment rate among this group is on the increase. Even more striking is the growing problem of poor students (21.4% in 2000 and 32.3% in 2004).[99] Unemployed people with academic degrees face a difficult situation because of the very strict repayment schedules for student loans. One consequence of this is a drop in the number of applications for tertiary education, implying that the objective of 50% of every cohort gaining a university qualification seems further away now than it was a year ago.

In general, people out of the labour market, such as unemployed people, retired and other inactive people, have a much higher risk of poverty (26%, 14% and 24% respectively) compared with the average at risk of poverty rate (9%). Single persons, especially women, and single parents also have a higher risk of poverty (19%, 20% and 18% respectively). For immigrants, especially recent, the poverty rate is much higher than for native born (18.9% and 6.9% respectively).[100]

[99] National data, source. Income distribution Survey 2004. N.B. The students concerned are not necessarily university students.

[100] National data: Income Distribution Survey 2004, National equivalence scale.

The employment rate for immigrants and foreign-born citizens remains much lower than for native Swedes. According to national data the employment rate for foreign born citizens was 61.6% in 2005 compared with 76.1% for native Swedes.

3.2 Key challenges and priorities

The Swedish social model is characterised by a general welfare policy and an active labour market policy. The overall objectives during the period 2006-2008 are to create more jobs, reduce ill-health in working life, improve care of the elderly, make society accessible for disabled people, combat homelessness, enhance integration, create the conditions for staying longer in working life and increase gender equality. The Swedish government has put forward four main priorities for action; firs, to encourage work and education for all; second, to enhance integration; third, to guarantee good housing and to combat homelessness; and fourth, to support groups in especially vulnerable situations.

There is a high degree of congruence between the 2006 Joint Report and the Swedish Strategic Report: the four priorities chosen match the challenges identified in the 2006 Joint Report. The contribution of the European Social Fund (ESF) is mentioned as one possible source of funding to combat social exclusion during the next programming period, especially when it comes to integrating disadvantaged people and reducing the number of people on long-term sick leave. However, the ESF budget is relatively low in comparison with overall spending in this field.

3.3 Policy measures

To promote work and education for everybody is the first priority chosen by the Swedish government to combat social exclusion and poverty. All children are offered pre-school education for at least 15 hours per week as from the autumn when they turn four years old and there is a maximum ceiling on what you pay for childcare. The government has made commitments to increase the number of staff in schools and also to improve the quality. More attention is also given to students who are not completing the year in primary and secondary school. The government has recently adopted a comprehensive employment package that will give 55 000 more people, corresponding to 1% of the labour force, an active labour market measure in the form of a job or work-place experience during 2006 and 2007. In line with the challenges for Sweden, those targeted are disadvantaged people such as certain groups of immigrants, disabled people, long-term unemployed and people on long-term sick leave. Measures to give disabled people the possibility to work have also been improved. Furthermore, the government's work on reducing the number of people on sick leave and bringing them back to work continues. The proposed measures seem extensive but a better balance between supply-side measures and demand-side measures is wanted.

The responsibility for implementing the policy measures within this first priority is mainly shared between the municipalities, the National Labour Market Board and the Swedish Social Insurance Agency. Under the proposed Swedish NSRF for the Structural Funds, the ESF will play an active role within this field during 2003-2007.

Increasing integration is the second priority in the Swedish NSR, the aim being to help people to participate in society, to have their own income, to protect democratic rights, to act for equal opportunities for men and women and to prevent racism and ethnic discrimination. Measures to improve integration during the years to come include giving more financial resources to the municipalities, enabling them to hire teachers with specific language

knowledge to work in highly segregated areas in order to decrease the percentage of children and youths with uncompleted years in primary school. In view of the increase in early school leaving and the high youth unemployment rate this is welcome. Furthermore, additional resources will be given to the National Labour Market Board (AMS) to improve integration into the labour market. Also measures to fight discrimination will be given priority within this field. In the years to come specific measures in urban areas to increase integration (with support from the ESF) will also be introduced. Given the relatively high at risk of poverty rates for immigrants, together with the low employment rate, it is crucial to improve the integration of immigrants in order to meet the target of increasing labour supply.

To secure decent accommodation and to combat homelessness is the third priority in the Swedish NSR. The Government has appointed a national co-ordinator with responsibility for proposing measures by the end of 2007 on how the situation for young people could be improved as regards accommodation. To combat homelessness the National Board of Health and Welfare has been given the assignment of developing methods to map out homelessness. A large proportion of homeless people have substance abuse problems or mental health disabilities, and, for the latter personal representatives play an important role in representing them in, for example, contacts with authorities. In order to combat homelessness the government has set aside approximately €3.5 million yearly for 2007 and 2008. Beyond this almost €11 million is spent on personal representatives for people with mental health disabilities. The Swedish government's view is that the effort made by society to prevent families becoming homeless must be improved and it should be done by enhancing co-operation among the relevant stakeholders involved. Even though very important this priority is less expanded upon than others, especially as regards the housing situation for young people. It remains to be seen what conclusions the national co-ordinator will draw.

The fourth and final priority in the Swedish report is to support groups in particularly vulnerable situations. For young people a three-year trial will be conducted to develop and test a consilidated care chain in juvenile care. The aim is to give young people who put their health or development in serious danger through criminality or substance abuse the specific care offered by special approved homes. The young persons are to have a care co-ordinator. Approximately €250 million will be spent on this project. The government will also continue their commitment on enhanced care to people with problems of abuse. Women and their children who are facing violence will be given additional resources, approximately €11 million yearly as from 2006. More support for people faced by both problems of abuse and mental problems will be made available during 2005 and 2006. The main responsibility for implementing policies that secure the support and help needed for people lies with the municipality where the people in need of assistance live. This priority could be further expanded upon, for example, on the situation of people who have recently received their residence permits and the recent increase in number of poor students.

3.5 Governance

Most of the relevant stakeholders seem to have been involved in preparing the Swedish NSR. However, the parliament has not been consulted, which has been criticised by the NGO network. The NGO network consists of a large number of voluntary organisations in which labour market organisations also participate. Beyond regular talks with the government, NGOs have also offset out their priorities in one of the three annexes to the NSR, albeit without concrete suggestions as to what kind of practices NGOs could provide. Central authorities and the Swedish Association of Local Authorities and Regions have also been invited to information meetings on the preparation of the NSR. The social partners have been

informed via the regular meetings held between them and the Ministry of Social Affairs. It is not clear, however, what their impact on the NSR has been. Most of the measures that are presented in the NSR are implemented by central authorities. The government monitors the implementation of measures with ordinary instruments already in place.

4. Pensions

In 2004, older people acknowledge a living standard relative of fairly close to that of the general population (80%), while the poverty risk among older people at 11% (gender differences are high, 6% for men and 14% for women) is estimated to be slightly higher than for the population below the age of 65.

The 2006 Sustainability report assessed Sweden as a low-risk Member State as regards the sustainability of public finances. Sweden's public pension system is expected to face only low pressure due to the ageing population: according to the 2005 AWG projections, public spending on pensions is projected to increase very slowly until 2050 (of only 0.6 percentage points). Replacement rates at a given age are projected to decrease in the coming decades, following the increase in life expectancy. According to ISG projections, a worker retiring at 65 after 40 years of work would see the net replacement rate markedly decrease from 71% in 2005 to 57% in 2050 (from 68% in 2005 to 56% in 2050 for the gross rate; this includes occupational pensions that cover about 90% of the workforce). Accordingly, cohorts who retire in 2050 would need to work for about 4 more years in order to achieve the same replacement rate as those who retire in 2005.

The 2006 Joint Report underlined that Sweden has managed to create a public pension system which is both adequate and financially stable, as long as people compensate for the significant projected decrease in replacement rates by leaving the labour market later. Sweden ensures the financial sustainability of the pension system by automatic adjustments embedded in the pension system and through a reserve fund created at the beginning of the 1960s. Occupational pensions also make a notable contribution as they cover around 90% of employees and usually provide extra income amounting to approximately 10-15% of a person's final wage/salary.

While the Swedish pension system provides very comprehensive information to individuals (for instance, by sending out annual statements of pension capital accumulated so far and a projection of future pension entitlements), the 2006 report notes potential deficits in the level of knowledge that require long-term efforts. Although actuarial neutrality in the statutory scheme and possibilities for flexible retirement would keep people from retiring early, some channels of early exit from the labour market are starting to develop, in particular through sick leave and disability benefit, while the design of occupational pensions could be more supportive of longer working lives, in particular for white-collar workers.

5. Health and long-term care

5.1. Health care

Description of the System: Health care in Sweden is coordinated within a three-tier structure. The national level sets out policy goals and financial transfer mechanisms. The regional county councils are responsible for the organisation and provision of health care, and municipalities have a duty to provide health services for the disabled and elderly in certain circumstances. The county councils and municipalities impose taxes to finance health services

and their autonomy means that services can be organised and prioritised differently in various parts of the country. Health care is mainly tax-financed and health care services are mainly provided by public providers: public health care centres, hospitals and pharmacies. The physicians, mainly employed in public health care centres, act as gatekeepers guiding patients to specialists, usually resident within public hospitals. Some private care providers are affiliated to the county councils' reimbursement systems for providers. Outpatient care, hospital care and prescribed medicines are usually provided with only patient co-payment fees to be paid. The co-payment method differs depending on the type of benefit that is provided. For some age groups medical and dental care is free of charge. Maximum, total co-payments per year per patient apply in most areas and county councils can apply different co-payment rules and amounts.

Accessibility: Several initiatives to improve accessibility and to reduce waiting times (such as a national action plan for the development of health care services) have been taken recently. Patients now have increased options to access health care in another county than the one they reside in, with databases being developed to enable waiting time comparisons. Since 1997, a care guarantee has been in use to ensure that counties provide health care within a set timeframe. Currently, county councils have agreed to provide planned treatment within 90 days of a doctor's diagnosis. Co-payment fees can deter individuals from using healthcare as needed, which has been noticeable for dental care in recent years. To counteract access limitations by co-payments, medical and/or dental care is completely free for certain age groups and maximum total co-payment limits are set for others. Out-of-pocket payments by private households' (as a percentage of total health expenditure) amounted to around 13.4% in 2004. (The EU value in 2004 was 16.7%.) A reduction in the availability of psychiatric care in recent years is a growing issue in Swedish public debate leading to the appointment of a national co-ordinator in 2003.

Quality: The National Board of Health and Welfare and the counties' administrative boards are responsible for supervision, follow-up and evaluation of county council and municipal healthcare services, through the establishment of norms and guidance, supervision and the furthering of knowledge. The Board is also an important referee for proposed new policy measures. The 21 county administrative boards are responsible for supervision, follow-up and evaluation at regional level. The National Board has the task of developing a set of national quality indicators. Health professionals have established national quality registers to follow up specific treatments for major illnesses, with patient data on diagnosis, treatments and results. Currently 57 registers exist.

Long-term sustainability: Total healthcare expenditure (9.5% of GDP and 2875 PPP$ per capita in 2004) was above the EU average (8.87% and 2376.33 in 2004) and the sixth highest in EU as a percentage of GDP. The share of GDP was 9.2% in 1980-1983, declining to 8.2% in 1990-1997, but has since risen again. Public healthcare expenditure as a percentage of total health care expenditure decreased continuously from 92% in 1980 to 85.4% in 2004. Public health care expenditure has grown from 7.1% of GDP in 1998 to 8.1% in 2004. According to the 2006 EPC/EC projections public health care expenditure is projected to increase by 1.0 percentage points of GDP by 2050 due to population ageing, whereas a national projection state 1.3% of GDP. The Swedish report notes that it is necessary to continue restructuring healthcare to improve quality, productivity and efficiency, e.g. by further increased use of day-care surgery, with quicker use of truly innovative medical developments, and also efficient rejection of non-useful treatments after a fair evaluation. More cost-efficient use of pharmaceuticals should be further promoted. The generic substitution procedure in pharmacies since 2002 is reported to have resulted in considerable cost savings with similar

treatment quality. The Swedish report in 2005 noted the challenge of quickly counteracting new deteriorations in the public health status so as to avoid future expenditure risks. It made reference to prevention and health promotion being further incorporated within the healthcare system, with normal patient consultations being used to support the individual's own efforts to prevent illness by life style changes, etc.

5.2. Long-term care

Description of the system: Sweden's 290 municipalities have a statutory duty to meet the social service and housing needs of persons with disabilities and the elderly. Their autonomy allows services to be organised and prioritised differently in different parts of Sweden. The individual's need for support is assessed (though not means tested) in relation to income. The national policy for the elderly and the national disability policy stipulates that both groups should be able to live independent lives and should be enabled to live in their own home as long as possible.

Accessibility: Care services for the elderly and persons with disabilities have been significantly restructured over the last 15 years, with a reduction in institutional living and care and an increase in those living at home (sometimes with special adaptations) and receiving services provided at home. Home health care services still require improvement and expansion, and coordination between the county councils and the municipalities must be improved. The quality of care for persons with dementia also needs to be improved, through better service integration and more education. The restructuring and downsizing of institutional care has, in some communities, led to a noticeable lack of places in institutions / special housing, resulting in long waiting times. More detailed statistics and evaluation are required to help monitor whether social home care services actually reach those requiring care at home.

Quality: Legislation related to care for the elderly has been refined to improve legal security for individuals requiring care services, especially as regards institutional care provided by the communities. Knowledgeable and engaged personnel are key prerequisites for achieving and maintaining high quality in care services. Two earlier initiatives, the "Competence ladder" and "Education leave", supported the development of local education and training in basic know-how for care occupations. A study is planned to present proposals for a national system concerning professional qualifications, education and training for care occupations, and to propose actions to enhance future personnel recruitment.

Long-term sustainability: The long-term sustainability of care for the elderly is dependent on sound public finances and high labour force participation to finance projected care needs. The National action plan for elderly care, from 2005, includes actions that focus on support for development efforts in the communities and county councils to improve service quality and increase efficiency. The ministry of health and social affairs is preparing a study on long-term needs and expenditure for welfare services, including care for the elderly. Between 2000 and 2004 total expenditure on care for people 65 years and older increased 1.5 times more than the numbers in this group increased. Only county councils' expenditures increased whereas the community sector's expenditure fell. According to the 2006 EPC/EC projections, public long-term care expenditure is projected to increase by 1.8 percentage points of GDP by 2050 due to population ageing (from 3.8% of GDP in 2004), whereas a national projection put this figure at 2.9 percentage points.

6. Challenges ahead

To continue with measures targeting the active inclusion of more people into the labour market by addressing the persistently high employment gap between immigrants and the native-born population as well as the worrying problem of high unemployment among young people.

To put further emphasis on transitions from sickness-related schemes, including the high stock of people already in sickness- and activity schemes, into the labour market.

To continue to address early exit from the labour market through sick leave and disability pensions and to monitor the outcome of current pension reforms.

Demographic developments will require not only a much more streamlined and efficient organisation of care services and more cooperation between different care providers, but it may also require significant reorganisation of the political and administrative levels responsible for care services.

To quickly counteract recent deteriorations in the public health status as to avoid future expenditure risks.

Sweden: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.3	118.8	**2000**	73,0	75.1	70.9	42.2	64.9	**2000**	5.6	5.9	5.3	10.5
2002	2.0	113.7	**2002**	73.6	74.9	72.2	42.8	68,0	**2002**	4.9	5.3	4.6	11.9
2004	4.1	115.4	**2004**	72.1	73.6	70.5	39.2	69.1	**2004**	6.3	6.5	6.1	16.3
2006	4.0f	116.1f	**2005**	72.5b	74.4b	70.4b	38.7b	69.4b	**2005**	7.8p	7.9p	7.7p	22.6p

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast; b: break in series; p: provisional*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health Exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	76.2	81.4	16.0	19.6	n.a	n.a	4.1	**1995**	8.1	86.6	-		
2000	77.4	82.0	16.7	20.0	63.1	61.9	3.4	**2000**	8.4	84.9	13.8	100	n.a.
2004	78.4sp	82.7sp	17.4sp	20.6sp	62.5e	62.2e	3.1	**2004**	9.5	85.4	13.4		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	34.3	37.4	22	10.8	11.4	6.2	12.2
2000	30.7	39.4	27	7.1	9.3	4.5	12.8
2004	32.9	40.1	25.4	6.2	9.6	3.9	14.8

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	26.4	29.6	10.6	6.7	3.8
2010	28.0	-1.4			
2030	38.5	1.3	0.4	0.7	1.1
2050	40.9	2.2	0.6	1.0	1.7

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64*	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	9	9	9	9	11	19	17	19	23	10	**Total**	3.3
Male	9	-	9	9	6	20	-	23	26	9	**Male**	-
femal	10	-	10	8	14	17	-	17	20	11	**Female**	-

* break in series

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	n.a.	n.a.	n.a.	n.a.	**1999**	1.9	2.2	1.4		**1999**	7.7	9.2	6.2
2004	n.a.	n.a.	n.a.	n.a.	**2004**	1.2	1.4	1.0		**2004**	8.6	9.3	7.9
2006	n.a.	n.a.	n.a.	n.a.	**2005**	1.2p	1.4p	1.0p		**2005**	11.7b	12.4b	10.9b

**: excluding students; p: provisional; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.797	0.865	0.754	***Aggregate replacement ratio***	0.581	0.605	0.543

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*						
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates			
			Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**				pensions (or social security)	pensions		
Total	Total	Statutory pensions				Statutory pensions	Occupational and voluntary pensions			Current estimate (2002)		Assumption
-15	-12	-13	NDC/DC	1	DB	100	90		17.2	13.7		13.7

** (DB / NDC/ DC); ** (DB / DC)*

2.27. UNITED KINGDOM

1. Situation and key trends

In 2005 UK GDP growth slowed to 1.9%, although forecasts for 2006 estimate an increase in GDP growth to 2.7%. Employment rates continue to grow, albeit modestly, and the UK exceeds all quantitative Lisbon targets on employment. Total employment in 2005 stood at 71.7% (male employment of 77.6% and female employment 65.9%). Employment amongst those aged 15-24 (54%) and employment amongst those aged 55-64 (56.9%) are both above EU averages. Unemployment remains stable at 4.8% (2005), yet the number of people living in jobless households continues to give cause for concern: 10.7% of 18-59 year-olds excluding students (EU25=10.2%) and 16.2% of children (EU25=9.6%); in this context it should be noted, however, that the UK has a high number of one-person, or one-adult households. Furthermore, whilst overall activity rates compare favourably with EU averages (75.3% as against 70.2% for the EU-25 in 2005), the number of people inactive because of poor health continues to be a key concern for the UK government. However, it is starting to fall and is now the focus of major labour market reform. In 2004, at 19%, the at-risk-of-relative-poverty rate[101] remains 2% points higher than the EU average. According to SILC provisional data, at-risk-of-poverty rates are particularly high amongst those under 18 (22%) and over 65 (27% in total, rising to 29% for women), but according to national data the rates for both groups have improved considerably in recent years.

The UK faces similar demographic trends to most EU Member States: the old-age dependency ratio (24% in 2005) is broadly in line with the EU average; and projections estimate that increases in the UK dependency ratio (to 45% in 2050) will be at a slower rate than the EU average. Life expectancy (76.3 for males and 81.1 for females in 2004) is above the EU average for males and below the EU average for females, showing a increase of two years since 1995 (74.0 and 79.2). Healthy life expectancy (61.5 and 60.9 in 2004) is well below the EU average, by about 3 years for males and 5 years for females. Infant mortality, at 5.1 deaths per 1,000 live births (2004), remains above the EU average of 4.5, but much reduced from 18.5 in 1970. Gross social protection expenditure was equal to 26.3% of GDP in 2004; there has been a steady net downward trend in expenditure as a proportion of national income, but that masks significant variation in the component parts of spending, e.g. as the number of people unemployed has fallen, consequent total expenditure on unemployment benefit has fallen. Total age-related social protection expenditure is projected to grow from its current level (19.6% GDP) by an extra 4 percentage points by 2050.

2. Overall strategic approach

The UK adopts a multifaceted approach to combating poverty and social exclusion founded on a principle of 'work for those who can and support for those who cannot'. Work is seen as the primary route out of poverty and to strengthen social cohesion, and many of the UK's initiatives are rooted in activation measures, facilitating access to the labour market, and providing financial incentives to work. Measures are often tested in small areas before being rolled out to a wider population. In its National Report the UK identifies its key challenges as:

101 Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the data presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) the data used was based on the national family resources survey that was not fully compatible with the SILC methodology based on detailed income data. The EU-SILC data for the UK is provisional.

maintaining a positive economic situation; ensuring access to employment; tackling child poverty; ensuring access to services; and tackling discrimination. Priorities for action stem directly from these challenges, chief amongst which is the commitment to eradicate child poverty. To this end the UK plans to intervene in favour of disadvantaged children and young people in order to break the transfer of poverty from one generation to the next. There is a strong correlation between the approaches set out in the UK's Lisbon National Reform Programme and the National Report on Strategies for Social Protection and Social Inclusion and a clear commitment to involving stakeholders in the development of policies that will affect them. Perhaps less clear is how inequalities in British society are being addressed and social cohesion achieved.

3. Social inclusion

3.1 Key trends

In 2004, according to SILC provisional data, the overall poverty rate of 19% of the total population remained above the EU average (16%). However, according to national data, it has improved slightly over recent years. Progress in reducing the proportions at risk of poverty can be noted, particularly with regard to pensioners and children. It is clear that additional resources targeting these groups are now beginning to take effect. Whilst the government's own targets on child poverty reduction were narrowly missed in 2004/5 significant progress has been made, with 700 000 fewer children at risk of poverty than in 1998/99 (national data). Nonetheless, ambitious targets for future years are unlikely to be realised without sustained extra effort and resources. NEET (young people not in education, employment or training) are likely to stay a particular focus of government efforts in the UK. Other groups such as disabled people, jobless lone parents, certain ethnic minorities and people living in areas of high deprivation continue to exhibit high at-risk-of-poverty rates.

The net income of jobless social assistance recipients is roughly equivalent to the poverty threshold, with lone parents better off as a result of transfers than single people or couples with children. The long-term trend shows a reduction in the proportion of jobless households, although this remains above the EU average and has slowed in recent years (for households with children the proportion continues to decline at a steady pace). Reductions in the employment gaps for some at-risk groups have been evident in recent years, most notably lone parents where the employment rate has increased by 11.3 percentage points since 1997. Income inequality remains significantly above the EU average; only Poland, Portugal and the Baltic States exhibit wider income disparities.

3.2 Key challenges and priorities

The key priorities identified by the UK in the NRS are: eliminating child poverty via a combination of measures to ensure financial stability and break cycles of deprivation, including via early years provision and improved education; increasing labour market participation where key policies focus on activation of lone parents, people out of work for health reasons and those over 50 years of age; improving access to quality services through more competition in their provision, measures to build the capability and capacity of civil and public service and the setting of public service agreement targets; and tackling discrimination – notably towards disabled people and people in and ethnic minority groups. The priorities selected would seem appropriate, and are consistent with the challenges for the UK identified by the 2006 Joint Report.

Much attention is paid to getting people into work. The importance of addressing the challenge of poor basic and transferable skills (particularly literacy and numeracy) as a driver to enhance individuals' chances for inclusion, employment and advancement is referenced in both the NRS and NRP. A fuller discussion of the quality and sustainability of work would benefit, however, and will be informed by research undertaken through the on-going Employment and Retention and Advancement Demonstrator.

There is recognition of the risks of over-indebtedness with the development of a strategy in 2004 to minimise the number of people falling into problem debt and improve support processes for those already in debt. The impact of action stemming from this strategy is as yet not demonstrated as personal debt has reached record high levels and the number of people signalling problems keeping up with debt repayment, including the number of personal insolvencies, continues to rise

3.3 Policy measures

UK government strategy continues to move away from a more passive welfare system to one which encourages the development of individuals' potential, including via a preventative approach. The UK has a wide and sophisticated array of initiatives and benefits aimed at increasing activation, alleviating poverty particularly child poverty, and making work pay. Worth highlighting are the National Minimum Wage and the new system of ‘tax credits’ which seek to increase the financial incentives to work. Many of the benefits available are means-tested or designed for specific target groups to focus on those most in need. Such schemes have been criticised for being overly complex and the initial impact of the tax credits programme was hampered by administrative problems. Simplification could help to ensure that people are aware of the support available to them and not discouraged from availing themselves of this.

The Welfare Reform Bill of 2006 seeks to introduce reforms to benefit systems, notably for incapacity and housing benefits. The successful 'Pathways to Work' activation pilot initiative will be extended nationally by 2008 to support the replacement of the existing system of incapacity benefits with a new simplified benefit with a clearer balance of rights and responsibilities. A Cities Strategy has also been launched for some of the most deprived areas of the country. Proposals include key targets of: reducing the number of people claiming incapacity benefits by a million in a decade; helping 300 000 more lone parents into work; and increasing the number of older workers by a million.

In addition, the UK government has announced its intention to ‘improve opportunity and strengthen society’ by increasing equality between races and deepening people’s sense of ‘togetherness’ amidst increasing concerns over divisions in society. An Action Plan has been launched to focus on the most vulnerable in society (children in care, families with complex problems, teenage pregnancies and people with mental health problems). Such groups undoubtedly face a greater risk of poverty and social exclusion and their targeting should be welcomed. However, it is not yet clear what mix of activation and support will be proposed. Some commentators have raised concerns that the approach taken by the UK government may risk stigmatising the very groups they are trying to assist. Furthermore, as the focus shifts yet further to the most excluded, success will increasingly depend upon ensuring the continued capacity of the relevant services and agencies to intervene flexibly according to the needs of individuals, in the context of substantial administrative efficiency savings.

Some reference to gender issues and the impact of inequalities is made in the NRS and in the Lisbon NRP. The UK average hourly gender pay gap is the highest in the EU. In addition, high UK rates of part-time employment amongst women impact upon earnings over working lives and pension prospects. Following the report of the Women and Work Commission report, the UK government has stated its intent to "take action to address all causes of the gender pay gap" but it is not yet clear that current measures will bring substantial results in narrowing the gender pay gap.

Because of the complex and inter-related nature of the measures cited, which will contribute to the achievement of the UK priorities, as set out above, the resource implications are not easily disaggregated. In addition to domestic resources, European Structural Funds, and particularly the European Social Fund, contribute to the reduction of poverty and social exclusion via a range of measures, often highly innovative and closely tailored to providing solutions to individualised and diverse needs. In the main this is achieved through a focus on the activation of disadvantaged groups via a pathway approach of 'soft' interventions to more mainstream active labour market policies. The strong partnership ethos in the allocation and delivery of ESF, through models such as Global Grants, has been particularly valuable in enabling small grass roots NGOs to work with the most disconnected in society who are often too hard to reach for more mainstream activities.

3.4 Governance

There is a clear commitment to delivery on goals set out in the National Report on Strategies at all levels and an increased impetus to do so. This is evidenced by the appointment of a Minister for Social Exclusion and by an increased engagement with stakeholders in the policy process. The UK has a complex system of government and an active voluntary and community sector.The National Action Plan on social inclusion, as part of the NRS, is highlighted as "providing an important means of linking action at central government level with the wide range of actors across the UK who are concerned with social inclusion". The 'Get Heard!' toolkit and 146 workshops held around the UK have informed the production of the NRS and serve as a valuable two-way communication with many and varied stakeholders. The substantial and qualitative involvement of these stakeholders in the design, implementation, and to some degree, monitoring of social inclusion policy and the framing of the NRS has undoubtedly had positive effects on the policy process and in many respects can be viewed as a model of best practice.

4. Pensions

In 2003 older people had an average income 72% of that for people aged 0-64. The at-risk-of-poverty rate among elderly people in the UK has declined significantly in recent years, but remains above the EU average and higher than for the general population.[102]

The 2006 Sustainability Report assessed the UK as a medium-risk Member State as regards the sustainability of public finances. According to the AWG projections of 2005 (which do not include the effects of the proposed 2006 pensions reform) spending on public pensions, including pensions of public employees, will increase by 2 percentage points of GDP from 6.6% of GDP in 2004 to reach 8.6% in 2050. According to ISG projections (which do not

[102] According to latest national figures, in 2004/05, when incomes are measured after housing costs, a pensioner in the UK is nowadays less likely to be in poverty than the rest of the population.

reflect the 2006 proposed reforms), replacement rates are set to decline slightly in the coming decades for people with supplementary pension provision, from 82% to 73% in net terms (under the assumption of a contribution rate of 23.7% - 18.7% employer and 5% employee - which is significantly higher than the current average contribution rates to occupational schemes).[103] For people with no supplementary pension provision (nearly half the workforce) the decline in replacement rates would be sharper (from 38% in 2005 to 23% in 2050, 53% to 38% in net terms), essentially reflecting current indexation rules and the clear incentives for supplementary saving.

The key challenges, identified in the last report, were for the UK to continue making progress in addressing the adequacy of pensions. The momentum in reducing pensioner poverty is expected to continue with the implementation, and improving take-up, of Pension Credit. As set out in the White Paper on pension reform – *Security in Retirement* – it had long been recognised that 'further steps would be needed to ensure that people could get the retirement income that they expect in the future'. The UK pensions system has historically been characterised by a reliance on occupational and personal pension schemes to ensure adequacy and sustainability, but participation and contributions to such schemes has declined since the early eighties. In response to this the UK government appointed a Pensions Commission in 2002 to make recommendations on the future adequacy of private pension saving and set out proposals for reform.

In 2006 the UK Government, after looking at the recommendations of the Pensions Commission, proposed to introduce (in particular in view of the decline in supplementary saving) low-cost personal accounts to give those without access to occupational pension schemes the opportunity to save. Individuals will be automatically enrolled into either their employer's scheme or a new, low cost, personal retirement account, with the freedom to opt out, and employers will also contribute to these accounts. In order to provide a solid foundation to private saving, the state pension system will be reformed by indexing both the guarantee element of Pension Credit and the basic state pension in line with earnings growth, rather than prices. Both elements of the state pension will be made more equitable and more widely available (which will especially benefit women and carers) and the State Pension age will gradually rise in line with increasing longevity, reaching 68 by 2046. Legislation on these proposals was submitted to Parliament in November 2006 (and is expected to receive royal assent by mid-2007), and a white paper on personal accounts was published in December 2006. The development of the reformed system will be watched with interest, in particular the development of automatic enrolment and personal accounts.

5. Health and long-term care

5.1. Health care

Description of the system. Health care is delivered through the mainly tax-funded National Health Service (NHS), which provides health care services free of charge at the point of delivery, with universal coverage based on residency in the UK. There are a limited number of patient co-payments for non-medical services, e.g. pharmaceuticals. Children, elderly people and benefit recipients, do not pay these charges. The responsibility for health care in Scotland, Northern Ireland and Wales is devolved to the respective administrations. The

[103] It should be noted that UK pension funds appear to have achieved higher rates of return in the past and lower administration costs than those assumed for the purpose of the ISG exercise

health strategy and challenges include: continuing to improve the quality and capacity of health care service (reduce waiting times); building a service that is responsive to patients and their needs; improving value for money; preventing ill-health; and addressing health inequalities (especially in access to HC services). England exhibits a clear purchaser-provider split in its NHS organisation, which is not present in the rest of the UK. In **England,** the Strategic Health Authorities (SHAs) are responsible for strategic leadership, for ensuring local systems operate effectively and deliver improved performance. Primary Care Trusts (PCT's) are responsible for improving the health status of their populations, contributing to well-being and protecting health. This includes the commissioning of health services to meet population needs. Hospital services are managed and run by NHS Trusts, which are self-governing organisations, managed by the SHAs. The Trusts receive most of their income from service level agreements with PCTs. The best performing NHS Trusts are awarded 'foundation status' as independent public benefit corporations, accountable to Monitor, an independent regulator. This status brings increased flexibility in managing their own budgets and the possibility of borrowing money privately. In **Scotland,** the power to provide comprehensive health care services is delegated to 15 NHS Boards, which establish Community Health Partnerships in order to further integrate primary care, specialist services and social care. In **Wales** the National Assembly has put in place a structure where 13 NHS Trusts are the main providers of hospital care. 22 Local Health Boards, created in 2003, are responsible for determining the health needs of the local population and commissioning appropriate services. In **Northern Ireland,** the four Health and Social Services Boards are responsible for commissioning integrated health and personal social services from a range of providers, with 19 Health and Social Services Trusts being the main providers.

Accessibility. Waiting times have been a major concern in UK health service provision. Substantial increases in public health care investment and expenditure throughout the UK in recent years have begun to improve waiting times in most areas, although these continue to give cause for concern for some types of treatments and in some geographic areas. NHS patients in **England** have the right to choose between different health care providers, since 2005. A target of 'free choice of provision' by 2008 has been set (providing that providers meet NHS standards and treat patients within the national maximum NHS price).Care is shifting from hospitals to primary care and the community. Steps to increase accessibility have been taken (walk-in centres, NHS Direct). National procurement is underway to provide more GPs in geographic areas where there are shortages. In **Scotland,** the overarching focus is placed on tackling health inequalities. Several initiatives are in place to help the NHS Boards optimise the use of acute hospital beds. In **Northern Ireland,** reducing the length of waiting times is a key priority and waiting times have been reduced significantly in recent years. There is a systemic shift of focus towards measuring total waiting times from referral to treatment. In **Wales**, there is high demand on acute hospitals, with high levels of emergency admissions resulting in long waiting times. In order to tackle the causes of poor health, a resource allocation model, which channels resources to Local Health Boards on the basis of residents' direct health needs, is being implemented. Despite improvements in access to health services, the 2009 target remains the reduction of maximum waiting times to six months.

Quality. In **England**, the development and delivery of National Service Frameworks has resulted in improvements in the quality of care, with progress made in tackling the country's bigger killer diseases. Patient-choice has been facilitated with an emphasis on helping patients decide on the time and place of their care, as well as the development of a new system of tariffs to ensure that money follows the patient. Maximum waiting times for inpatient treatment has been reduced from 18 months to less than 6, and by the end of 2008 will be a

maximum of 18 weeks from GP referral to treatment. **Scotland** has a poor record on healthy life expectancy and there are large gaps between the health status of rich and poor. A key objective is to improve health generally through persuading and supporting people to make healthy lifestyle choices. In **Wales,** a new resource allocation model aims to reduce acute hospital treatment by improving illness prevention, developing more comprehensive primary care and improving social care provision. Patients and the public are being given a greater role in local decisions about the NHS. The standards set have been broadened to include an evaluation system based on a 'balanced scoreboard' approach. In **Northern Ireland,** a statutory duty of quality has been in place since 2003. A number of new standards will be introduced in the coming years to assist service providers in assessing risks and in reporting on the quality of service provision. A range of initiatives are underway concerning wider determinants of health and encouraging people to make healthy choices.

Long-term sustainability. In recent years the UK government has implemented historic levels of increased investment in health care whilst recognising the importance of promoting healthy lifestyles to ensure the financial sustainability of its health care system. Health care investment is expected to increase and reach around 9% of GDP by 2007-8, combining both public and private sources as well as reflecting the overall GDP growth. According to the 2006 EPC/EC projections, public health care expenditure is set to increase by 1.9 percentage points of GDP by 2050 due to population ageing. In **Scotland,** the 2006-7 budget for health and community care services is £9.5bn. Scottish authorities have identified significant cash savings over the three-year period to 2007-8 and a Scottish National Tariff is being implemented to create a set of standard prices for most procedures. Several initiatives in health improvement policy are in place, helping people make healthy lifestyle choices. In **Wales,** commissioning arrangements are being strengthened in order to make these as effective as possible. *Health Challenge Wales* has raised the profile of health improvement and the Health Inequalities Fund has contributed significantly in reducing health inequalities across the Welsh nation. The expected increase in demand for health and social services in **Northern Ireland** is to be addressed through encouraging individual responsibility for their own care, the promotion of their own health and their communities.

5.2. Long-term care

Description of the system. In **England,** Local Authorities (LA's) have a statutory duty to provide social care. Most LA's commission social care from private and voluntary organisations, although some local authorities also provide services. In the majority of local authority areas access to social care services is means-tested and determined through eligibility criteria. Service users can choose to receive a direct payment rather than a pre-determined care package. In **Scotland,** 32 local authorities are responsible for service delivery. They have a duty to assess and provide appropriate services to people in need and to decide upon the most appropriate service for individuals, taking into consideration their wishes. Social services in **Wales** are delivered by around 1 800 statutory, private and voluntary organisations. Most social services are commissioned by Local Authorities (22), which have a legal duty to provide support in ways that meet individuals' needs, and are provided by the independent sector. In **Northern Ireland,** residents who are assessed by their local Health & Social Services Trust as requiring social services are entitled to have those needs met, subject to available resources. Social services are required to carry out regular reassessment of an individual's needs. Where care is delivered in a residential setting, Trusts assess the client's ability to pay for those services with possibilities for charges recovery.

Accessibility. In **England,** local councils are responsible for determining eligibility for adult social care in accordance with a national eligibility framework. Guidance requires regular reassessment to ensure that the care provided is still appropriate and necessary. Social services are means-tested and out-of-pocket payments are the norm, even though many people receive support via welfare benefits; the use of direct payments is increasing. The government has taken several steps to support informal carers: increased financial support through enhanced social security provision and statutory changes to increase flexibility for carers. **Scotland** introduced free personal and nursing care in 2002. People who live in care homes and pay their own fees will receive payments if they require nursing care. Persons aged 65 and over are also eligible for payments towards the cost of their personal care. People at home, aged 65 and over, in receipt of personal care services from the local councils are not charged for them. The **Welsh** Assembly Government has emphasised its commitment to supporting carers and has announced a significant package of investment to support older and disabled people through a range of initiatives. These will reduce the burden of paying for home care while at the same time offering people and their carers additional services and support. In **Northern Ireland** free personal care in residential care and nursing homes has not been introduced, despite recommendations. Direct payments are increasingly used and a plan for delivering a range of practical support services for carers has been introduced (e.g. respite services for carers).

Quality. In **England,** service users generally prefer support to stay at home if possible; the Government has prioritised this and expects to meet its PSA target. A ten-year strategy to ensure fair, high quality integrated health and social care services for older people has been set up. The government has committed itself to creating a single, integrated regulator of both health and social care. In **Scotland,** community care policy has tended to enable people to live as normal a life as possible in their own homes. The Social Work Inspection Agency replaced the former inspection arrangements with a national Performance Inspection Model (2005). In **Wales,** the establishment of a Commissioner for Older People is being considered. In **Northern Ireland**, recognising that older people prefer to remain in their own homes wherever possible, there is a target for 2007 stating that 42% of people in care management should have their needs met at home. The DHSSPS has commissioned the development of a single comprehensive assessment process for care needs.

Long-term sustainability. Throughout the UK there have been substantial increases in the level of funding or resource allocation for long term care to the relevant authorities and bodies. According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.8 percentage points of GDP by 2050 due to population ageing. In **Wales,** the Revenue Support Grant in 2006-7 included an extra £45m to help LA's to address pressures in the health and social care system, avoiding admissions to hospital, improving commissioning and addressing the needs of an ageing population. In **Northern Ireland,** the 1993 changes have moved service provision away from institutional settings to community and domiciliary care services.

6. Challenges ahead:

To continue efforts to reduce persistent inequalities, such as those in income, health, skills and 'life chances'.

To tackle levels of economic inactivity by improved engagement with vulnerable groups whilst adequately supporting the transition to quality and sustainable work.

To pursue the reform process and continue to address the pensions adequacy gap, in particular for those with more modest incomes; to ensure continued and increasing access to quality supplementary pension provision and that the pension system offers adequate incentives to save and work longer.

To address health inequalities (regional and socio-professional groups), particularly with regard to access in both health care and long-term care, since some parts of the UK have made some care services free (Scotland, Northern Ireland) and the remaining counterparts have maintained means-testing and discretion in the provision of long-term care.

To look at ways of integrating health and social care services to achieve a uniform setting for the continuation of adequate and high quality care, throughout the UK.

UK: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,8	111,8	**2000**	71.2b	77.8b	64.7b	56.6b	50.7b	**2000**	5,5	6,0	4,9	12,6
2002	2,1	116,1	**2002**	71,3	77,6	65,2	56,1	53,4	**2002**	5,1	5,6	4,5	12,0
2004	3,3	118,0	**2004**	71,6	77,8	65,6	55,4	56,2	**2004**	4,7	5,0	4,2	12,1
2006	2.7f	117.2f	**2005**	71,7	77,6	65,9	54,0	56,9	**2005**	4,8	5,1	4,3	12,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,0	79,2	14,6	18,2	60,6	61.2e	6,2	**1995**	8,19		:		
2000	75,4	80,2	15,7	18,9	61.3e	61.2e	5,6	**2000**	7,3	80,9	10,5	100	10
2004	76.3sp	81.1sp	16.6sp	19.6sp	61.5e	60.9e	5,1	**2004**	8,1	85,9	10,8		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	28,2	43,1	24	5,6	8,9	7,5	10,9
2000	27,1	48,8	25,5	3	6,9	6,4	9,4
2004	26,3	44,6	30,4	2,6	6,7	6,4	9,2

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	24,4	19.6 (20	6.6 (2005)	7 (2005)	1 (2005)
2010	25,1	-0.2			
2030	30,3	+2.2	+1.3	+1.1	+0.3
2050	45,3	+4	+2	+1.9	+0.8

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	19pb	22pb	18pb	15pb	27pb	21pb	19pb	22pb	24pb	19pb	**Total**	5.6pb
Male	18pb	-	16pb	14pb	24pb	23pb	-	24pb	26pb	19pb	**Male**	-
Female	19pb	-	19pb	16pb	29pb	20pb	-	21	22pb	20pb	**Female**	-

b: break in series; p: provisional

	People living in jobless households					Long-term unemployment rate				Early school-leavers			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	18,4	11,8	9,6	13,9	**1999**	1,7	2,2	1,0		**1999**	18,4	19	17,9
2004	16,8	11,0	9,0	13,0	**2004**	1,0	1,2	0,6		**2004**	14.9i	15.7i	14.2i
2006	16,2	10,7	8,8	12,5	**2005**	1,0	1,3	0,7		**2005**	14	14,7	13,2

** excluding students* *i: change in methodology*

SILC income 2005	Total	Male	Female	SILC income 2005	Total	Male	Female
Relative income of 65+	0.720pb	0.738pb	0.713pb	***Aggregate replacement ratio***	:	:	:

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)			Contribution rates	
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or social security)	Current estimate (2002)	Assumption
3	3	2	DB	0	DB	100	56	17.75-10.9	16,6	23,7

**:(DB / NDC/ DC); ** (DB / DC)*

3. ANNEXES

3.1. 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 inclusion104. 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.

[104] 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

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

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

3.2. 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[105].

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[106] 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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[105] 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.

[106] 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.[107]) that were not fully compatible with the SILC methodology based on detailed income. Following the implementation of EU-SILC in a given country, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years. This is why no trends in income based indicators are presented in this year's report.

Limitations

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

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

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

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

Confidence intervals

Indicators are estimated values based on a sample drawn from the target population and thus are affected by sampling error. Statistical theory provides us with tools for calculating

[107] See specific footnotes in each country profile

confidence intervals in which the population value lies with a high probability. The confidence intervals are centred around the estimated values reported and their length is a measure of the precision of these estimates. The precision depends on the design of the survey and can thus vary between the countries. However, the EU-SILC regulation provides for national samples to be designed so as to achieve a confidence interval of +/- 1% around the estimated value of the total at-risk- of-poverty rate. Eurostat is computing these intervals for a number of indicators and exact values will be reported in EU quality reports. First computations show that the confidence intervals around total at risk of poverty rate are of the order of +/- 0.8%. For S80/S20 income quintile share ratio, the confidence intervals are of the order of +/- 0.2. For the relative median at risk of poverty gap, they are of the order of +/- 1.7. For the Gini-coefficient, they are of the order of +/- 0.9. These indications of precision must be taken into account when interpreting the data.

AGE-RELATED EXPENDITURE PROJECTIONS

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

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

PENSION EXPENDITURE

The "pension expenditure" aggregate according to the ESSPROS definition, goes beyond that of public expenditure and also includes expenditure by private social protection schemes. "Pension expenditure" is the sum of seven different categories of benefits, as defined in the 1996 ESSPROS Manual: disability pension, early retirement benefit due to reduced capacity to work, old-age pension, anticipated old-age pension, partial pension, survivors' pension and

early retirement benefit for labour market reasons. Some of these benefits (for example, disability pensions) may be paid to people who have not reached the standard retirement age.

REPLACEMENT RATES

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

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

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

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

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