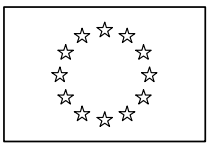

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Joint Report on Social Protection and Social Inclusion

accompanying document to the

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

Proposal for the Joint Report on Social Protection and Social Inclusion 2008

(COM(2008) 42 final)

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Scope and Outline of the Report

This supporting document complements the 2008 Joint Report on Social Protection and Social Inclusion (Commission proposal: COM(2008) xxx) with a more detailed account of the work carried out in the framework of the Open Method of Coordination (OMC) on Social Protection and Social Inclusion in 2007. This was the first year of the OMC without full reporting since the three strands social inclusion, pensions and health care/long term care were brought together into one process in 2006 under the common objectives[1]adopted by the European Council. This allowed a more in-depth exploration of some themes already identified in the preparation of the 2007 Joint Report[2] . The thematic focus for inclusion is child poverty (chapter 1), for pensions the focus is on promoting longer working (chapter 3) and privately managed pensions (chapter 4), and for health it is on inequalities in health outcomes (chapter 5) and on long-term care (chapter 6).

The chapters on the thematic work for the year are complemented by an analysis of how Member States finance social protection in general (chapter 2) and by an assessment of how the social dimension has been integrated in the Operational Programmes (OPs) of the Member States for the 2007-2013 Structural Funds (Chapter 7) and how, thereby, the structural funds will contribute to the common social inclusion and social protection objectives.

Some Member States have submitted up-dates of the National Strategic Reports they presented in 2006.[3] Chapter 8 provides a brief summary of the main developments reported.

An overview of statistical data will follow shortly in a Commission Staff Working Document and will include the most recent data on the indicators developed to monitor progress towards the overarching common objectives of the social OMC.

[1] http://ec.europa.eu/employment_social/social_inclusion/objectives_en.htm
[2] http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm
[3] France, Sweden and Slovenia have submitted complete up-dated reports. Austria, Finland, the Netherlands, Romania, Spain and the United Kingdom have provided partial updates flagging up significant new developments: http://ec.europa.eu/employment_social/social_inclusion/naps_en.htm

1. TACKLING AND PREVENTING CHILD POVERTY AND THE SOCIAL EXCLUSION OF CHILDREN

1.1. Introduction: A shared sense of urgency

The March 2006 European Council invited Member States "to take necessary measures to rapidly and significantly reduce child poverty, giving all children equal opportunities, regardless of their social background".

A number of stubborn facts have made the need to significantly reduce child poverty and social exclusion even more acute in the last decade:

- In most Member States children are at greater risk of poverty than the overall population. In some, more than one in every four children is at risk.

- The persistence of high and sometimes increasing levels of child poverty and social exclusion in the richest group of countries in the world has been criticised by the UNICEF, among others, notably in its 2005 and 2007 Report Cards[4].

- Children growing up in poverty and social exclusion are less likely than their better-off peers to do well in school, enjoy good health, and stay out of dealings with the criminal justice system.

- Child poverty and social exclusion may also have a damaging effect on the future life opportunities of children, and on their future capacity to contribute to tomorrow's society. Children who grew up in poverty and social exclusion are likely to face greater difficulties integrating within the labour market and finding their place in society.

In their strategic reports for 2006-2008, Member States responded with commitments to breaking the intergenerational transmission of poverty and exclusion. Almost all selected as a priority the need to develop an integrated and long-term approach to preventing and addressing poverty and social exclusion among children. Action on these commitments will foster human development and lead to stronger and more sustainable social cohesion.

The 2007 focus on child poverty has been underpinned by a range of activities. A task force within the Indicators Sub-Group (ISG) of the Social Protection Committee has carried out an in-depth evaluative review of child poverty and the exclusion of children in the EU-27 on the basis of existing commonly agreed indicators and related statistics. The ISG taskforce has also examined existing monitoring mechanisms with a view to proposing a set of concrete recommendations for a common framework for analysing and monitoring child poverty. Further, Member States have responded to a comprehensive questionnaire on their policies to combat child poverty and promote child well-being, including case studies on their policies towards children and families in particularly vulnerable situations. The replies to the questionnaire formed the basis for an in-depth examination of policies to fight child poverty in the Social Protection Committee on 3 October 2007. The network of independent experts

4 UNICEF (2005), Child Poverty in Rich Countries, Innocenti Report Card No. 6, Innocenti Research Centre, Florence. UNICEF (2007), Child Poverty in Perspective: An Overview of Child Well-Being in Rich Countries, Innocenti Report Card No. 7, Innocenti Research Centre, Florence. See also Bradshaw, J., Hoelscher, P. and Richardson, D. (2007), "An Index of Child Well-Being in the European Union", Social Indicators Research, No. 80, pp. 133–177.

on social inclusion has provided assessments of child poverty in each Member State and the overall policy framework in place to address the issue[5]. In addition, several European networks active in the area of fighting poverty and social exclusion have given particular attention to the issue of child poverty over the year.[6] Input from all these activities has informed the preparation of this assessment.

The following section summarises the analysis carried out by the ISG taskforce, whereas section 1.3 draws mainly on Member States' replies to the questionnaire on policies to combat child poverty and on the October 2007 SPC in-depth review.

1.2. Main lessons from the in-depth review of child poverty and its determining factors

This section provides a summary of the in-depth evaluative review of child poverty and exclusion of children in the EU-27 on the basis of existing commonly agreed indicators and related statistics carried out by the task force within the Indicators Sub-Group of the Social Protection Committee.

1.2.1. Some figures on the share of children affected and the severity of their situation

19 million children living under the poverty threshold in the EU-27

In 2005, there were 97.5 million children aged 0-17 in the EU-27. They represent 20% of the EU population, as against 22% in 1995, and this share is projected to decrease further to around 15% in 2050, as a result of the ageing of European societies. This highlights the need to enhance our investments in future human resources, and thus in children.

Yet, in 2005, 19 million children lived under the poverty threshold in the EU-27, meaning that 19% of children were at risk of poverty[7], as against a rate of 16% for the total population (see Figure 1). In most EU countries children are at a greater risk of poverty than the rest of the population, except in the Nordic countries (where 9 to 10% of children live below the poverty threshold), Slovenia (12%), Republic of Cyprus (13%), and Greece (20%) where the child poverty rate is lower or equivalent to that of the overall population. In almost half of the EU countries, the risk of poverty for children is above 20%, reaching 25% in Romania, 27% in Lithuania and 29% in Poland.

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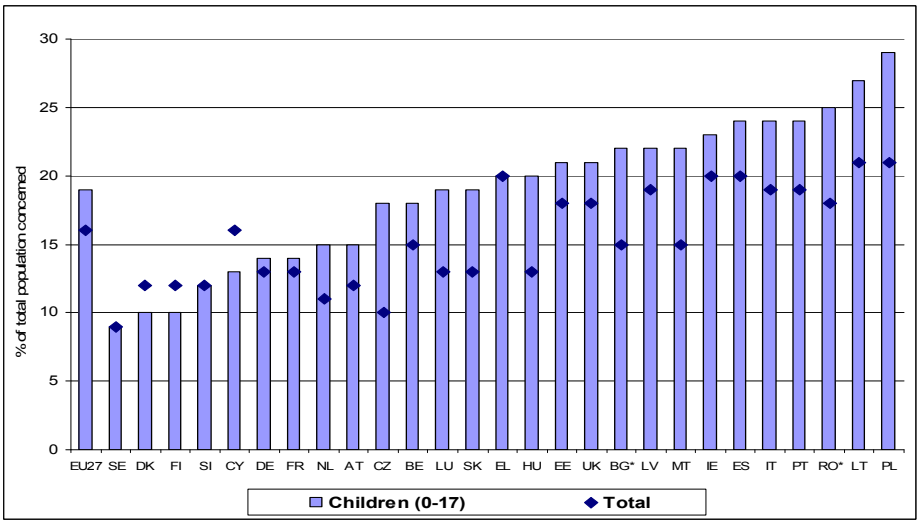
[5] .On the basis of the 27 expert's national contributions, the Network's Core Team has written an independent detailed report drawing out key lessons on "Tackling child poverty and promoting the social inclusion of children in the EU". For these national contributions and related Synthesis Report, see: http://ec.europa.eu/employment_social/spsi/expert_reports_en.htm#2007

[6] Eurochild:Report on Child Poverty (analysis of MS' NSRs) and a Fact Sheet. http://www.eurochild.org/ FEANTSA - A webpage and several activities dedicated to children and homelessness: http://feantsa.horus.be/code/EN/pg.asp?Page=675 European Social Network: Statement on Child Poverty and Welfare http://www.esn-eu.org/policy.htm

[7] The income data used in this part of the report refers to the 2005 SILC survey year as available from Eurostat on 07-12-2007. Following the implementation of EU-SILC in 2005, the values of all income based indicators 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 those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.
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 and non-cash employee income. This particularly affects the poverty estimates in some of the New Member States. 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.

Figure 1: At-risk-of poverty rate in the EU (%), total population and children, 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK); except for BG and RO - estimates based on the 2005 national Household Budget Survey. UK data provisional

The living standards of poor families vary widely within the EU

The standards of living of "poor" children vary greatly across the EU, as illustrated by the thresholds under which a household with 2 adults and 2 children is considered at risk of poverty (Table 1). While in 11 of the 15 "old" Member States these thresholds are higher than €1500, they are less than €500 per month in 9 of the 12 "new" Member States. When corrected for the differences in the cost of living (values in PPS), the variation in national thresholds is approximately one to six between the 3 lowest and the 3 highest values (i.e. the average of the highest is six times that of the lowest).

Table 1: Monthly at-risk-of-poverty threshold (illustrative values) for a household with 2 adults and 2 children, EUR and PPS, 2005

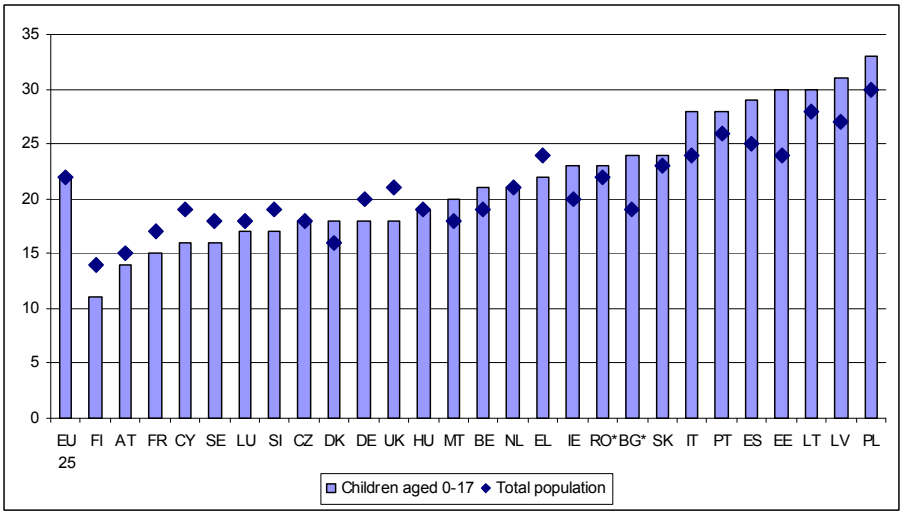
	BE	**BG***	**CZ**	**DK**	**DE**	**EE**	**IE**	**EL**	**ES**	**FR**	**IT**	**CY**	**LV**	**LT**
EUR	1740	153	444	2323	1798	313	1965	989	1111	1673	1506	1381	231	216
PPS	1660	356	816	1677	1731	502	1576	1141	1231	1526	1442	1538	420	410
	LU	**HU**	**MT**	**NL**	**AT**	**PL**	**PT**	**RO***	**SI**	**SK**	**FI**	**SE**	**UK**	
EUR	2990	362	831	1783	1889	266	755	98	924	297	1828	1817	1956p	
PPS	2866	591	1157	1695	1848	503	876	226	1233	546	1488	1502	1864p	

Source: SILC (2005) - income reference year 2004 (except for UK income year 2005 and IE moving income reference period 2004-2005); except BG national Household Budget Survey (HBS) 2004 (income year 2004) and RO - national HBS 2005 (income year 2005). UK data provisional. EU aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

How severe is the poverty of poor children?

In the EU, the severity of child poverty as measured by the poverty gap[8] for children is the same as for the overall population. However, this hides a much more contrasted picture across EU countries (Figure 2). In one third of countries (MT, IE, BG, IT, ES, EE, LV, PL) the intensity of poverty is 3 to 6 percentage points higher for children than for the overall population, and the poverty gap ranges from 20% to more than 30%. In contrast, the intensity of child poverty is lower than for the overall population in FI, AT, FR, CY, SI, SE, DE, and the UK. It is therefore in the countries with the highest child poverty rates that the intensity of poverty is most severe, except in EL.

Figure 2: Relative median at-risk-of-poverty gap of children vs. the overall population (%), 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK); except for BG and RO - estimates based on the 2005 national Household Budget Survey

1.2.2. Household characteristics: children in lone-parent household or in a large family are most at risk, but great variation remain across EU

Among the factors influencing the income situation of children, the size, composition and characteristics (age, educational level of parents) of the household they live in play an important role. Household structures evolve on the basis of the way individuals choose to organise their lives. This happens in the context of specific cultural, social and demographic trends, where economic conditions play a very important role. The prevalence of different household structures in a country, and especially those that are exposed to the greatest risks of poverty (e.g. lone-parent households) can depend on the availability of affordable housing (which influences the ability to afford living independently), access to the labour market (and thus to earnings from work), the design of tax and benefit systems (e.g. individualised or not), and in particular the level and conditionality of social transfers (in cash or in kind).

Half of poor children live either in a lone parent household or in a large family

In the EU, half of poor children live in the two types of households that are most at risk of poverty: 23% live in lone-parent households and 27% in large families. As illustrated in

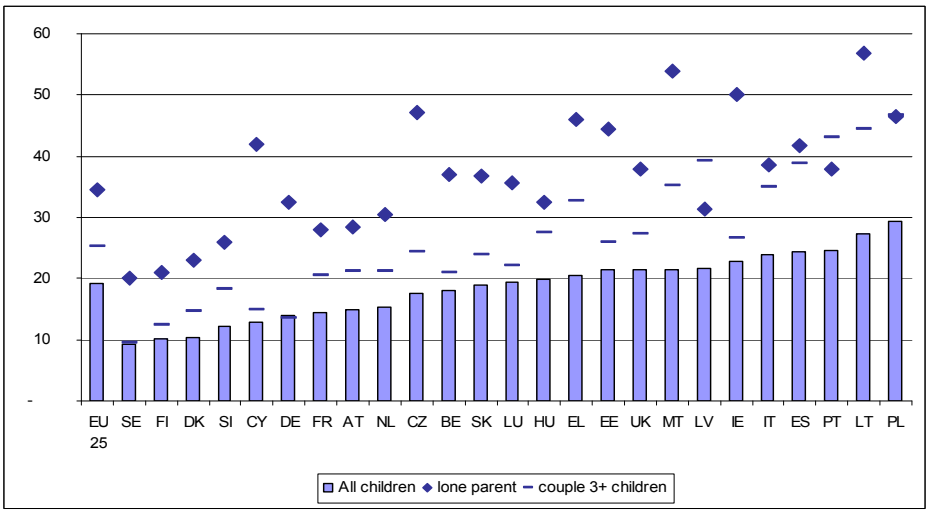
8 The poverty gap measures the distance between the median equivalised income of people living below the poverty threshold and the value of that poverty threshold; it is expressed as a percentage of the threshold.

Figure 3, these two types of families suffer from significantly higher poverty risks than other households with children:

- 13% of children in the EU live in a lone-parent household, their numbers have increased in most countries and their share is around 20% in DK, DE, EE, SE and the UK. On average, as well as in most countries, their risk of poverty is almost twice as high as for children as a whole (34% against 19%) and their parent is more often low-skilled. However, children living in lone-parent households face very different risks of poverty across the EU, from around 20% in the Nordic countries to 50% or more in IE, LT and MT. In 90% of cases, the lone parent is the mother, but the main causes leading to lone parenthood (out-of-wedlock birth, separation) vary across countries. Children in lone-parent households depend, more than others, on state support in the form of financial transfers or enabling services to support the parents' access to the labour market (e.g. care services, reconciliation measures and active labour market policies that improve the parents' employability and career prospects).

- 21% of children live in large families (with 3 children or more) and face a risk of poverty of 25% on average in the EU. The shares of children living in large families are lowest in Southern countries (15% or less in EL, ES, IT, PT) and in CZ, the Baltic States and SI (14 to 18%) where on the other hand they face the highest risks of poverty (30% or more except in CZ, EE and SI). By contrast, the number of children in large families is highest in the Nordic countries (26% to 33%) and in IE and Benelux (31% to 33%) where they face the lowest risks of poverty (9 to 15% in the Nordic Countries and 21-22% in the Benelux) and are more often than elsewhere in households headed by parents with a higher level of education. In SE and DE living in a large family does not increase the poverty risk for a child. While the numbers of large families have dropped in the Southern countries and Ireland over the last 10 years, they have remained stable in the Nordic Countries and Benelux where their living conditions are better, probably because parents benefit from better support and access to the labour market.

Figure 3: At-risk-of-poverty rate for all children and for children living in households most at risk (%), 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK), PT, UK data provisional

The extent to which lone-parent households and large families experience greater risks of poverty depends both on their characteristics (age, education level of parents, etc.), and on the labour market situation of the parents (joblessness, in-work poverty, etc), which can be influenced by the availability of adequate support in the form of services and policies enabling to reconcile work and family life, such as childcare, flexible working time arrangements and leave schemes, and personalised support by employment services, as well as by conditions and incentives such as in-work income support.

Age and educational level of parents

In the EU, children whose parents are below 30 years of age have a significantly higher risk of poverty than those living with older parents: 27% when the mother is below the age of 30, as against 19% when the mother is between 30 and 39 and 16% when she is between 40 and 49. Across EU countries, the risk of poverty among children of young mothers (less than 30) ranges from 15-16% in CY and SE to 31-35% in IE, IT, PL, and the UK. The age of the parents is indeed one determinant of the financial situation of households with children in that earnings from work in all countries show a strong progression from the early 20's until the mid 50's. In addition, the incidence of joblessness is greater among the youngest[9].

The educational level of the parents is another key determinant of children's current and future situation since it affects both the current labour market and income situation of the parents and the children's own prospects of doing well at school[10]. In the EU, most children have at least one parent who has completed secondary education. The percentage of children living with low-skilled parents (no parent with secondary education) ranges from less than 10% in nearly half of the countries (including most of the central and eastern European EU-12 Member States) to 30% or more in the southern Member States and IE, reaching 65% in MT and PT. The education profile of the parents of poor children differs significantly from that of the parents of their peers, since for more than 30% of poor children none of their parents has completed a secondary education (as against 16% for all children), and only 16% have a parent with a higher education (as against 32% for all children).

1.2.3. Labour market situation of parents

The labour market situation of parents is a key determinant of the conditions in which children live and develop. Earnings from work are normally the main source of income for parents in their prime age, and joblessness represents the main risk of poverty for households with children. In-work poverty also remains an important cause of low income among families. The capacity of parents to draw an adequate income from work depends on their level of earnings and on how much the adults in the household work (1 or 2 earners working full-time or part-time, and the extent to which they work continuously throughout the year). Finally, the labour market attachment of parents depends on the combined impact of making work pay and active labour market policies supporting parental employment (and especially mothers' employment), policies promoting the reconciliation of work and family life and the availability and affordability of enabling services (e.g. child care).

Earnings are the primary source of income for families supplemented by social benefits to various degrees

9 EUROMOD working paper N° EM3/06; T-T Dang, H Immervoll, D Mantovani, K Orsini and H Sutherland; An age perspective on economic well-being and social protection in nine OECD countries; September 2006.

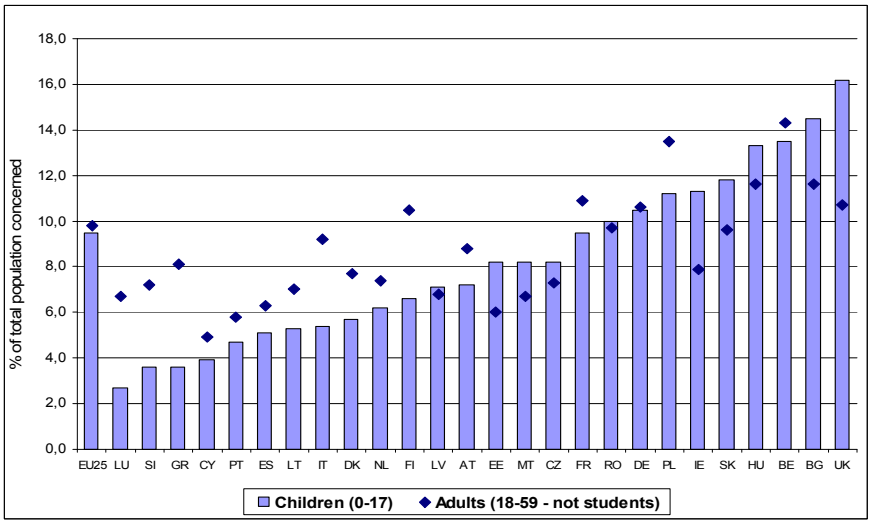
10 See the chapter of the ISG task force report analysing the results of the SILC 2005 module on the intergenerational transmission of disadvantage.

While earnings are the primary source of income for households with children (just like other households, especially those with people of working age), they represent only 60% of the gross income of families at-risk-of-poverty (as against 90% of the gross income of non-poor families). Social transfers other than pensions represent slightly more than 1/3 of the gross income of poor families with children, with family allowances playing the biggest role in supplementing the income of these families. However, when looking specifically at poor households, there are strong cross country variations in the relative contribution of earnings and benefits to the gross income of families. This reflects the very different set-ups in the organisation of social transfers across countries.

Joblessness: a persistent trend that significantly affect children's living standards

Living in a household where no-one works is likely to significantly affect both the current living conditions of children and their future development. In 2006, almost 10% of EU-27 children lived in jobless households ranging from less than 4% in LU, SI and EL to more than 14% in BG and the UK. In the EU as a whole, the situation has not improved over the last 5 years. In half of EU countries, the general increase in employment rates did not benefit those families that are furthest away from the labour market. Among the countries for which we have consistent trend data, only BG, EE, EL, ES, IT, LT, and to a certain extent LU and the UK have shown signs of a decrease in the number of children living in jobless households.

Figure 4: Adults and children living in jobless households (%), EU-27, 2006



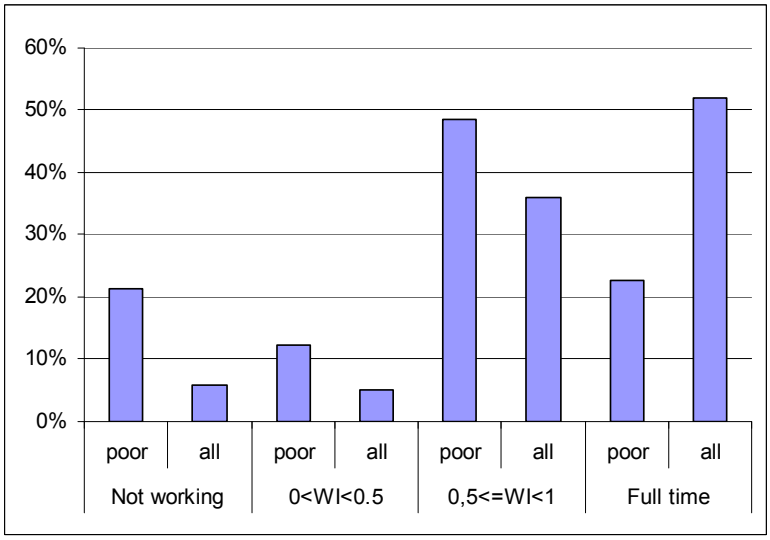
Source: Eurostat Labour Force Survey, spring results, data missing for SE

In the EU, joblessness mainly affects households headed by lone parents who face particular difficulties in reconciling work and family life. In 2006, 47.3% of children living in a jobless household lived in a lone-parent household, 40% in a 2-adult household and 12.3% in a household with 3 adults or more. However, this pattern varies significantly across countries. In BE, CZ, DE, EE, LU, the NL and the UK half or more than half of children in a jobless household lived with a lone parent. This rate reaches 60% in LU and 67% in the UK.

In a number of other countries joblessness primarily affects couples with children: in EL, ES, FR, IT, HU, AT, PT and FI half or more of jobless households are 2-adult families. In some new Member States (LV, LT, HU, SI, SK) joblessness also affects complex households.

As illustrated in Figure 5, the impact of joblessness or low work intensity[11] on the poverty risk is in all countries much higher for households with children than for households without children. On average in the EU, more than half of the children in households with no or very weak attachment to the labour market are at risk of poverty. This shows that social transfers alone do not compensate for the lack of work income of families with children and underlines the need to foster the labour market attachment of parents in order to durably protect the children from poverty and social exclusion.

Figure 5: At-risk-of-poverty rate by type of household and work intensity (%), EU-25 average, 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and UK). UK data provisional

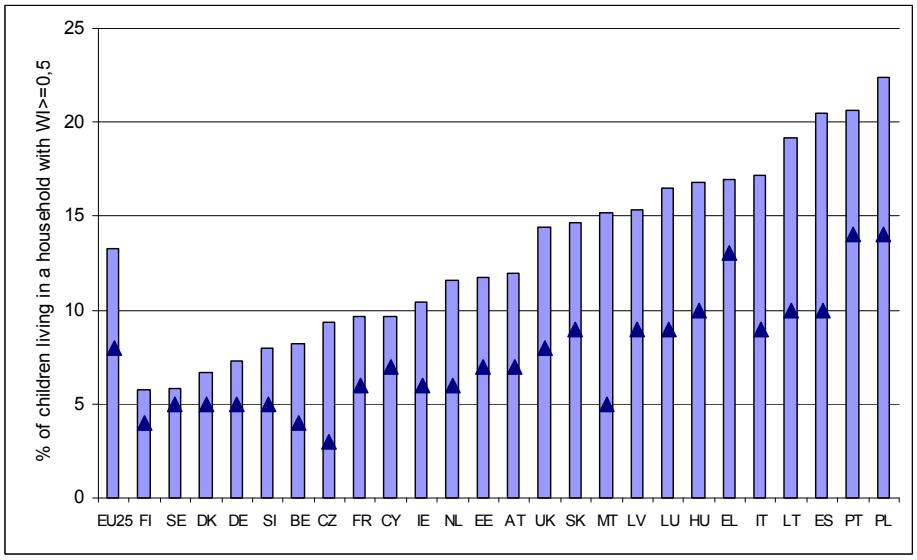
Parental work protects children from poverty to varying degrees in the EU, and in-work poverty remains an issue in the majority of countries

In the EU as a whole, the great majority of children have either one or two parents at work. Half of children live in a household in which all adults are working full-time. This proportion ranges from around 40% or less in ES, IE, IT, MT and PL to more than 60% in DK, HU, SI and SE.

However, not all children whose parents are at work are protected from the risk of poverty. 13% of children living in households at work (work intensity greater than 0.5) are living under the poverty threshold (Figure 6). This rate ranges from 7% or less in the Nordic countries to more than 20% in ES, PT and PL. In-work poverty results from various combinations of low wages and low work intensity. Low work intensity may be the result of labour market shortcomings such as recurrent unemployment or unstable jobs and involuntary part-time work, or from particular household structures (too few adults working in the household in relation to the number of dependants). These can in particular be influenced by disincentives embedded in tax-benefit systems and the lack of reconciliation measures.

11 The work intensity of the household is defined as the overall degree of work attachment of working-age members in a household (excluding students). WI=0 means no-one in employment; WI=1 corresponds to full-year work for all working-age adults in the household; and 0<WI<1 corresponds to either less than full-year work for some or all members of the household or only some of the adults in the household being at work.

Figure 6: At-risk-of-poverty rates of children living in households at work, EU-25, 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK).

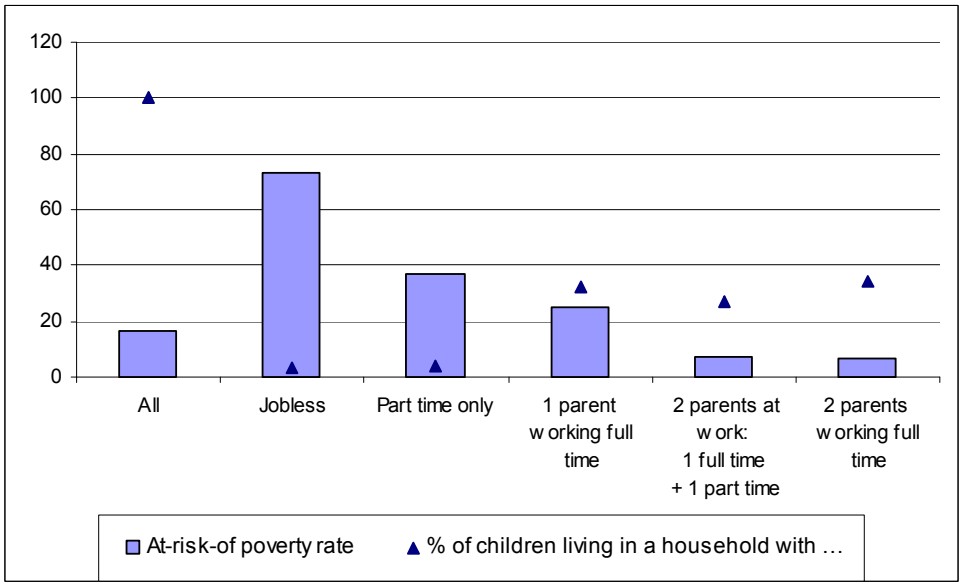
Among children living with both parents, the two-bread-winner model is the norm while the impact of part-time work varies across countries

In the EU, the two-bread winner model is the norm for nearly two thirds of children living with both parents. This rate reaches 75% or more in HU, SI, SK and the Nordic countries and is lowest (though just above 50%) in DE, ES, IE, IT, LU, AT and PL. As illustrated in Figure 6, **among couples with children** the poverty risk for children living with both parents working full-time is 7% on average in the EU, ranging from 6% or less (in approx. 2/3 of countries) to 11% or more in, HU, NL, PL, PT, and SK. In contrast, 25% of children with only one out of two parents at work (working full-time) are at risk of poverty. This rate ranges from around 10-13% in DK, DE and SE to 30% or more in ES, HU, IT, LT, LV, PL, PT, SI and SK.

Having both parents in work seems to protect children from the risk of poverty in most countries, whether the parents both work full-time or not. At EU level, the risk of poverty among children with one parent working full-time and the other working part-time is 7%, i.e. the same as for children with both parents working full time. In a number of countries, the risk of poverty among children with one parent working full-time and the other working part time is equally low (BE, CZ, DK, IE, FR, IT, CY, AT, SE, FI, UK) or even lower (DE, NL) than for children whose parents both work full-time. In these countries, part-time work may be seen as an element of work/life balance for two-earner families.

In other countries, on the other hand, both parents need to work full time to ward off the risk of poverty for their children. In EE, EL, LT, LV, PL, PT and SK, the risk of poverty among children with one of their parents working only part-time ranges from 19 to 32% and is 2 to 4 times higher than the risk of poverty among children with both parents working full time. The impact of part-time work on household income depends on the level of skills, the number of hours worked and the availability and affordability of childcare and other support services available to families.

Figure 7: At-risk-of-poverty rates of children living in two parents households by activity status of the parents, and percentages of children concerned, EU-25, 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK).

52% of children living in **large families** have both their parents at work. They face a poverty risk of 13% if both parents work full-time and 10% if one of them works part-time. In contrast, a single earner is not sufficient to keep children of large families out of poverty since 33% of them live under the poverty threshold. Again, the impact of part-time work varies across the EU; in half of the countries, part-time work can be regarded as an element of reconciling work and family life for large families, while in the other half (EE, EL, ES, HU, LT, LV, LU, PL, PT, SK, and to a lesser degree the UK) the part-time work of one parent significantly increases the risk of poverty.

Children living in lone parent households are at much lower risk if their parent works full-time

If their parent works full-time, the children of lone parents face a relatively low risk of poverty of 15% (as against 19% for all children). This risk falls to between 4 and 14% in BE, DE, DK, IE, FR, NL, FI, SE and the UK, although it is only in the Nordic countries, the UK and FR that the majority of children living with a lone-parent have their parent working full time. In contrast, children whose lone parent works part-time face a much higher risk of poverty, 30% on average in the EU. While country estimates for this population lack statistical reliability (due to the small sample size), the poverty rates of lone parents working part-time reach 30% or more in two thirds of EU countries. Considering that low-skilled women are overrepresented among lone parents, and that they are often in involuntary part-time employment (industrial cleaning services, distributive trade, personal services jobs), children living with these mothers appear to be especially at risk and require specific support. This illustrates that the higher risks of poverty faced by the children of lone parents are closely linked to the ability of lone parents to fully integrate the labour market.

1.2.4. Government intervention

Assessing the impact of government intervention on child poverty is a complex task since a broad range of government policies influences the actual living standards of households with

children.[12]. Tax and benefit systems can redistribute income towards families by different means, such as providing a minimum income for those without paid employment (unemployment benefits, social assistance, disability allowances) or supplementing the income of all households with children whether they are in employment or not. The income of families can also be influenced by minimum-wages policies. Child poverty is also influenced by policy choices in education (free schooling at an early age, length of the school day), health (access to free services for children), housing, and child care services, etc.

Levels of social expenditures and at-risk-of-poverty rates among children: those that spend most have the lowest poverty rates

A simple correlation between risk of poverty rates and levels of social transfers shows that the countries with the lowest child poverty rates are those which spend most on social benefits (excluding pensions[13]), with the notable exception of the Republic of Cyprus and – to a lesser extent - Slovenia. This partly reflects the wealth effect observed among EU countries whereby the richest countries are those which can afford the highest levels of social protection and redistribution. However, differences in the starting positions of households before receipt of benefits, as well as in the design and overall effectiveness of the tax and benefit systems, mean that countries with similar levels of wealth and social spending as a percentage of GDP experience widely differing levels of child poverty.

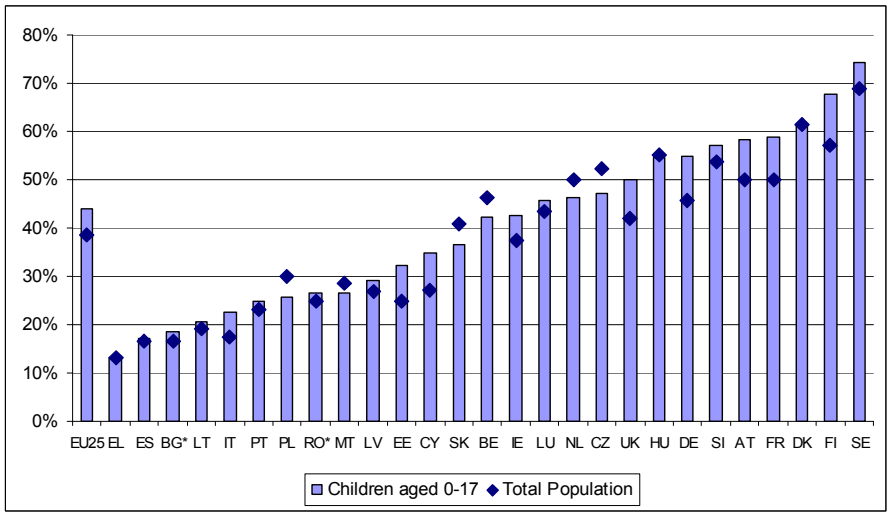
In the EU-25, social transfers alleviate the risk of poverty for children to varying degrees

On average in the EU social transfers other than pensions reduce the risk of poverty for children by 44% (see Figure 8), which is more than for the overall population (38%). The impact of social transfers is higher on child poverty than on overall poverty in most EU countries, except in PL, SK, BE, NL and CZ, where it is slightly smaller. In DK, FI and SE, social transfers (other than pensions) reduce the risk-of-poverty for children by more than 60%, as against 44% on average in the EU. Only FR and AT approach this level. In BG, EL and ES, this reduction is less than 20% (also for the overall population).

12 Corak M.., Lietz C., and Sutherland H. (2005); The Impact of Tax and Transfer Systems on Children in the European Union, UNICEF Innocenti Working Paper No. 2005-04, UNICEF IRC, Florence.

13 In the analysis presented in the last section, pensions are considered part of the original income.

Figure 8: Impact of social transfers (excl. pensions) on the poverty risk for children and for the overall population (in % of the poverty risk including all social transfers), 2005



Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK); except for BG and RO estimates based on 2005 national household budget survey; UK data provisional

Benefits specifically targeting children have the strongest impact on child poverty

Countries where social transfers have the greatest impact on child poverty are also those where family benefits reduce child poverty the most (see Table 2). In HU, AT, SI, FI and SE family benefits reduce the risk of poverty among children by 36% or more (up to 49% in AT), and by 26% to 32% in CZ, DE, EE, FR, HU, and LU. In these countries, the differences in final child poverty outcomes are partly due to the very different levels of pre-transfers risk-of-poverty, which depend *inter alia* on the incidence of joblessness and in-work poverty. Among the countries with the greatest impact of social transfers, HU and the UK have the most difficult initial conditions, combining high levels of joblessness and in-work poverty. DK, the NL and SI, where the incidence of both joblessness and in-work poverty is low, enjoy the best pre-transfers conditions.

Table 2: At-risk-of poverty rates for children before and after transfers (excluding pensions), and after family benefits, %, EU-25, 2005

Country	CY	EL	DK	NL	SI	ES	SK	MT	DE	LV	FI	EE	IT
At-risk-of-poverty rate before transfers (excl. pensions)	21	23	25	28	28	29	30	30	31	31	32	32	31
At-risk-of-poverty rate after family benefits	16	22	21	23	17	28	23	24	21	25	19	23	27
At-risk-of-poverty rate	13	20	10	15	12	24	19	22	14	22	10	21	24
Impact of all transfers (%)	**36**	**9**	**60**	**42**	**57**	**14**	**37**	**27**	**53**	**29**	**66**	**32**	**23**
of which, impact of family transfers (%)	**24**	**2**	**18**	**19**	**39**	**2**	**24**	**19**	**31**	**19**	**40**	**28**	**14**

Country	PT	BE	CZ	LT	FR	LU	SE	AT	PL	IE	UK	HU
At-risk-of-poverty rate before transfers (excl. pensions)	31	34	34	35	34	36	35	37	39	40	42	45
At-risk-of-poverty rate after family benefits	27	26	24	30	25	24	21	19	35	31	34	29
At-risk-of-poverty rate	24	18	18	27	14	19	9	15	29	23	21	20
Impact of all transfers (%)	**23**	**45**	**49**	**21**	**57**	**42**	**73**	**57**	**25**	**43**	**49**	**53**

of which impact of family transfers (%)	**12**	**22**	**30**	**13**	**26**	**32**	**39**	**49**	**10**	**23**	**18**	**36**

Source: SILC (2005) - income year 2004 (income year 2005 for IE and the UK)

1.2.5. Key findings on child poverty

Table 3 summarises the main findings of the analysis of the main determinants of the risk of child poverty presented above. In the first column, countries are assessed according to their relative performance in child poverty outcomes, by 6 levels from +++ (countries with the highest performance) to --- (countries with the lowest performance). Child poverty outcomes are assessed by a score[14] summarising the relative situation of children in a country with regard to: a) the poverty risk for the overall population in that country, b) the average child poverty risk for the EU as a whole, and c) the average intensity of the poverty risk for children (*poverty gap*) at EU level.

In the next three columns, countries are assessed according to their relative performance (also using a 6-level scale) with regard to three main factors influencing the child poverty risk[15], namely: children living in jobless households, children living in households at risk of in-work poverty and the impact of social transfers on the risk of child poverty.

The analysis allows to gather countries into 4 main groups (in line), according to which combination of the 3 key factors predominantly affects their risk of poverty.

Table 3: Relative outcomes of countries related to child poverty risk and main determinants of child poverty risk

		Child poverty outcomes	**Joblessness: children living in jobless households**	**Children living in households confronted with in-work poverty**	**Impact of social transfers (excl. pensions) on child poverty**
GROUP A	**AT**	++	+	+	++
	CY	+++	+	++	-
	DK	+++	+	+++	++
	FI	+++	++	+++	+++
	NL	+	+	+	+
	SE	+++	(++)	+++	+++
	SI	++	+++	++	+
GROUP B	**BE**	+	--	++	-
	CZ	-	--	+	-
	DE	++	--	+++	+
	FR	++	-	++	++
	EE	--	--	+	--
	IE	-	---	+	-
GROUP C	**HU**	-	---	--	+
	MT	-	--	--	--
	SK	-	---	--	--

14 The scores are z-scores that rank countries by 6 levels of relative performance, from --- to.+++. The levels are defined such that the performances of countries are very similar within each level and that there is a significant step between levels.

15The method used to define the 6 levels of performance for the three risk factors is the same and combines:

- the share of children in jobless households in one country is compared with the share of adults in jobless households in this country and with the EU average share of children in jobless households;
- in-work poverty of children in a country is compared with in-work poverty of adults in this country and with the EU average in-work poverty rate for children;
- the impact of social transfers (excl. pensions) on child poverty in a country is compared t- with the EU average.

		Child poverty outcomes	Joblessness: children living in jobless households	Children living in households confronted with in-work poverty	Impact of social transfers (excl. pensions) on child poverty
	UK	+	---	--	-
GROUP D	**EL**	+	+++	--	---
	ES	--	+	---	---
	IT	--	++	--	---
	LT	---	+	---	---
	LU	+	+++	--	-
	LV	--	-	--	--
	PL	---	-	---	---
	PT	--	+	---	---
	BG	--	---	:	:
	RO	--	--	:	:

Source: Figures 1 & 2, Figure 4, Figure 6, Figure 8 and detailed calculations in ISG report. BG and RO cannot be included in the full assessment since data is missing for the in-work poverty and the impact of social transfers.

The detailed analysis of table 3 confirms that child poverty outcomes result from complex interactions between these main factors and that the countries achieving the best outcomes are those that perform well on all fronts, notably by combining strategies facilitating access to employment with enabling services (child care, etc.) and income support.

A detailed description of the four groups is given below:

- Group A comprises the three Nordic countries (DK, FI, SE) as well as AT, CY, NL, and SI. These countries achieve relatively good child poverty outcomes by performing well on all three fronts. They combine a relatively good labour market performance of parents (low levels of joblessness and of in-work poverty among households with children) with relatively high and effective social transfers. It is worth noting that the Nordic countries achieve these goals despite high shares of children living in lone parent households. They seem to succeed in doing so in particular by supporting adequate labour market participation of parents in such families through appropriate activation policies, childcare provision and a wide range of measures to reconcile work and family life. While the impact of social transfers on child poverty is relatively low in the Republic of Cyprus, children in this country seem to have so far been protected against the risk of poverty by strong family structures dominated by 2-adult families and complex households in which all adults are at work. In the Netherlands, while children partly benefit from the low levels of inequality in the country and from the relatively good integration of their parents in the labour market, child poverty outcomes may be further improved by addressing the intensity of poverty (as measured by the poverty gap, see p.9) and improving the impact of social transfers (which is lower than for other countries in this group).

- Group B comprises BE, CZ, DE, EE, FR and IE which achieve relatively good to below average poverty outcomes. The main concern in these countries is the high number of children living in jobless households. While 10% or more of children live in families affected by joblessness, families at work experience lower levels of poverty than in other EU countries. In most of these countries, nearly half of the children in jobless households live with a lone parent. In France, the high number of jobless couples with children is also a matter of concern. Among these six countries, DE and FR seem to be more successful at limiting the risks of poverty for children through relatively high and effective social

transfers. The interaction between the design of these benefits, the availability and affordability of child care and the labour market participation of parents could be explored further[16]. In particular, activation policies aimed at promoting the labour market integration of those parents furthest away from the labour market may contribute to reducing child poverty in these countries.

- Group C comprises HU, MT, SK, and the UK who have average or just below average child poverty outcomes, despite a combination of high levels of joblessness and in-work poverty among parents. In the UK, joblessness mainly affects lone parents, while in HU, MT and SK it affects mainly couples with children. The main factors behind in-work-poverty are low work intensity in MT (very few 2-earners families) and the UK (incidence of part-time work) and low pay in HU and SK where the poverty rates of 2-earner families are among the highest in Europe. In this group of countries, the UK and HU partly alleviate the very high risks of pre-transfers poverty among children through relatively effective social benefits. In MT and SK, despite the relatively poor integration of their parents in the labour market, children have a low pre-transfers risk of poverty, probably as a result of protective family structures; in Slovakia, the rather narrow income distribution may also play a role. In these 4 countries, different policy mixes may be needed to improve the chances of parents living in jobless households to find a suitable job, to enhance the labour market participation of second earners and to adequately support the incomes of parents at work.

- Group D comprises EL, ES, IT, LT, LU[17], LV, PL, and PT. These countries have average (EL, LU) or relatively high levels of child poverty. While they have low shares of children living in jobless households, they are characterised by very high levels of in-work poverty among families. The main factors behind in-work poverty in these countries are the low work intensity (the number of 2-earner families being among the lowest in ES, EL, IT, LU, PL) combined (or not) with low in-work incomes (the poverty rates among 2-bread-winner- households being among the highest in ES, EL, LT, PT and PL). In these countries (apart from LU), the level and efficiency of social spending are among the lowest in the EU. The analysis indicates that family structures and intergenerational solidarity in these countries continue to play a role in alleviating the risk of poverty for the most vulnerable children. Living in multi-generational households and/or relying on inter-households transfers in cash and in kind[18] may be a way to compensate for the lack of government support for parents in the most vulnerable situations. These countries may need to adopt comprehensive strategies to provide better support for family incomes and to facilitate labour market integration, especially for second earners.

1.3. Member States' policies to prevent and tackle child poverty

1.3.1. Ensuring sufficient resources for families including through active inclusion[19] strategies

In their aim to ensure sufficient resources for families, most countries have adopted an **integrated approach** to poverty that combines income support for families (to all but in

16 See make-work-pay analysis, including childcare costs components, in the 2007 edition of Benefits and Wages, OECD.

17 It should be pointed out that the relatively high risk of child poverty in Luxemburg is partly the result of the specific structure of the population.

18 SHARE analysis of cash transfers and transfers in kind (e.g. child care) between generations.

19 See an explanation of the concept Active Inclusion in the box at the end of section 1.3.1.

particular lone parents and large families) and policies enhancing labour market integration of parents, often through a comprehensive active inclusion approach (see box at the end of section 1.3).

Supporting households' income

All countries support to some extent the income of households with children. Tax and benefit systems redistribute income towards families by different means, such as facilities that take the family composition into account (tax allowances, income splitting, etc.), cash benefits (family allowances, unemployment benefits, social assistance, disability allowances, housing allowances) and benefits in kind (access to free services in the areas of health, education, child care, housing, etc.). The income of families can also be influenced by minimum wages policies.

In most countries, **family benefits** play an important role in supporting the income of families with children (on average in the EU they represent approximately half of cash social transfers to these households). They include benefits to support income during maternity leave (flat-rate or earnings-related payments), birth/adoption grants, parental leave benefits, family or child allowances to partly offset the costs of raising a child and other cash benefits for families with specific needs (handicapped children, lone parents, foster families, etc). Family benefits may vary depending on the age and number of children.

Most countries combine **universal and targeted benefits** to various degrees.

Universal benefits are distributed to all families with children (in the form of tax allowances, cash benefits, etc), and often depend on the size of the family. Their main purpose is to compensate (at least partly) for the cost of raising children. The main advantages of these schemes are that they help create a favourable environment for families with children, do not contribute to traps, and are not discriminatory and therefore not affected by take-up issues.

Targeted benefits are meant to support the most vulnerable families (low-income, lone parents, large families, families with disabled children, etc.) by redistributing social transfers towards those who are most in need. However, they can create disincentives to take up work or work more for low-income families. A number of countries have specific measures to address these trap effects for parents (in-work income supplement mechanisms, access to childcare regardless of the labour market situation of parents, etc.).

Other social benefits also support family incomes, with levels depending in some cases on the number of children in the household: unemployment benefits, social housing, basic guaranteed income, minimum wages, etc.

Provision of in-kind benefits

Many Member States support families by providing services free of charge or at reduced fees, which may be either universal or targeted at the families most in need (low-income, families with special needs). These services target children in the field of child care (see below), health care (preventive health care at school or at community level), education (school meals, school books, transport, etc.), and participation in sports and recreational activities (including subsidised holidays), or target the family, notably in the area of housing (social housing). Integrated services are likely to respond more effectively to user needs.

Integrated services for improved access

In France, the Plan périnatalité 2005-2008 contains multi-dimensional actions to support underprivileged pregnant women. They cover food, housing (guaranteeing a decent and stable housing during pregnancy), addictions, facilitated access to health insurance, medical follow-up, etc.

In Malta, the family resource centre ACCESS is a an innovative service platform bringing together a number of different social welfare service providers in the fields of social security, employment and training, housing, family and child care, and education. This platform serves as an entry point for access to services, providing better results than centralised or segmented service provision.

Enhancing the labour market participation of parents:

Most countries promote the active inclusion of parents in the labour market by supplementing family income support with activation measures and incentives for parents to take up work, remain in work or work more. These measures include income supplement mechanisms (such as tax reductions or in-work cash benefits for those on low incomes) and free or subsidised access to childcare for parents both in and out of work (in particular to facilitate parents' access to paid work, training or job search). Effective active labour market policies, such as better access to training and special qualification and re-qualification schemes also support parents wishing to enter the labour market, or re-enter it after a career break. These measures may target specific categories of parents, such as lone parents, the unemployed, parents in jobless households, or second earners.

Eliminating the barriers to work for parents

In Hungary, a series of measures are aimed at supporting the parents of young children in their efforts to re-enter the labour market, by increasing the supply of institutional care (+800 places in 2007) and by eliminating disincentives to take up work. These measures include flexible childcare allowances (paid to parents of children <3) that may be transferred from one parent who wants to take-up work to the other, or to a grand-parent, where both parents want to work; the continuation of childcare allowance after taking up work; and priority for persons on parental leave wishing to attend university and vocational training programmes.

Belgium supports parents' wishing to return to work by combining measures to eliminate disincentives to take up work with enabling services. The Flemish government has introduced a fixed reduction in personal taxes mainly in order to raise the financial incentives to work for low-income workers, while jobseekers receive free childcare and subsidies to attend training. It is also planning to increase flexible on-demand childcare offered to jobseekers attending training and job interviews.

In Ireland, the Family Income Supplement is a weekly tax-free payment for families at work on low pay. This preserves the incentive to remain in employment in circumstances where work does not pay enough in comparison with out-of-work benefits.

In the United Kingdom, the Whaddon Sure Start Children's Centre in Cheltenham houses both a childcare facility and a vocational training centre, so that parents who may find it difficult to leave the house to learn new skills are able to study with their children cared for nearby.

Countries also highlight the importance of measures to reconcile work and family life for parents.

Enhancing the supply of childcare both quantitatively and qualitatively can help both to reconcile work and family life and to ensure equal opportunities for all children. Some countries highlight the need to develop adequate childcare both for children below school age and during after-school hours. The measures described by member states include an increase in the supply of institutional day care, strategies to address staff shortages and the professional qualifications of personnel, the promotion of quality standards both in institutional care and for personal services, the promotion of partnerships and of work in network, the implementation of a child right to day care (DK, DE, FI), a tax subsidy to employ a child minder at home (FR), etc. Giving more choice to parents by supporting a wide range of care arrangements is an interesting feature of a few systems. Some countries also support flexible on-demand childcare (e.g. 24/7 child care) to address the issue of atypical working hours and the specific needs of jobseekers. These countries also have measures to promote family-friendly working arrangements and limit atypical working hours for parents.

Enhancing the supply and quality of childcare

In France, the supply and quality of childcare are being enhanced by a **quantitative increase in supply** and **greater variety of childcare solutions**: an increase in the number of places in institutional day care, professional qualifications for child-minders working at home (35000 new certificates per year), financial incentives for parents to employ a child-minder at home, and very early schooling (from age 2). In order to allow access to care for parents working atypical hours and for jobseekers with occasional needs, flexible types of institutional care are being developed such as 24/7 child care and 'haltes garderies'. In total, €12.2 billion was invested in 2006.

In Finland, every child has an **individual right** to municipal day care below school age (~7), regardless of their parents' income and labour market situation. While charges depend on parental income, care is free for low income families. 24-hour day care is offered to parents who need it, although measures are in place to reduce atypical working hours among parents.

In Hungary, the National Strategy 'Let it be better for children' and the Government Action Plan 2007-2010 support the creation of integrated institutions (nursery and kindergarten groups in the same institution) in small villages where nurseries are not affordable and kindergartens are not viable due to the decline in the number of children.

Flexible working time and leave arrangements are another set of key tools to reconcile work and family life. Across countries, the effectiveness of parental leave schemes depends on whether or not the leave is paid, and on the right **balance between the size and duration of the allowance,** since the length of the career break can have a negative impact on the parent's prospects of re-entering the labour market and on the conditions under which he/she can find a new job. Another key feature of such leave arrangements is whether the rights are **individual** (for mothers and fathers separately) or can be shared between the two parents. Introducing individual rights mainly has a positive effect on the take-up rates of fathers, and ultimately on the sharing of care responsibilities within the household.

A number of countries have measures **to involve employers** (in cooperation with trade unions) in the provision of company-based/subsidised childcare and flexible working time arrangements.

Involving employers in promoting the reconciliation between work and family life

Germany has recently launched the 'alliance for families', a strategy for better reconciling work and family life, involving the government, employers and trade unions. The strategy includes: 'career and family' audit schemes; networks of local agencies to enhance dialogue with municipalities; awareness-raising campaigns; and mutual learning schemes among employers on issues such as flexible working time, company-based childcare provision and the return of parents to work after leave. This is in addition to Germany's commitment to dramatically increase the supply of childcare by creating 230 000 new day-care places by 2010.

In France, the government supports the development of company based child care provision through tax credits and by applying the same VAT as to the non-profit sector while social partners have the obligation to address the issue of reconciliation in their negotiations.

The availability and affordability of public transportation – including outside city centres – also plays a role in enabling parents to enter or remain in the labour market.

The **active inclusion** approach aims to promote the social and labour market integration of the most disadvantaged by combining **income support** at a level sufficient for people to live in dignity with **links to the labour market** through job opportunities or vocational training and with better **access to enabling social services**. In 2006, the Commission launched a public consultation, including a consultation under article 138 of the EC Treaty, on the need for action at EU level to promote the active inclusion of people furthest from the labour market.

The responses to the 2006 consultation highlighted that the 1992 Council Recommendation on 'Common criteria concerning sufficient resources and social assistance in social protection systems' was still considered a reference instrument for EU policy in relation to poverty and social exclusion. For most, however, the adequacy of minimum income schemes had to be assessed in the broader context of access to employment so the comprehensive approach taken by the Commission was welcomed. While prescriptive rules were not considered appropriate in the light of the diversity of situations across Europe, most respondents expressed support for a renewed effort at EU level.

Active inclusion was also one of the key priorities in most of the 2006-2008 National Reports on strategies for social protection and social inclusion, and its three-pillar approach was examined in an in-depth review by the Social Protection Committee (April 19-20) and the sixth meeting of People experiencing Poverty (4-5 May). A stakeholders' conference in Brussels (15 June 2007) pointed out the need for strong and coordinated interaction between the pillars while the Sixth Round Table on poverty and social exclusion (16-17 October 2007) underlined how active inclusion can provide a broad general framework for action at European and national level since it combines the principles of empowerment and protection. The involvement of the social partners through their bilateral dialogue was deemed to be of paramount importance.

Based on the results of the 2006 consultation and the initiatives that followed, the Commission has proposed, in a new broad consultation launched on 17 October 2007, to deepen the Open Method of Coordination in this area through the adoption of common principles and their subsequent monitoring and evaluation, respecting fully the principle of subsidiarity as well as the autonomy and different situations and needs of the Member States. The common principles on each of the three strands of active inclusion would stress the need

for a holistic approach and provide a concrete and integrated framework for their implementation. This structured process is essential in order to identify the best policy responses to the common social challenge of guaranteeing the fundamental right of all EU citizens to social and housing assistance as to ensure a decent existence for all.

1.3.2. Supporting the development of the child

The importance of early intervention is very strongly emphasised by the Member States, in particular the role of pre-schooling. There is a clear recognition that it can play a vital role in compensating for socio-economic disadvantage and effectively paving the way for a child's future successful development. Some make reference to the rich evidence that the return to society on investing in pre-school education is particularly high. The prevention of early school leaving is also seen as vital in this context. Furthermore, many Member States attach strong weight to ensuring access to health care at an early stage as indicated below. Some recognise that housing conditions have a major impact on children's development opportunities and require full attention in any social inclusion policy.

As highlighted in chapter 1.3.1, many Member States are focusing on expanding child care provision to facilitate the labour market participation of parents. At the same time in recognition of the potential levelling impact of access to quality child care and pre-schooling for disadvantaged children, an equal opportunities perspective is gaining ground. Thus beside the need in most Member States to increase overall provision, increased consideration is being given to the need to improve access in education, in particular pre-schooling, and to support parents. In addition, special attention is being given to children in deprived areas and to children from disadvantaged families.

Pre-schooling and access to education

A number of Member States are increasing the national budget devoted to pre-school education (IE, UK, IT) in order to increase the supply of education services in deprived areas. As mentioned in chapter 8 some are making use of EU structural funding for projects that provide the infrastructure for pre-school education (HU: increasing the places available in kindergartens and for the renovation of buildings; PL: a programme called 'Small kindergarten in every village' with the aim of establishing 65 small kindergartens in four regions).

Some Member States have adopted specific policies and set quantitative targets to increase the number of places available and the number of teachers in pre-school education (IE, IT, PL, ES). Some have policies to improve access to pre-school education with a focus on urban disadvantaged areas (IE, FR) and rural disadvantage areas (PL). Increasing the number of places and early intervention are a means to ensure equal opportunities for the rest of a child's future school career. In AT and DE, where children of an immigrant background make up a substantial proportion of young people leaving school without a qualification, language teaching is already made available already in kindergarten, where teachers are also trained as language teachers as well (DE).

Some Member States that have introduced systems of universal pre-schooling and further stages of education are adapting them to children at risk, with some using pre-schooling to screen for children at risk and may need extra help and support in learning (CY, DE, LU). Comprehensive support and learning is offered to pupils with a disability, illness, delayed

development or some other disadvantage in order to promote equal opportunities for these children (FI).

Another way Member States are ensuring equal opportunities for all children is by focussing resources on the most deprived schools where pupils are failing (UK, SE). Standardised indicators are also being adopted in a growing number of Member States (IE, BE) in order to identify the schools in need of support, which are often in impoverished neighbourhoods or deprived areas. Integrated school systems encompassing kindergarten, primary and junior secondary schools are also being created to provide additional support for children with special needs and to guarantee access to immigrant children and prevent early school leaving, also with the involvement of the local community (CY).

Some Member States go further and have individual learning plans for children (DK, LU). Keeping children at school longer and investing in their education contributes to improved educational outcomes and therefore better performance in the labour market. The evidence is to be found mainly in national Government statistics, which highlight correlations between unemployment and qualification levels (IE, SI, EE, HU, LT, ES, SE, LU). Other evidence mentioned includes surveys (IE) and academic research (SI, BE).

While some form of educational support for foreign-born children or children with a migrant background, in particular for learning the language of the host country, is frequently reported, it seems that refugee or asylum seeking children, unaccompanied minors and undocumented children are not receiving the required attention. Again, most Member States with a significant share of Roma population, as well as PT and ES, report measures to improve the situation of Romani children, with the focus on educational support.

Preventing early school-leaving

Early drop out from school is a widespread social problem encountered not only among children and young people living in disadvantaged situations but also among children from wealthy backgrounds (EL and (Northern) IT). The low level of well-being at school experienced by pupils when transferring to secondary education is highlighted as a factor in this context (FI). The inability of families to care properly for their children is also mentioned among the causes leading children and young people to drop out of school (LT).

In order to retain pupils at school, two elements are important: the quality of educational services offered and their responsiveness to the challenges of modern society, in particular as regards employment and household needs (EL). Tackling this problem requires an integrated approach individually tailored to different needs and also providing adequate support for all those needing to acquire appropriate language skills (NL) in particular children with a mother tongue other than the majority language. Specific measures focus on low skilled school-leavers seeking jobs (BE, Flanders). Targeted action is also envisaged to respond to more specific needs, e.g. schools are being set up within hospitals to allow children who are unable to attend school for health reasons to pursue their education (IT).

Close interaction is required among the different parties involved in preventing and addressing early drop-out from school. Such interaction could support academic performance, for example by providing teaching support to weak students (EL, DK), or by setting up structures outside school or a combined "school and job" system (NL). Some Member States require all schools to report high levels of absence to the local council (DK), the municipality (SE) or the competent social service (MT). Work with the family (IE), cooperation between

families, social workers, psychologists, pedagogues and medical specialists (FI, LT, LV) or an integrated cross-community and cross-sectoral approach based on the development of local strategies to ensure maximum participation levels in the education process (IE) are some of the solutions adopted. Changes to the curriculum in order to adapt them to pupils skills (ES), providing courses fostering self-confidence and promoting intercultural respect (EL) or the intervention of 'cultural mediators' (IT) can enhance the sense of 'belonging' and may encourage young people to stay at school. Financial support is also available for improving teachers' skills in handling potential drop-outs (LV, MT). The scheme 'Every Child Matters'(UK) helps schools to spot where problems outside the classroom are affecting a child's development, and bring in the relevant support agencies to deal with them.

Several Member States follow up measures to reducing the number of early drop-outs by setting specific targets (PT) or introducing monitoring and evaluation based not only on statistics but also on evidence-based experiments (NL) and specific indicators (EL).

It could be recalled that in 2003, in the framework of the Education and Training 2010 work programme, Member States committed themselves to reducing the EU early school leaving average to a maximum of 10% by 2010. Even if some progress has been registered since, substantial efforts are still required in order to meet such a target. Currently, the EU average for early school leaving is around 15 % - in some countries (Italy, Spain, Portugal, Malta) the average is above 20%.

Counselling to parents

Many countries underline that in order to create a positive environment for children there is a growing need to provide counselling to families to **support them in their parental role**. Finland gives advice to parents through its perinatal scheme. Estonia sees counselling to support parenting skills as one of its priorities. France has developed its *Réseaux d'écoute, d'appui et d'accompagnement des parents* (REAAP) to support parents. These strategies have a positive effect in fostering a secure environment for growing up and preventing crises, thereby minimising the need to move the child from the family.

Health care

Children born into low-income families are much more likely to experience social exclusion, unhealthy lifestyles, and poorer access to health services. A number of Member States have launched innovative initiatives to increase access to health services for young children and their families. They include preventive care such as prenatal and health care for young children, antenatal services for vulnerable pregnant mothers, regular check-ups of children and free maternity and child clinics. Several Member States have health consultants in schools that offer vaccinations, provide dental care, give advice on mental health, provide information on substance misuse, contribute to sexual education and health and promote healthy eating habits. However, for these initiatives to be successful barriers such as the imbalance in professional expertise between regions and additional costs of access need to be overcome to ensure fair access to health services.

In Belgium, antenatal services have been available to vulnerable pregnant mothers since 2006. The Office for birth and childhood (*Office de la naissance et de l'enfance*, O.N.E.) offers a free service comprising free vaccinations for a number of illnesses and advice on healthy nutrition. The Promotion of Health at School initiative (*Promotion de la Santé à l'Ecole*) complements the services provided by O.N.E. by ensuring regular check-ups of children, thus

improving the accessibility of health care services for low-income families with children.

In Bulgaria, mobile medical teams geared at intercultural communication have been established to reach Roma families.

In France at Orléans hospital, mediators with an intercultural background working with administrative and medical teams to facilitate access to social and health care for migrant pregnant women.

The universal coverage of health insurance has a strong influence on access to health care. Many countries, including those with a well developed service, are focussing on how to tackle those not covered by health insurance such as recipients of social assistance and migrants (AT, PL, BE). There are also non-financial barriers to health services, for instance a lack of information on the services available or the inability of staff to work in a multi-cultural environment. Even where services are universal, strategies to promote effective access are required, since vulnerable people often do not use the available services if left to their own devices.

In general, health care services for children are provided and funded at local level, but the financial resources available differs depending, for example, on the size of the municipality. The lack of competent professionals is also a major cause of geographical inequalities in the level and quality of health care provision.

Housing

Most Member States acknowledge that housing is one of the fields where a growing number of families have been facing increasing difficulties in recent years, with negative consequences for the health, well-being and development of the most vulnerable children in particular. Many children are still living in inadequate, provisional accommodation or even in unsound dwellings. Further, the social and occupational integration of young people in particular may be hampered by the non-availability of housing at affordable prices.

There is a strong need for comprehensive and consistent strategies to address the shortage of dwellings, the qualitative mismatch between supply and demand, and the rise in prices for both renters and buyers. Eradicating slum areas, subsidising more social housing and promoting a more efficient use of land are key priorities for several Member States in this regard.

Several Member States have strategies to prevent children from being evicted from their homes (SE) or to reduce the number of households in temporary accommodation (UK). Hungary provides temporary shelters where families who have lost their homes can stay up to six months so that children are not taken away from the family (on the grounds of the absence of a decent home).

Nonetheless, there is generally scope to make policy strategies more comprehensive to ensure quantitative adequacy and qualitative consistency with existing needs. Stated goals include: guaranteeing unconditional shelter for street children or families with children, developing social housing where availability falls short of demand, promoting social diversity in order to avoid creating areas of exclusion and facilitating a fluid rental market. The local authorities' have major responsibilities in these fields but act within national policy frameworks.

In Sweden, four objectives have been set for 2007-2009: 1. Everyone is to be guaranteed a roof over their head and continued coordinated help on the basis of individual need; 2. Greater number of women and men admitted to or registered with correctional facilities, treatment units, supported housing or care homes to have housing arranged for them when they are discharged; 3. Entry into the regular housing market is to be made easier for women and men who are in training apartments or other types of housing supplied by the social welfare services or others; 4. The number of evictions is to fall and no children are to be evicted.

1.3.3. Targeted interventions to reach the most vulnerable children and families

Children in foster care (linked to ongoing de-institutionalisation) and disabled children

In the majority of Member States more and more children are being placed in foster care as opposed to institutional care, as foster care is seen as a more nurturing, stable and family-like environment (FI, SL, EE, CY, HU, IT, PO, SE and IT). Issues warranting more attention, however, are whether and how foster carers are to be assessed; how Member States can recruit more foster carers to cope with the increase in the number of foster care placements; appropriate training for foster carers and the issue of adequate financial resources for carers and children.

A stable placement is mentioned by many Member States as important for children in care. It avoids the damaging impact on children of frequent moves that hamper access to education and health care. In Sweden for example, in case of long-term placements in foster care (> three years) the social welfare committee is obliged to consider whether custody could be transferred to the foster parents. In addition to ensuring stability, care planning is also seen as crucial for some Member States. In Denmark, action plans setting out what an institution is to do for each child are reviewed regularly, firstly, three months after the placement of the child outside the home, and then once a year.

Clear through-care and aftercare policies are in place in several Member States. It is well documented that many young people lack the skills for independent living when they leave care. The aim is to help children and young people leaving care to identify and consider their career choices, and to prepare them emotionally and practically so that they can take up work or a place in further education. Denmark has a scheme for supporting and training 18-22 year-olds to live independently, including the appointment of a permanent contact person and a phasing-out plan in the care facility where the young person is currently accommodated." Another possibility is to extend the placement or provide a personal adviser. In Ireland there is legislation allowing the Health Service Executive to provide aftercare to a young person on leaving care and a standard for aftercare has been defined. In Luxembourg young people leaving institutions are cared for in open accommodation facilities ('Structures de logement en milieu ouvert'), which are private associations funded by the government. They provide accommodation and are supported by an educational team. Centres for social and professional integration offer specific professional courses and trainings for children and adolescents in homes in order to develop their social integration and professional autonomy.

Some Member States are taking significant steps to improve the educational attainment of children in care. The United Kingdom is introducing a legal duty for local authorities to take on this responsibility coupled with legislation to enable local authorities to direct a school admissions authority to give a child in care a place in a school (Denmark also has this).

The training of social workers and carers is an important factor in preventing the social exclusion of children in care as relationships with skilled adults can help children and young people in care develop successfully. In Estonia the compulsory training of welfare workers is being extended to foster carers as from 2007.

Some Member States highlight the importance for this target group of developing and strengthening social services through better standards, improving local coordination and increasing early intervention. In Denmark the emphasis is on early action, involvement of the family networking and relevant documentation. Ireland has increased investment in early intervention services in the form of Family Resource Centres and subjects care services to inspections to ascertain compliance with existing standards.

For disabled children most Member States report additional financial assistance and have specific strategies and programmes in place, for example initiatives to increase the number of individual plans for children with disabilities in Sweden or early diagnosis and intervention programmes in Poland. Several Member States provide specific services to disabled children, such as rehabilitation. Italy, for example, offers therapy, rehabilitation and assistance in daytime social rehabilitation and education centres. Some draw attention to services provided to children and youngsters with mental health problems (SE, DK, UK, EE, MT). But there is also an emphasis on the need to ensure access to mainstream care facilities whenever possible, notably by ensuring that every child care facility is open to children with specific care needs (BE).

Children and families living in deprived areas

Children at risk of poverty often live in impoverished neighbourhoods in large cities and in depopulated rural areas. The combination of disadvantages results in particularly difficult situations to tackle. Education and urban regeneration are two powerful tools to ensure equal opportunities but long-term efforts are required.

For instance, almost one child in four in London lives in households at risk of poverty. High housing costs and fewer opportunities to combine work and family responsibilities are the main causes. A National scheme, the UK New Deal for lone parents has been adopted to tackle this problem. Building on this scheme in London, additional support is provided for lone parents who take up work through in-work credits and an in-work emergency fund that supports lone parents through crises that could otherwise mean their losing their jobs. Slovakia is focussing on community development. The network of social services in areas most in need is being expanded and upgraded Poland.

Urban policies can also be combined with broader policies to address the needs of youth. Sport activities are recognised as contributing positively to self-control and the development of social competencies. Cultural activities can help to foster intercultural dialogue and values of respect, understanding and tolerance between various ethnic communities, as with some projects in Bulgaria. In France, the promotion of access to culture and sport in impoverished neighbourhoods is a priority. In Belgium (Flanders) more of the budget for municipal youth work is being allocated to municipalities with a high degree of social deprivation (as measured by eight youth deprivation indicators). The 'Kind en Gezin' agency targets large cities and deprived neighbourhoods with specific, reinforced services (antenatal support units

and low threshold[20] educational support units). In Germany an 'expertise agency' helps young people from disadvantaged areas to seek employment.

Denmark has developed a strategy to tackle 'ghettoisation' (2004). There are 15 projects in areas characterised by poor physical conditions, social problems, and uneven resident composition. A special urban development fund provides financing for social and preventive measures, renting rules are imposed, and social housing is being sold off.

Families with a migrant or ethnic minority background

Several Member States stress the fact that families with a migrant or ethnic minority background are entitled to the same measures as other families (IT, SK, HU). Nonetheless a more targeted approach is sometimes needed to ensure social inclusion: e.g. the Roma in Slovakia, Turkish and Roma children in Bulgaria and travellers in Ireland.

In Bulgaria a new, more targeted policy approach to the social inclusion of ethnic minorities has recently been adopted. Mediators from minorities have been appointed within service provider organisations. Part of their work is to counsel the parents of children from particularly vulnerable groups. There is special emphasis on the educational integration of Roma children.

Hungary has a specific policy to ensure the social inclusion of the Roma population through specific measures (fighting discrimination). In addition, the situation of the Roma is also addressed by more universal policies to tackle problem situations where the Roma are overrepresented. In fact, as mentioned under 1.3.2, most Member States with a significant Roma population, report measures to improve the situation of Romani children, with the focus on educational support. However, the multi-dimensional disadvantages faced by Romani children are rarely captured, for instance the number of Romani children in special or segregated schools. The recent decision of the European Court of Human Rights in the Roma Segregation Case shows that those shortcomings are likely to become even more evident. Among the Member States that have experienced a recent influx of Roma from Eastern Europe, only IT reports some measures to support immigrant Gypsy children.

Ireland has a specific policy for the social inclusion of travellers. A traveller accommodation programme (2005-2008) provides funding for local authorities to reduce the number of traveller families on unauthorised sites.

Denmark has developed a project to strengthen networks of ethnic minority women who have just arrived in the country. The project focuses on language training, help with housework, introducing the women to local community and recreational organisations.

Member States highlight the importance of the immediate and ongoing needs of unaccompanied minors or separated children seeking asylum (CZ). In Ireland one government body (HSE) has responsibility for accommodation, medical and social needs, as well as application for refugee status (under the Refugee Act (1996) and the Child Care Act (1991)). Measures to ensure participation in education are also important (LU's School integration programmes).

20 A reference would be useful here

Activities at EU and national level in the course of 2008, which has been designated as the European Year of Intercultural Dialogue, are expected to go some way in furthering social inclusion of migrants and people from ethnic minorities, as intercultural dialogue reinforces active citizenship and promotes respect for cultural diversity.

Other children and families in especially vulnerable situations

Families declared or at risk of being declared incapable of caring for their children: Many Member States (SK, LV, IT, BG, HU, SE, LU, CZ, DK, IE, BE, RO) emphasise the importance of preventive measures to support families at risk and thus prevent the abandoning of children or decisions to remove them from the family. Various services have been put in place at local level: prenatal consultancy services, preschool and out of school facilities, parental support centres, teen parents support centres, abandonment prevention services, relief centres and community centres. In a first stage efforts are made to persuade parents to cooperate voluntarily if the situation warrants intervention. Social support services can intervene when children are still present in the home.

In cases where children are removed from the family (e.g. placed in foster care) several countries have taken measures to ensure that this situation is reversible (temporary), e.g.: by obliging the caring institution to keep the original family informed of the child's development (LV, HU); by providing supporting services to help resolve the original problem (IT, LV) and to sustain contacts between parents and children (LU); or by granting a specific family benefit to the original family in order to support continuing contacts between parents and children (BE). It is clear that many Member States face significant challenges in providing all these services in sufficient quantity and quality (standards).

Street children: Member States address this group through various strategies such as the UK's strategy on young runaways, the Youth Homelessness Strategy (IE), the centre for combating child begging (IT), and social services for street children, street social work and district social work (HU and BG). The United Kingdom reports that a lot of children live in **families that are financially excluded**. One in twelve households have no access to a bank account and 30% of people living in such households are children. A strategy has been developed to provide access to banking services, affordable credit and free face to face money advice.

Children who are (potential) victims of abuse and violence: Measures reported by Member States include special programmes, centres and phone and internet lines (PL, EE, HU). In Czech Republic, a phone line and internet helpline have been established for abused and neglected children under the Safer Internet Plus project. Estonia is drawing up a plan for preventing violence in intimate relationships and trafficking. Italy highlights information and awareness campaigns, with a national centre for the fight against child pornography on the web and an observatory for the fight against paedophilia and child pornography.

Children who have contact with the criminal justice system: Many Member States have national prevention strategies or programmes to tackle crime prevention. Other measures include community-based initiatives to help divert young people away from crime and towards positive and socially responsible behaviour by offering opportunities for education, employment, training, sport, art, music and other activities while providing a structured environment. In Sweden specific procedures are in place to ensure that the social services are present when a young person is interviewed by the police to enable an assessment of his/her support needs. The United Kingdom is supporting families of offenders by addressing poverty

and skills needs, among other things to try to prevent the intergenerational transmission of problem behaviour and social exclusion.

Children at risk of substance abuse: Several Member States have specific national strategies or programmes to combat this problem by targeting the children directly. In Sweden a three-year trial (2006-2008) is being conducted to develop and test strengthened links between juvenile care and social services.

1.3.4. Strengthened governance for a greater impact on child well-being

In the 2007 Joint Report, Member States and the Commission concluded that the OMC was helping to strengthen the governance of EU and national social policies, notably by promoting increased involvement of stakeholders including the people directly affected in preparing social reforms. But it was noted that the quality of the involvement could be improved among other things by extending more systematically the role of stakeholders to include implementation and follow-up. Interaction also needed to be reinforced between national and EU policy levels and regional and local levels where implementation largely takes place.

Most of the points highlighted in last years report[21] with respect to social inclusion policies are equally valid for policies specifically addressing the social inclusion of children. Furthermore, several key governance elements are examined in the analysis provided in chapter 1.2 above. This section therefore looks mainly at the articulation between the national strategies for social inclusion and children's rights policies, and, on the basis of the report prepared by the SPC ISG, at the existing arrangements in Member States for monitoring and evaluation of child poverty and the social exclusion of children.

Some Member States (CY, EE, IE, IT, HU, UK) have elaborate arrangements for **mainstreaming** child well-being considerations in national policy-making, while others are taking steps in this direction.

In Hungary a special commissioner has been designated in the Ministry of Welfare and Labour to foster mainstreaming; he acts as secretary of the Social Policy Commission, which operates alongside the cabinet. The ministries involved each have a senior official charged with managing children's issues and a 'Chances for Children' group has been set up within the Office of the Prime Minister.

As illustrated in chapter 1.2 there are Member States where child-related issues are integrated and mainstreamed within a universal welfare policy. Clearly defined policy objectives, embedded in long-term strategies and underpinned by appropriate quantitative targets and strong political commitment seem to be a successful formula for ensuring actual implementation.

An integrated and coordinated approach to the implementation of social inclusion policies in general is important to ensure that policies reflect the multi-dimensional nature of poverty and exclusion and to ensure the effective delivery of policies and services on the ground. Some Member States take specific action here, recognising that efficient coordination and interagency co-operation might be vital in order to improve the situation of children most at risk of poverty and exclusion.

21 A more detailed assessment is given in chapter 3.1.3 of the Supporting Document to the 2007 Joint Report. (SEC(2007) 329).

In Ireland the Office of the Minister for Children (part of the Department of Health and Children) has been set up to harmonise policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young peoples participation, research on children and young people, and cross-cutting initiatives for children. The Minister for Children attends all government Cabinet meetings and his Office is charged with implementing the National Children's Strategy, the National Childcare Investment Programme 2006–2010 and the Children Act and with developing policy and legislation on child welfare and child protection.

Unexploited synergies between social inclusion policies and the children's rights agenda

There is growing awareness of the importance of children's rights. This is largely driven by the impact of the UN Convention on the Rights of the Child (UNCRC). Several Member States now protect children's rights through laws or administrative decisions. But there are unexploited synergies in almost all Member States between anti-poverty strategies and children's rights policies.

Where such legal or administrative provisions have been introduced there is still in most cases a need to move beyond those formal commitments and to focus on their active implementation. Rights to services and to minimum quality standards still remain to be developed in several Member States. This is also true for appropriate accompanying institutional arrangements.

In a few countries policies for children have a long tradition of being strongly informed by a children's rights perspective (SE). Among the Member States that have ratified the UN convention on children's rights several have launched National Action Plans to follow up (AT, EE, ES). Several Member States have appointed an Ombudsman for Children (EL, FI, IE, HU, PL), an Ombuds-Committee for children's rights (LU) or a National commission for children's right (BE, PT). HU has appointed a children's rights advocate, as the legal representative of children in care with a view to helping children to know and enforce their rights. In Denmark the local social authorities are obliged to ensure policy consistency between general and preventive measures and targeted efforts towards children in need of special support. However, access to social rights, as distinct from political or civil rights, for children continues to be a challenge in many Member States. Moreover, given that attention to the views of children themselves is an important element in a children's rights approach a key challenge for several countries will be to move beyond a formal acknowledgment of and commitment to children's rights to a focus on their active implementation.

The level and coverage of minimum standards differ across the Member States. But several report that children and their families have rights to some services in terms of access and minimum quality standards (SE, FI, PT, CY). In Italy the state establishes the minimum levels for services on the basis of which the regions fix the quality standards. The United Kingdom uses a mix of rights, needs and welfare-based approaches to secure concrete benefits for children and young people.

Since 2005 Finland has had an Ombudsman for Children, linked to the Ministry of Social Affairs and Health, with a view to implementing and monitoring the rights of the child. In cooperation with other authorities and actors concerned, his task is to promote f the interests and rights of children, including by ensuring that they are taken into account in legislation and that societal decision-making includes assessing the impact on the well-being of children. He

is charged with monitoring the living conditions of children and adolescents and with conveying information concerning children to children, to those working with children, to authorities and to other sections of the population.

In several new Member States a shift in policy approach can be noticed from the previous focus on children in difficulty to a focus on promoting and respecting the rights of all children. The implementation of rights to access to (quality) services is in several cases hampered by lack of resources.

Monitoring and evaluation

Part II of the ISG report on child poverty and well-being focused on the monitoring arrangements in place in the Member States. The responses to the technical questionnaires providing the input for a broad review of the data sources and indicators used in the monitoring of policies to fight the poverty and social exclusion among children and to promote their well-being. An in-depth review[22] focusing on eight countries helped to identify the key features of the monitoring systems.

The monitoring systems are often part of an **integrated policy coordination process** with the improvement of the situation of children as an overarching objective. A key challenge is the coordination of a large number of policy actions that traditionally fall under scattered responsibilities, involving different areas and levels of government. Policy objectives are set through a complex awareness raising process involving a range of stakeholders (NGOs, researchers and representatives of the different levels of government), international reporting and benchmarking, and the use of existing indicators and research findings. DE, IE, and PT involve stakeholders in the implementation, monitoring and evaluation of the national strategies. DK, IE and the UK highlight the role of international benchmarking. Member States stress the need to embed monitoring and assessment in the strategy (as in IE, FI, and the UK).

Knowledge building also plays an important role. The monitoring systems reviewed have benefited from politically supported long-term investments in knowledge building in the area of child well-being. This includes statistical capacity building (by making better use of existing statistical and administrative data sources and filling data gaps); long-term research programmes that provide an in-depth understanding of the nature, determinants and dynamics of child well-being; and tools to support policy analysis (e.g. micro-simulation tools in DE, IE, FI, UK).

22 These responses were collected through the standard Task-Force questionnaires sent to all Member States as well as through individual contacts established between TF members and the countries concerned so as to complete and check the information under review.

Member States also highlight the need to **forge a link between the scientific community, data and policy analysts and policy makers**. DK, FI and the UK describe the way key policy recommendations can emerge from research programs that have been implemented in a specific policy context. Regular reporting supported by efficient dissemination (by government, through advocacy groups, or as part of the EU policy process) play an important role in raising the awareness of the process and thus creating political commitment and accountability.

Establishing the link between policies and outcomes remains a considerable challenge. Member States set quantified objectives and use indicators to monitor progress towards those objectives. Overall outcome targets create political commitment and accountability. They should therefore be based on a diagnosis of the causes of poverty, and should be supplemented by objectives relating to the key factors identified by this diagnosis. The monitoring of these objectives is often based on a hierarchy of indicators headed by key outcome indicators, and followed by more specific output and input indicators. The UK has set up priority objectives and key outcome-based performance targets. For an in-depth understanding of the impact of policies on outcomes, a number of countries use micro-simulation models and other analytical tools as operational tools for policy making.

1.4. Summary

At 19%, the risk of poverty among children in the EU is higher than that of the general population. The rate approaches 30% in the worst affected countries. Joblessness, in-work poverty and insufficient financial support remain the main determinants of low income among households with children. Child poverty outcomes result from a complex interaction between these main factors.

About 10% of all children live in households where nobody works and more than half are at risk of poverty. Despite overall progress in the labour markets, this figure has not changed since 2000. But 13% of children whose parents are at work are also at risk of poverty. In-work poverty is the consequence of low work intensity, low earnings or insufficient in-work support. When both parents work, only 7% of children are at risk of poverty, but the rate reaches 25% when only one parent works, thus illustrating the key role of labour market integration to durably escape poverty and exclusion. Other factors affecting child poverty, when coupled with low work intensity, include living with only one parent or in a large family. On average in the EU, social transfers other than pensions reduce the risk of poverty for children by 44%, which is a higher direct impact than for the overall population (38%). However, the impact of social transfers on child poverty, in particular the impact of family allowances, varies greatly across the EU.

In their aim to make a decisive impact on child poverty and social exclusion and to break the intergenerational transmission of disadvantages, most Member States have adopted long term integrated approaches. While the families in which children are raised remain the main target of intervention (income support, active inclusion of parents), most countries also have measures that directly target the children (e.g. in the field of child care, education or health). Education in particular emerges as a crucial factor if children from a disadvantaged background are to enjoy equal opportunities where life-chances are concerned. The trend is toward intervention at a very early stage: pre-schooling is already a good time to start.

But countries also highlight the need to embed the fight against child poverty within a wider context through approaches aimed at creating a favourable environment for all families and for family formation (e.g. reducing the cost of having a child, promoting a work life balance for men and women who decide to have children), and promoting child well-being. This often translates into national strategies that combine universal schemes with measures targeted at children and families that are most in need, and that integrate interventions in a wide range of policy fields, going from active labour market policies to tax and benefit systems, education and healthcare.

The assessment of Member States' policies seems to indicate that more efforts are needed in order to address the risk of social exclusion facing children suffering from multiple disadvantages, such as Roma children, children with disabilities, children without parental care or at risk of losing it, and children of migrant background who tend to be particularly marginalised. This could entail supporting family-strengthening projects and parenting support for families experiencing difficulties in order to counter the risk of premature separation of children from their biological parents. In cases where children cannot grow up with their biological parents or it is not in their best interest, alternative family- and community-based care solutions may be considered in preference to institutional care. Regardless of which care solution is chosen, there is a need to ensure quality standards in all phases of the care process (decision-making and admission, care-taking, leaving care). In spite of a general aim towards de-institutionalisation, the number of children growing up in institutions has remained steady, if not increased slightly in several Member States, in recent years. The design of appropriate and effective measures targeted at the most vulnerable children and youngsters comes across as one of many areas with evident potential for policy development and mutual learning (e.g. with respect to alternatives to institutional care: assessment and training of care-givers, recruitment to cater for the envisaged increase in placements, after-care services etc.). Continued efforts to strengthen overall monitoring and evaluation of policies to fight child poverty need to take into account the fact that capturing the situation of the most vulnerable children requires specific monitoring instruments.

In most Member States the mutual reinforcement of social inclusion policies and action linked to the children's rights agenda could be enhanced.

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The analysis by the Indicators Sub-Group (ISG) of the Social Protection Committee, presented in detail in section 1.2, of the relative performance of countries with regard to the three main factors (joblessness, in-work poverty and insufficient financial support) provides a broad diagnosis, which needs to be supplemented by an in-depth country analysis of the causes of poverty in each country. Four groups of countries are identified depending on the nature of the main challenge they face.

- Group A comprises countries that achieve relatively good child poverty outcomes by performing well on all three fronts. They combine a relatively good labour market performance among parents (low levels of joblessness and of in-work poverty among households with children) with relatively effective social transfers. These countries need to continue monitoring the developments of child poverty at national level, since in some of them it has recently increased.

- Group B comprises countries with relatively good to below average poverty outcomes. The main matter of concern in these countries is the high number of children living in jobless households. Policies aimed at enhancing access to quality jobs for those parents furthest away from the labour market may contribute to reducing child poverty in these countries.

- Group C comprises countries that record average or just below average child poverty outcomes, despite a combination of high levels of joblessness and in-work poverty among parents, either thanks to relatively efficient transfers, or because parents are still able to rely on strong family structures. Different policy mixes may be needed to give parents in jobless households access to quality jobs, to enhance the labour market participation of second earners and to provide adequate support for the incomes of parents at work.

- Group D comprises countries recording average or relatively high levels of child poverty. While they have low shares of children living in jobless households, they are characterised by very high levels of in-work poverty among families. These countries may need to adopt comprehensive strategies to provide better support for family income and to facilitate access to quality jobs, especially for second earners.

2. FINANCING OF SOCIAL PROTECTION

2.1. Introduction

By providing coverage against social risks (mainly unemployment, healthcare and long term care, disability, family and child benefits, and old age and survivors' pensions), social protection systems also have a considerable impact on the economy and the redistribution of resources. The large scale of financial flows involved obviously plays an important role in public finances and strategic financial planning. Indeed total social protection expenditure is the majority of total public expenditure in the European Union Member States, equivalent, on average, to around a quarter of GDP. A number of other factors in particular the organisation of social protection systems and the way they are financed, also play a key role in this context.

As asserted in the 2005 Communication to the Hampton Court summit[23], while responsibility for determining most aspects of financing of social protection remains firmly with Member States, it is beneficial to encourage exchanges of knowledge on how Member States adapt to the various challenges that their social protection systems are facing. As stated in the 2005 COM working document, Sustainable Financing of Social Policies in the European Union[24], *it is clear that financing arrangements are critical to ensuring that social policies contribute to growth and employment while preserving overall budgetary sustainability*.

The links between the financing of social protection and the goals of growth and employment are reflected in the Lisbon Integrated Guidelines. Related considerations are set out in the macro guidelines, notably GL 1 (*...Member States should avoid pro-cyclical fiscal policies…*), GL 2 (*...reform and reinforce pension, social insurance and healthcare systems to ensure that they are financially viable, socially adequate and accessible…*) and GL 3 *(... re-direct the composition of public expenditure towards growth-enhancing categories in line with the Lisbon strategy, adapt tax structures to strengthen growth potential…)* but also in the employment guidelines: GL 17 *(...Implement employment policies aiming at achieving full employment, ..., and strengthening social and territorial cohesion*), GL 19 *(...continual review of the incentives and disincentives resulting from the tax and benefit systems…)* and GL 22 *(Ensure employment-friendly labour cost developments ...reviewing the impact on employment of non-wage labour costs and where appropriate adjust their structure and level, especially to reduce the tax burden on the low-paid)*.

This section reviews recent developments in the financing of social protection provided by public or private schemes in the Member States, and relies notably on recent work and country summaries by MISSOC. The data used are mainly from ESSPROS (in which social protection covers all public and private interventions, except where simultaneous reciprocal or individual arrangements are involved; see ESSPROS box on page 41). Recent expenditure developments are first examined before changes in the financing of social protection are reviewed. The expected employment and redistributive impacts of reforms of social protection financing are then briefly discussed.

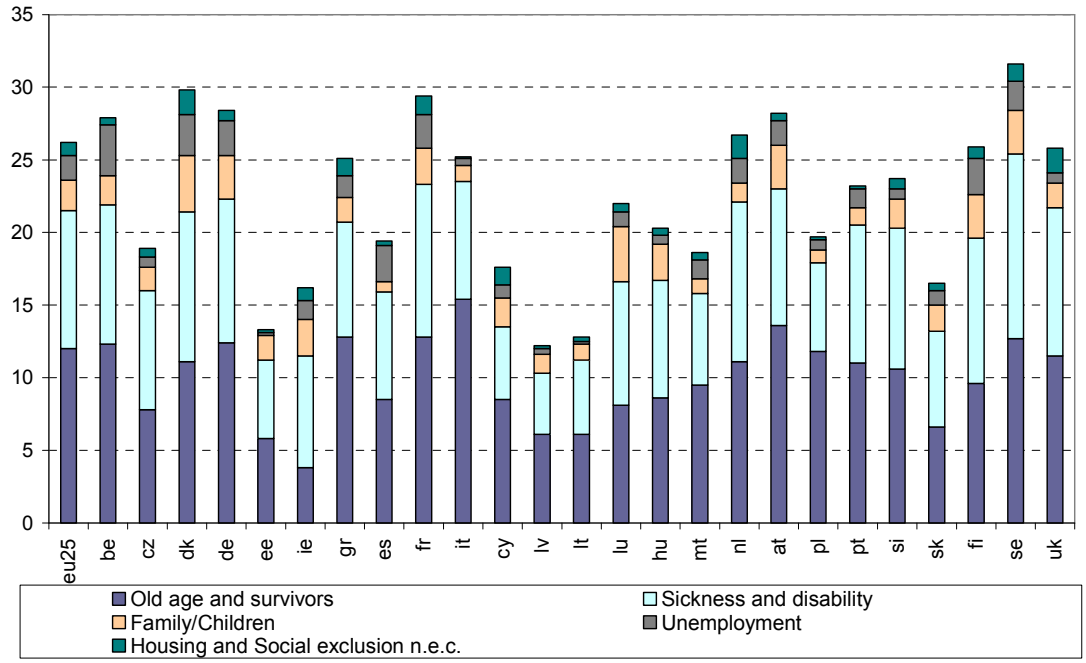
23 COM(2005) 525

24 SEC(2005) 1774

2.2. Recent development of social protection expenditures

Expenditure on social protection represented 26.2% of GDP in 2004 (see Figure 9).[25] It was around 12-13.5% of GDP in the Baltic States, and between 15% and 20% in IE, SK, CY, MT, CZ and close to 20% in ES, HU and PL. It was nearly 30% of GDP in BE, DE, DK, FR, AT or above (SE).[26] In all EU countries, old age and survivors' benefits (on average 46% of total expenditure on social protection benefits) and health care (28%) represent the bulk (three quarters) of social protection expenditure. The rest is spent, to varying degrees, on disability, family-related benefits, unemployment, housing and other social exclusion benefits.

Figure 9: Level and structure of expenditures on social protection benefits (2004) % of GDP



Source: ESSPROS.

Recent trends in social protection expenditure can help in analysing the development of their financing. The share of social protection expenditure in GDP (graph 2) depends on both the growth of expenditures and that of GDP. The ratio of social spending to GPD increased sharply in the early 1990s when growth rates were very low, and then decreased until 2000, in line with improved economic performance during the second half of the 1990s.

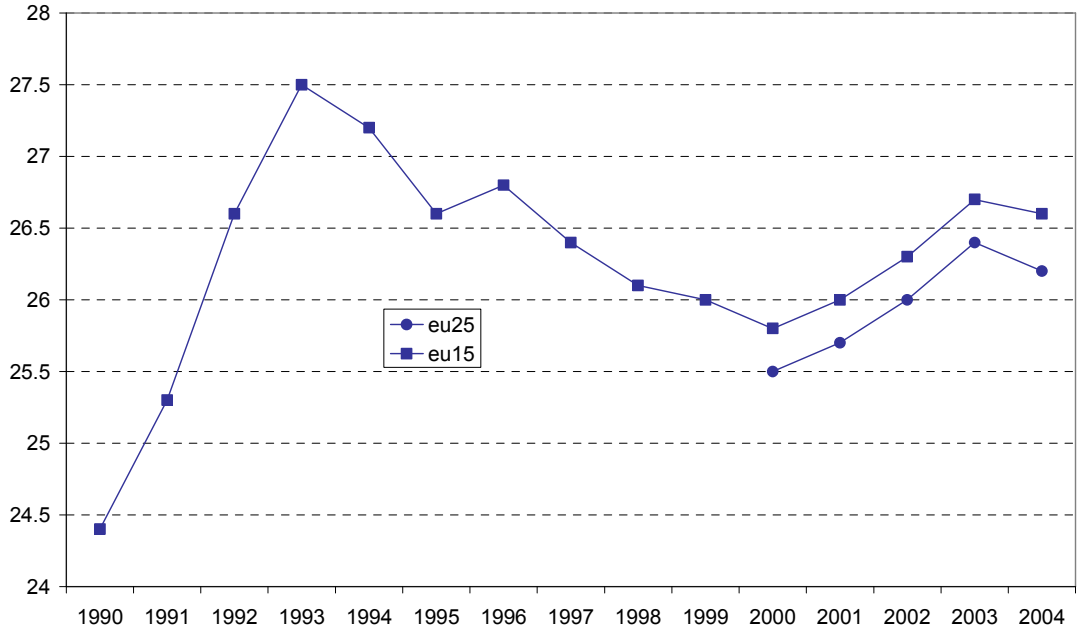
In recent years (2000-2004), social protection expenditure has grown slightly more rapidly than GDP (figure 10), reflecting a more rapid increase in health care expenditure (annual growth rate of 3.8% at constant prices) and unemployment expenditure (annual growth rate of 3.4% at constant prices). In the meantime, pension (old age and survivors'), invalidity, family,

25 See in particular Eurostat, Statistics in Focus 99/2007, Social Protection in UE. Former Supporting Documents of Joint reports (2006, 2007) provide elements on the financing of Social Protection and in particular the structure of expenditures.

26 It should be noted that comparisons of gross social protection expenditure can be misleading to the extent that account is not taken of the contribution of the tax system. Net social protection expenditure (after direct taxes are accounted for) can provide a clearer indication of resources reallocated through social protection systems. Such estimates are carried out notably by the OECD for a selection of countries. As such estimates are often derived from micro-data sets and models they inevitably involve some degree of uncertainty and should therefore be interpreted with caution. Recent estimates were provided in the annexes of the 2006 Joint Report on Social Protection and Social Inclusion.

housing and other social exclusion expenditure benefits have grown at a more modest pace (between 2.1 and 2.3%).

Figure 10: Expenditures on social Protection benefits since 1990 in EU- % of GDP



Source: ESSPROS.

Links between social protection expenditure and growth are numerous and vary depending on the time horizon. In the short run, social protection expenditure and receipts act as automatic stabilisers by exerting counter-cyclical effects.[27]

The dynamics of expenditure and receipts are partly linked to the economic cycle. Obviously, expenditure linked to employment, such as unemployment benefits or various income support benefits such as minimum resources (or more generally means tested benefits), are affected by developments in the economy. Other benefits can also be affected, like healthcare (for instance when access is linked to employment), or early exits from the labour market (for instance due to restructuring). Furthermore, in periods of slower GPD growth, social protection receipts also grow more slowly, in particular reflecting the slower growth of labour income. In the longer run, the impact of social protection expenditure on growth relies on a number of factors, notably those aimed at ensuring security against life risks and enhancing the adjustment capacity of labour markets. These include, amongst others, health care and social services meant to ensure population well being - and thereby to preserve human capital; and employment incentives embedded in making work pay and active ageing strategies. Benefits and services financed also directly contribute to growth and employment, for instance through health care and social services.

27 See for instance Van den Noord (2000), The size and role of automatic fiscal stabilisers in the 1990s and beyond, OECD Economics Department working paper 230.

Box: The European System of Social Protection Statistics ESSPROS

The data on social protection expenditure and receipts that are used in this analysis have been compiled by Eurostat in the framework of the European System of Integrated Social Protection Statistics (ESSPROS). ESSPROS provides data on all Member States except RO and BG, which were not included in the 2004 data, but are included in the 2005 data, to be published soon.

Social protection expenditure includes social benefits, classified by function, and the administrative and other costs incurred by social protection schemes. Social protection is defined as encompassing "all interventions from public and private bodies intended to relieve households and individuals of the burden of a defined set of risks or needs, provided that there is neither a simultaneous reciprocal nor an individual arrangement involved". Thus, the scope of ESSPROS extends beyond social security (i.e. social protection offered or imposed by government) to include benefits provided by private social protection schemes, but does not include personal pension provision.

ESSPROS is designed to provide comparable information on the scale of expenditure and receipts in the EU Member States together with developments over time. However, due to the marked differences in social protection systems across the Union and the difficulties in allowing for them, the data cannot be considered fully comparable between Member States.

Two issues should be highlighted regarding the overall scale of expenditure: firstly, social benefits are recorded gross, without deducting taxes or other compulsory levies payable on benefit income, and any fiscal advantages granted to households as part of social protection are excluded, even though the contribution of the tax system to social protection varies considerably across countries (see for instance the 2006 Joint Report);secondly, the boundaries between social protection and other areas of social policy or services are not always easy to determine across Member States due to different national contexts: for example the distinction between social protection and education in the case of childcare services.

As regards the break down of spending by functions, and their comparability across countries, in most Member States old age, survivors' and disability benefits are part of a coherent group set up as a single system. ESSPROS rules classify these benefits under their respective functions, but the strong interdependence between them may make it difficult for some countries to do so. The broad functions, or areas of need, in the ESSPROS classification system are defined as follows:

- Sickness/health care: income maintenance and support in cash in connection with physical or mental illness, excluding disability. Health care intended to maintain, restore or improve health irrespective of the origin of the ailment, includes paid sick leave, medical care and the supply of pharmaceutical products.
- Disability: income maintenance and support in cash or kind (except health care) in connection with the inability of people with physical or mental disabilities to engage in economic and social activities, includes disability pensions and the provision of goods and services (other than medical care) to the disabled.
- Old age: income maintenance and support in cash or kind (except health care) in connection with old age, includes old-age pensions and the provision of goods and services (other than medical care) to the elderly.
- Survivors: income maintenance and support in cash or kind in connection with the death of a family member (e.g. survivor's pensions).
- Family/children: support in cash or kind (except health care) in connection with the costs of pregnancy, childbirth and adoption, bringing up children and caring for other family members.
- Unemployment: income maintenance and support in cash or kind in connection with unemployment, includes unemployment benefits and vocational training financed by public agencies.
- Housing: help towards the cost of housing, includes interventions by public authorities to help households meet the cost of housing.
- Social exclusion not elsewhere classified: benefits in cash or kind (except health care) specifically intended to combat social exclusion where they are not covered by one of the other functions, includes income-support benefits, rehabilitation of alcoholics and drug addicts, and various other benefits (other than health care).

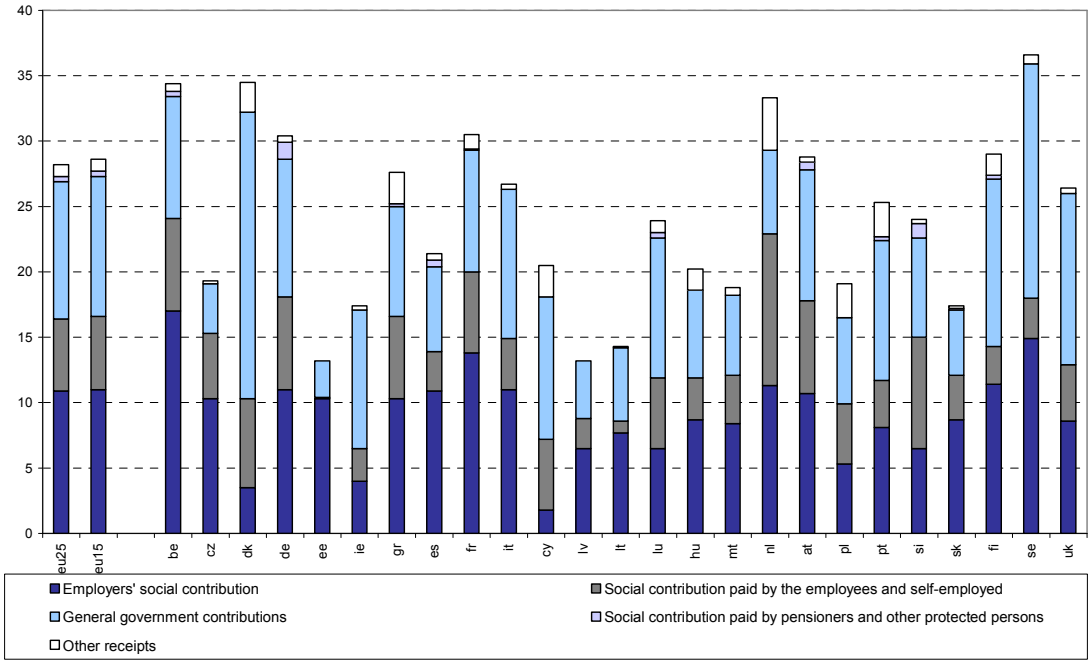
2.3. Recent trends in the financing of social protection

2.3.1. Overview of financing structures

The structure of financing

Social protection can be financed through taxation on labour, capital or consumption. It is actually funded mostly by social contributions on wages and to a lesser extent by general taxes (consumption, household income, capital income and corporate taxes). In the EU, social protection spending is thus to a large extent financed through contributions from wages paid by employers and employees (including the self employed). In 2004, those social contributions accounted for 16.4% of GDP and nearly 60% of the entire social protection expenditure (Figure 11), while general Government contributions and contributions paid by pensioners and other recipients represented 11.8% of GDP.

Figure 11: Structure of social protection financing in the EU (2004) - % GDP



Source: ESSPROS.

This masks large national differences in the structure of social protection funding, in particular between Member States with a stronger Bismarckian emphasis where benefits are financed through social contributions and, those with a stronger Beveridgian emphasis where benefits are financed more from general government budgets.[28] In CY, DK, IE, and the UK, the relative shares of social contributions and general government revenues are relatively close. In the remaining countries, social contributions (paid by employers, employees and the self-employed) represent the main share of financing (around 70% or more of total receipts in BE, CZ, EE, NL and SK).

28 Different definitions for the classification of tax payments as social contributions exist. For a different definition see, e.g., European Commission (2007), "Taxation trends in the European Union: Data for the EU Member States and Norway". These differences have an impact on the share of social contributions in the financing of the social spending in some Member States.

It can be argued that social protection expenditure with a strong collective dimension (such as health and long-term care, but also family, housing and social exclusion benefits) are better financed from general revenues, while those with a stronger insurance dimension (such as unemployment benefits or pension benefits) are more appropriately financed through social contributions. Indeed, social contributions could focus on financing benefits where individuals perceive a stronger link between contributions and benefits.[29] Nevertheless, to maintain health expenditure, many strategies maintain a link between individual consumption levels and the cost to individuals (for instance out of pocket payments).

The various risks of social protection are financed through different sources[30]. Only in Malta are all the risks financed in the same manner. Generally, old age pensions and unemployment benefits are predominantly financed by social contributions, while family and social exclusion benefits are financed by general government revenues. The financing of health care expenditure varies greatly among Member States.

2.3.2. Average decline in the direct share of contributions from wages

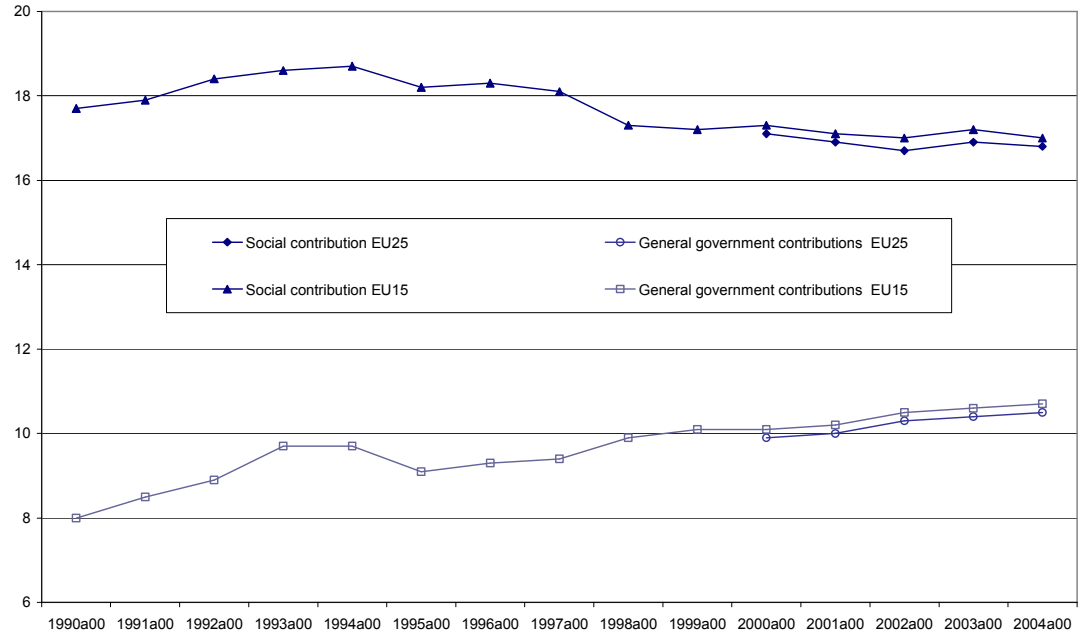
In the face of relatively low levels of employment, a number of Member States have introduced reforms to modify the structure of social protection financing in recent years. The economic rationale behind these reforms is to promote an increase in employment levels by avoiding increases or even reducing the level of taxation on labour and, at the same time, increasing on the contribution from other tax bases through government budgets. In the "Hampton Court" Communication[31] the Commission underlined the interest in a shift in taxation from labour to consumption and/or pollution taxes as part of a broader strategy to increase employment levels.

29 See OECD 2007, Financing Social Protection, the Employment Effect.

30 See MISSOC Info 2007 and MISSOC table 1 on the structure of financing for each main social risk.

31 COM 2005(525)

Figure 12: Evolution of the financing structure in EU (1990-2004) - % GDP



Source: ESSPROS.

Starting in the early 90's (see figure 12), a shift can be observed in the financing structure of social protection:

- On the one hand there has been, on average, a slight decrease since 1990 in the share of social contributions to the financing of social protection (minus 0.7% of GDP since 1990 for EU15). There was an increase in the first half of the 90's and then a decrease in the second half (notably in 1998 for FR and IT) and a slight decline since. This has been driven by both declines in employers' and employees' contributions (see below).

- On the other hand, there has been a significant increase in the share of social protection financing from general budgets (of 2.7% of GDP since 1990 for EU15), which provides the resources for the overall increases in expenditure. This has come from general revenue and earmarked taxes while the contribution of other receipts has declined slightly.

How is the shift in financing shared?

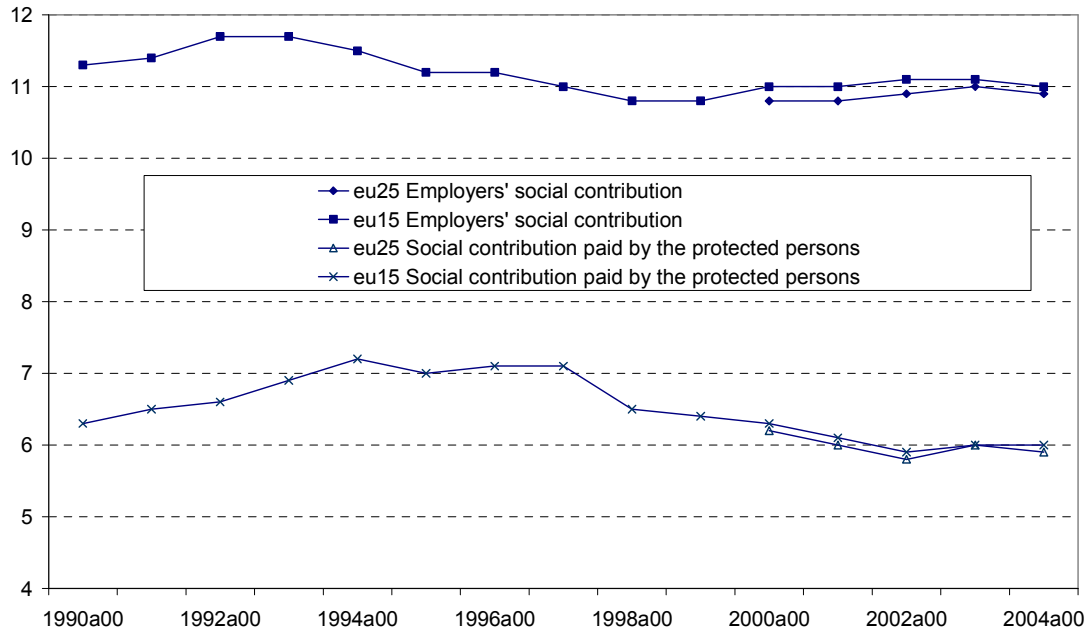
The average decline in financing directly through contributions levied on wages is partly shifting the financing of social protection to other sources, namely capital and consumption (general or targeted on specific products like tobacco, etc.). This reflects a broadening of the financing base (in addition to labour income, different types of income notably capital income and also corporate tax, VAT, or excise duties).

Since the 1980s, overall revenues (including social contributions) from labour (around 20% of GDP in EU25), capital (around 9% of GDP) and consumption (around 11% of GDP) have shown slight changes: taxation on capital has slightly increased by 2-3 percentage points and taxation on labour has slightly decreased (also taking into account decreases in personal income taxes).

The decline in social contributions is shared between employers and employees

The decline in the financing of social protection from social contributions has equally affected employers' and employees' contributions, although the dynamics are different (figure 13).

Figure 13: Employers and protected persons contributions - % GDP



Source: ESSPROS.

In principle what matters for labour demand is the total tax burden on labour and not its distribution between the employer and employee. Nonetheless, the short term effects of changes in employer and employee contributions are in principle different: a decrease in employer contributions directly affects labours costs, while a decrease in employee contributions first affects net income and consumption.

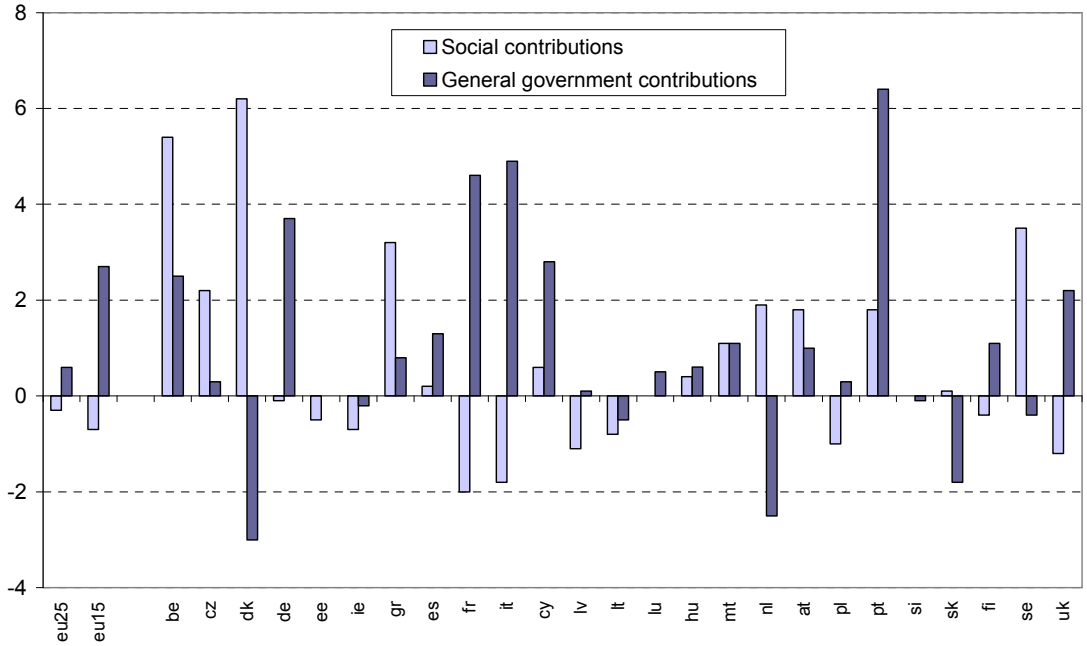
2.3.3. Is there convergence in the structure of financing?

A number of Member States have experienced trends in recent years bringing their financing structure closer to the European average (figure 14). In DE, FR, ES, IT, PT, where financing has traditionally been relied upon social contributions, there have been some significant increases in financing through general government revenues (for instance to cover additional non contributory expenses and also in FR and IT to compensate for declines in social contributions). In Portugal from 2008 onwards, the financing of Social Security will have a more important contribution from the state budget to its expenses. Conversely, in Denmark, there has been a shift from general government resources to social contributions.[32]

32 It should be noted, however, that this observation depends on the definition of social contributions used in ESSPROS. When using alternative definitions, as mentioned above, no increase in social contributions for DK is visible in the time period covered. See European Commission (2007), Taxation trends in the European Union: Data for the EU Member States and Norway.

These developments suggest that there is some convergence within EU in the structure for financing social protection. In some Member States, however, the original structure of financing has been strengthened like in NL (more social contributions) or the UK (more general government resources).

Figure 14: Changes in financing structure, shares of social contributions and general government contributions as percentage points of GDP



Note: data for 1990-2004, except EU25, EE, CY, LV, LT, HU, MT, PL and SI 2000-2004; CZ and SK 1995-2005.
Source: ESSPROS.

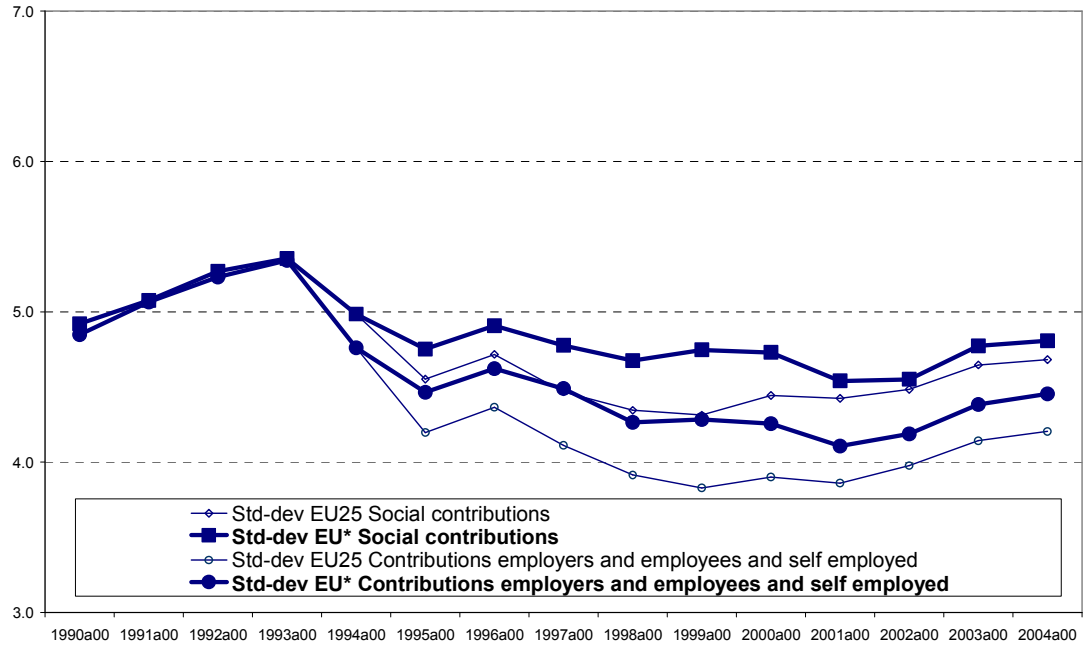
Some signs of convergence

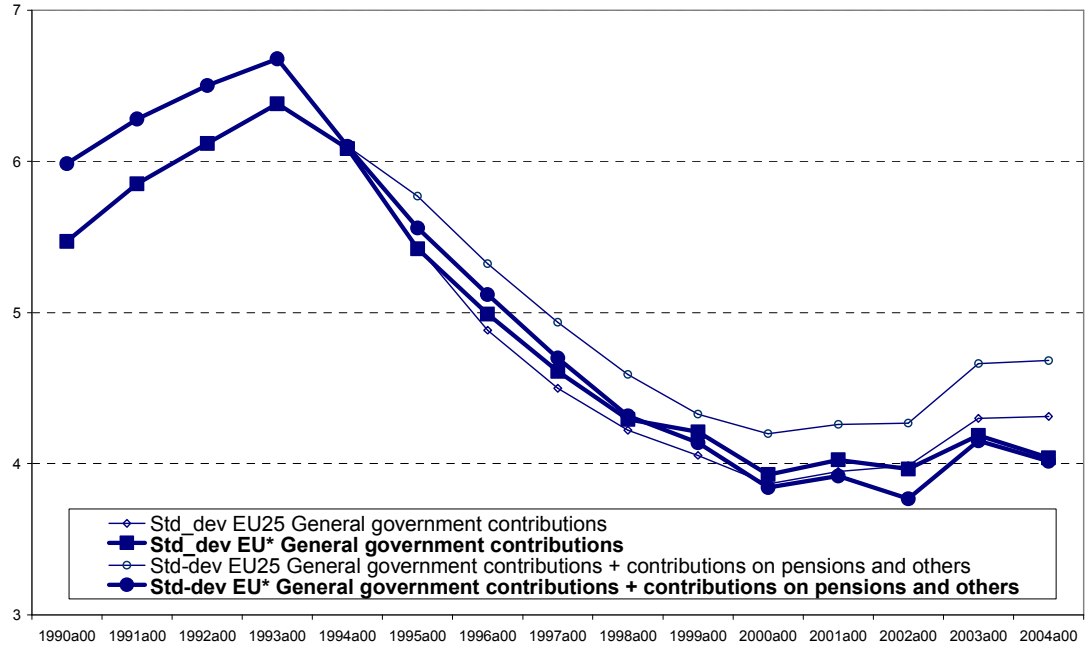
A simple analysis confirms that there are signs of convergence, although in reality the picture appears more balanced (this is based on the average standard deviation of the shares of financing sources expressed in percentage points of GDP).

There is some evidence of a convergence of the share of GDP financing social protection through general government revenues since 1993, but there is no clear evolution of the dispersion as regards the financing though social contributions.

For social contributions, a period of divergence (1990-93) was followed by slow convergence until 2000. From 2000 there seem to be signs of divergence again, or at least an absence of further convergence (until 2004).

Figure 15: Evolution of dispersion of structures for financing social protection in EU (standard deviation of sources of financing expressed as shares (%) of GDP)





Source: ESSPROS. - Note EU refers to a group of Member States for which data are available for the whole period.*

Role of tax competition

European and global economic integration may affect the ability of Member States to finance social protection through one or other type of tax or contribution. As highlighted in the

Commission working Document on Sustainable Financing of Social Policies in the European Union[33], if governments competed by lowering taxes in order to attract investments; highly skilled workers; or simply wealthy residents, then it would become more difficult to raise resources. Nevertheless, recent evidence does not suggest that Member States have been under heavy constraints to collect revenues from mobile sources.[34]

2.4. Recent reforms and their impacts on employment and redistribution

In the face of high unemployment levels, a number of Member States have introduced reforms in order to reduce or keep stable the level of taxation on labour. The two main aims appear to be to:

- control of expenditure levels in order to limit additional demands for increases in financing in the future. For instance, in the field of pensions in recent years, a number of measures have tried to curb the future projected increase of expenditure. A number of changes in the parameters of calculation of benefits go in this direction, but more systemic measures have also been put in place, like in Denmark with the introduction of a sustainability factor, or in Finland through the accumulation of funded reserves in the general PAYG scheme.

- control or reduce social contributions on wages by shifting part of taxation to other bases. Recent increases in the share of government resources spent on financing social protection expenditure in a number of Member States reflect this trend. These increases in government contributions can take the form of a broader tax base, including capital income (like in FR with the CSG), or of a shift towards taxation on consumption. Increased taxation on consumption can be general, through VAT (like in PT in 2006 and DE in 2007) or more focused with the objective of reducing some types of consumption, for instance on energy (like for instance in ES and LU), or tobacco or alcohol in a number of Member States.

These reforms can have a significant impact on employment and growth, as the mechanisms for collecting the resources needed to finance social protection schemes can affect positively or negatively economic incentives for agents in the economy. This is particularly relevant for the choice between various production factors (at the most general level between labour and capital) or between consumption and savings by households. The financing of social protection obviously also has strong redistributive effects between households and various levels and types of income.

2.4.1. Employment effects

Social protection financing structures affect employment levels, particularly unemployment levels. Nevertheless recent evaluations, notably by the OECD[35], show that the effect of reforms is generally modest for budget neutral packages. However, such evaluations mostly rely on econometric models and thus also depend on the assumptions used.[36]

33 SEC (2005) 1774.

34 Carone, Schmidt and Nicodème (2007), Tax revenues in the European Union: Recent trends and challenges ahead, European Economy, Economic Papers 280 and European Commission (2007), Taxation trends in the European Union.

35 OECD Employment Outlook 2007, Financing Social Protection: The Employment Effect, Chapter 4.

36 For instance it has been estimated that for the EU as a whole (European Economy, Public Finance in EMU – 2000.) that a cut of 1% of GDP of labour taxation would have a long term (after 10 years) a positive impact of +1% on employment (under the most favourable assumptions that unemployment benefits are kept constant in real consumption terms).

Different financing methods have different employment effects. For instance, the size of the employment effect resulting from an exemption from social contributions would probably be greater if targeted than if general as it could be focused on groups for which the effect is more significant and so reduce dead-weight costs. Furthermore, the size of the employment effect also depends on how the base broadening is designed and any potentially adverse effects (for instance on consumption due to changes in price, or on investment because of increased taxation of capital).

The OECD also notes that the employment effects are probably more significant when the financing of social protection is made more progressive, notably for a low skilled labour force. In particular, flat tax rates are non neutral in the presence of a binding minimum wage and lower social contributions can avoid adverse effects on the low skilled labour force. Furthermore, there is an imbalance in the labour market between supply and demand for lower qualifications, and labour demand is more sensitive to labour costs at the bottom of wage dispersion, which could notably be explained by the fact that substitution with investments (capital) is more difficult for higher qualifications.[37] Thus some Member States have introduced exemptions from social contributions for lower earners (notably BE, DE, FR, NL and UK).

2.4.2. Redistributive effects

Different types of financing obviously also have very different redistributive effects; in particular their incidence is different at various income levels.

Redistributive effects can be a direct consequence of reforms of social protection financing, for instance when different tax bases affected (like wages, consumption and capital income) or different levels of income. A shift to consumption taxes will clearly affect those on lower incomes more than higher earners, while an increase in the taxation of capital income will have a more redistributive effect. Tax exemptions that provide incentives to households to use some services (like private pensions, health insurance, or private child care) can have regressive redistributive impacts as the take up of these exemptions or credits is generally more important among higher incomes (see SPC(2005)[38] or OECD(2004)), while refundable tax credits can also be progressive. The cost of these tax credits can be far from negligible.

Financing arrangements can also have more indirect redistributive effects, for instance through their employment or consumption effects (for instance an increase in taxes on health consumption can also decrease access to healthcare). One should also note that changes in the financing of social protection can also have a strong effect on the dispersion of labour costs (for instance through a cut in social contributions), thus reducing the tax wedge, i.e. the difference between labour costs and net wages.[39] This also modifies the actual dispersion of costs for employers, which is another channel of redistribution (this redistributive effect can be measured by taking primary income market costs as a reference instead of gross wages). And as discussed above, this can also have an induced effect on employment, thus increasing incomes of those who would otherwise not have been employed.

37See for instance Malinvaud E. (1998), Economic Analysis of Employers Social contributions, Conseil d'Analyse Economique, Report n° 9.

38 Privately managed pension provision (2005), Report by the SPC available at the following link :

http://ec.europa.eu/employment_social/social_protection/docs/private_pensions_en.pdf

39 See OECD (2007), Taxing Wages, 2006 edition.

On the whole, the effects on employment and redistribution of reforms of social protection financing appear then to be potentially significant. Nevertheless, while the evaluation of the effect of reforms has developed significantly in the last decade, progress could be made in assessing the respective effects of various options in terms of both expected employment and redistributive outcomes.

2.5. Conclusion

Social protection expenditure and growth can be mutually reinforcing over both the short and long term. The ratio of social protection expenditure as a share of GDP has declined during periods of rapid growth in the second half of 1990s, after having increased sharply in the early 1990s when growth rates were very low. In recent years (2000-2004), social protection expenditure has grown slightly more rapidly than GDP due to more dynamic developments in health care and unemployment expenditure. Clearly, policies that affect expenditure also have a direct impact on the need to adapt social protection financing.

In recent years, a trend can be observed towards increased resources from general government budgets devoted to social protection, away from a reliance on social contributions levied on wages in the financing of social protection. There are also some signs of convergence in the EU of the financing structure, though the convergence shift is not entirely clear. These trends reflect an attempt to broaden the tax base from labour to other bases.

The method of financing social protection can have significant economic and redistributive effects, but the orders of magnitude of potential gains should be borne in mind. Reforms in the financing of social protection form part of the response to the challenge raising employment levels, but they cannot be a substitute for reforming employment and social protection policies – including training. In this respect, while evaluation of the effect of reforms of social protection financing has developed significantly in the last decade, it is essential to invest more in the analysis of both the employment and redistributive effects.

3. PROMOTING LONGER WORKING LIVES

The 2006 Synthesis Report on Adequate and Sustainable pensions[40] reported that nearly all Member States are increasing incentives to retire later and are reforming their Social Protection systems in order to promote longer working lives. Raising the effective retirement age is a way of adapting pension systems to population ageing. The 2006 Synthesis Report identified policies to enable flexibility in retirement age as an area for further analysis and the exchange of good practices.

The pension challenge is, essentially, to counter the currently low employment rates of older people, even lower than levels of some decades ago, despite parallel improvements in health status and the ongoing trend of increased life expectancy at 60. Most Member States have reviewed pension provisions to increase retirement ages, while a number of Member States have introduced more flexibility around when to retire and restricted early paths out of the labour market in order to help bring about a general increase in working lives. In practical terms, this can be done by modifying incentives to retire later, cutting early retirement options, and introducing options to combine pensions and earnings through partial retirement.

The next section gives an overview of developments in the labour market and demography that are influencing the outcome of pension systems. It is followed by an analysis of the options keeping people working longer under statutory pension schemes. This is based on the SPC horizontal study, finalised in April 2007, which focused on the design of statutory pension systems in promoting longer working lives through flexibility in retirement. The section also draws from the peer review on active aging held in Helsinki in November 2007. The last section discusses early pathways out of the labour market using the conclusions of the second horizontal SPC study from the second half of 2007. The latter focused on early exits from the labour market and, in particular, the contribution of different types of scheme (notably specific early retirement schemes, unemployment schemes, private pension schemes and disability schemes).

3.1. Labour market developments for those aged 55-64

Gains in life expectancy are the key driver of future pressures

The latest demographic projections from Eurostat (2004 demographic projections) provide a clear view of the anticipated pressure on pension systems, which (as measured by the demographic dependency ratio e.g. population aged 65+ relative to the population aged 15-64) is expected to nearly double from 2004 to 2050 (from 25% to 53%) in the baseline scenario. By comparing alternative scenarios, it is clear that the projected increase in life expectancy, particularly at 60 or 65, is the main driver of the demographic pressure on pension systems (in the EU it is more significant than the current low levels of fertility).

Employment rates in the EU decline between 55 and 64, although most transitions from work to retirement are not direct but involve periods in receipt of unemployment or disability benefits or other non-contributory periods, which clearly puts additional pressure on the future adequacy and sustainability of pension systems.

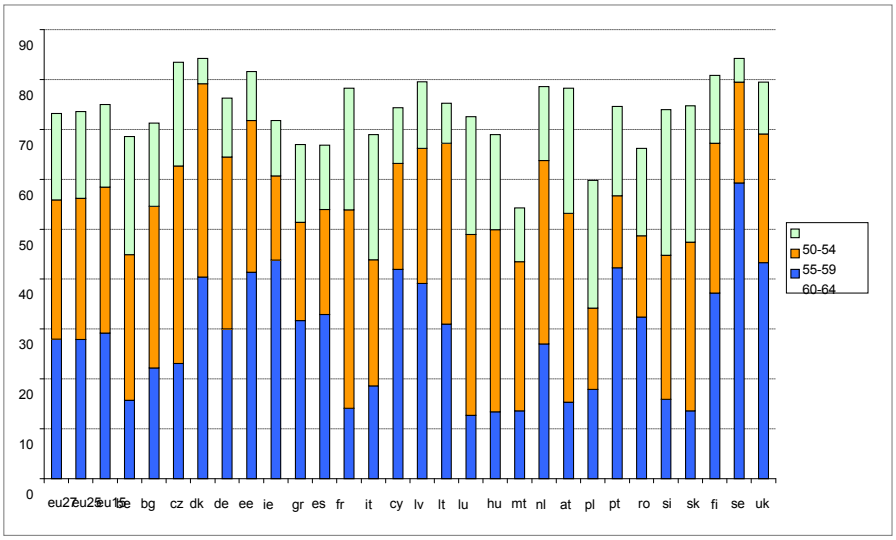
40 SEC(2006)304 of 27/02/2006

http://ec.europa.eu/employment_social/social_protection/docs/2006/rapport_pensions_final_en.pdf

Still a huge potential of progress

In 2006, in EU 27 on average the employment rate of those aged 50-54 was 73 %, 55- 59 was 56 % and 60-64 was 28%. The decline in employment rates was 17 percentage points from 50-54 to 55-59 and, more importantly, 28 percentage points from 55-59 to 60-64 (see graph below). Employment rates among the 50-54 bracket vary much less between Member States than for higher ages. They range generally at around 70% with a number of Member States closer to 80% or 85% (with the exception of MT at 55% and PL with 60%). The share of retired people increases significantly (by more than 10percentage points) at ages 60 and 65 reflecting the design of national pension policies.

Figure 16: Employment rates in 2006 (age brackets 50-54, 55-59 and 60-64)



Source: LFS (2006).

Reducing the decline in employment in the 55-59 age bracket can make a huge contribution to increasing the employment rates of older workers, and is also a necessary step in any attempt to increase employment rates among older workers (60-64 and 65+). For instance, reducing the drop in employment rate in the 55-59 age brackets to the best levels observed in the EU would alone reach the Lisbon target of 50% employment for those aged 55-64.

Recent developments…

Following the first steps toward pension reform and labour market improvements, the employment rate of those aged 55-64 has increased in recent years, from 36 % in 1997 in the EU27 to 44 % in 2006, although this is partly due to the higher activity rate of the baby-boom generation which is approaching retirement age. It nevertheless remains far below the Lisbon target of 50%. There are also significant discrepancies between Member States: despite recent improvements, the employment rate of older workers lies below or around 30% in a number of Member States (BE, IT, LU, HU, MT, AT, PL, SI and SK) and exceeds 55% in only a few (DK, SE and the UK). It is worth noting that progress has been slower in a number of Member States where employment rates of older people are already lower, which indicates a need for greater efforts. However some of the implemented reforms will take time to affect current workers.

The latest projections from the AWG suggest that the employment rate of older workers will reach 50% by 2013 and 60% by 2050[41].They also expect public pension expenditure to increase by 2.2 percentage points of GDP by 2050 in EU25.

... partly explained by increased part-time employment

The general increase in the employment of older people is linked to the growing numbers of people who opt to continue longer in employment but with reduced hours. The share of part time employment among older workers has significantly increased within the EU in the last decade. It is now nearly 25% for the EU15 (22.5% in the EU25 and 22% in the EU27). This trend is not just due to the structural increase in the employment rate of women, who more often work part-time. The part-time work among men has also increased steadily.

In the EU15, half of the growth in the employment of older workers during 1995-2000 was accounted for by increases in part-time employment. The trend slowed during the period 2000-2006, but around a third of the net increase in the employment of older workers is still accounted for by part-time work (about 30% of the increase during 2000-2006 for the EU25).

A significant share of new retirees takes a pension before standard retirement age…

The share of new retirees retiring before, after and at the standard ages vary greatly among Member States, clearly reflecting the various current options for flexibility in retirement age. It should be noted that in some Member States, most new retirees retire before the standard retirement age (BG[42] DE, EE, CY, IT, HU, PL, SK). In other Member States, people retire mostly at standard retirement age (DK, ES, FR, LT, PT, FI, SE, UK). Standard retirement age here refers to the statutory retirement age specific to Member States legislation but, given the differences in standard retirement ages, it could be more telling to compare the labour market status of workers at different ages.

…but a large share of transitions from work to retirement are not direct

Direct transitions from employment to retirement among those aged 55-64 are slightly increasing in the EU15, though a decline can be observed between 2000 and 2006 in the EU25. The frequency of early exits has fallen over the last decade in the EU15 but has remained roughly constant in recent years for the EU25. Moreover, the share of exits due to lack of employment has also increased in recent years, highlighting the need to develop better employment opportunities for older workers. Currently an estimated 10% of active people aged 50+ reduce or plan to reduce their working hours before full retirement, 40% have no plans in this respect, and the remaining 50% do not plan to reduce hours before retirement[43].

As workers get older, the share of those who do not plan to retire "in a progressive manner" remains nearly constant at around 50%. Consequently, we need to examine not only possibilities for reducing working hours (especially without taking up a pension) but also other paths out of the labour market. Only about half of older workers leave their last job or business to take up a pension. They are also often either unemployed (13%), long term sick, or disabled (12%). At higher ages the share of older workers who leave their last job or

41 Economic 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

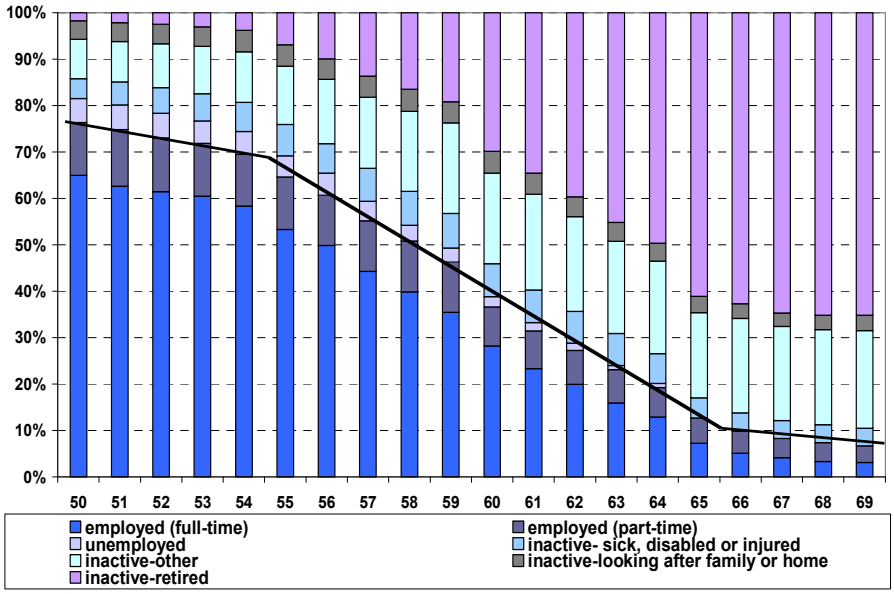
42Mainly through disability schemes

43 Eurostat, EU LFS ad hoc module based on 2006 data.

business to take up a pension increases steadily, while the percentages leaving for unemployment and, to a lesser extent, for long term sickness or disability decrease sharply. Exits directly to pension withdrawal are particularly low in some Member States (notably BE, ES and CY). The share of exits through unemployment is around 15% on average and rarely lower than 10% (except in LU) and can exceed 25% (DE, ES, FR, LT, PT, FI and SE). The share of exits due to long term sickness or disability is also generally around 15% (lower than 10% only in IT but around or often higher than 25% in AT, EE, ES, CY, HU, LT, NL and FI). However it should be noted that disability is not always equate to economic inactivity and many recipients of disability benefits remain active in the labour market.

The graph below represents economic activity by age in all Member States indicating that, in addition to a significant decline in employment rates when workers get older, the share of inactive (for sickness or other reasons increases) significantly from 50-54 to 55-59 and then remains roughly constant between 60 and 64 before declining slightly from 65.

Figure 17: Economic activity by age in EU27 (2006)



Source: LFS.

The main reason for retirement or early retirement among those aged 50-69 is reaching statutory retirement age (about 40%), which obviously increases with age. Around 10% of reasons given for retirement related to difficulties in the labour market (job loss 7%, problems related to job 2%), and 14% health difficulties (own health or disability 12% or care responsibilities 2%). Another 9% give favourable financial arrangements as the main reason, while for 20% the main reason is the desire to stop working. It is striking that the share of retirements linked to difficulties in the labour market remains quite constant with age, while difficulties with personal health and disability decline along with favourable financial arrangements.

Risks of divergence

Improvements in the employment of older people differ greatly between countries. It is worth noting that progress can be slower in Member States where employment rates of older people are already lower. The analysis shows that while there has been a convergence over the last

two decades in the employment rates of the 25-54 population, there is divergence among the 55-64 age bracket, especially since the mid 90's where, on average, a positive trend is observed.

While the employment rate of those aged 55-64 has increased by 7 percentage points since 2000 in the EU25, the increase is 6 points for men and 8 for women. Catch-up has been rather slow, and levels remain very uneven - 36% employment for women and 53% for men. In this context, there is a need to pay particular attention to the situation of women as they approach retirement age. Gender differences in employment have significant consequences for pension outcomes, as do different eligibility ages in retirement schemes for men and women. As such the gender harmonisation of eligibility rules for pension schemes can make a significant contribution to reducing gender differences in the employment rates of older workers.

There are also discrepancies in employment rates according to the level of education. Since 2000 the increase in employment rates among 55-64 year olds has been relatively slower for the less qualified within the EU25: 5 points for the less qualified compared to 6 or 7 points for medium or highly qualified. At the same time the evolution of employment rates for the less qualified has been more favourable for the 25-54 age bracket, probably reflecting targeted employment measures.

These uneven employment trends have raised some concerns about the future adequacy of pensions, as working longer is central to accruing pension rights. More effort should be made in targeting groups that have made slower progress.

3.2. Flexibility of retirement age and statutory pensions

Preferences expressed by the population as regards flexible retirement

There are indications that a large share of people have a positive attitude to more flexibility in retirement (notably in DE, DK, IT, PL, SK, SE). Research suggests that older workers would welcome more choice in how they manage their working lives in the period up to and beyond retirement, including options to downscale or downshift work commitments, to retire gradually, to choose when they retire and whether to choose to continue working beyond statutory retirement age[44]. A Eurobarometer survey of 15 EU countries indicates wide support for flexible retirement - 78% of respondents agreed that older workers should be allowed to retire gradually - although only 25% gave strong support[45].

In practice, however, the demand for flexible retirement seems rather more limited, which may to some extent be imputed to institutional barriers. In DK, for example, nearly half of people active in the labour market and a quarter of people already retired state that they would stay (or would have stayed) longer in the labour market if they had secured a part time job and part time pension. The low level of actual take-up of flexible retirement can often be explained by firms pushing out older workers and on the rules on the accumulation of pension and work income. In the United Kingdom, recent research has highlighted that the attitudes of employers and individuals affect the ability to extend working life[46]. Furthermore, until recently, people were often not able to scale back their hours or downshift work commitments

44 Loretto, W. Vickerstaff, S. and White, P. (2005) Older workers and options for flexible work. Equal Opportunities Commission Working Paper Series No. 31.

45 The future of pension systems. Special Eurobarometer. Fieldwork September-October 2001, published 2004.
http://ec.europa.eu/public_opinion/archives/ebs/ebs_161_pensions.pdf

46 Irving et al 2005, Factors affecting the labour market participation of older workers: Quantitive research, DWP Research report 281.

with the same employer due to tax issues and often had to seek part-time employment with a different employer.

To work longer an individual must be in good health, must be receptive to the idea of working longer and must have the opportunity to do so. As such, working conditions of elderly employees, health and safety at work, possibilities for life long learning and shorter working hours are all important aspects. Yet flexible working is not suitable for all professions, particularly for hard manual jobs, though retraining may provide opportunities for prolonging working life. Advances in Information and Communication Technology, aided by the European Action Plan for "Ageing Well in the Information Society", will contribute to allowing older Europeans to stay active for longer.

Government responses to the need to promote longer working lives

As highlighted in the first part of the 2007 SPC study on flexibility in retirement ages, most Member States are reviewing or reforming the conditions for taking-up statutory pensions in order to prolong working lives and contribute to the adequacy and sustainability of their pension systems. Key dimensions in those reforms are to:

- Introduce more flexibility in the choice of path from work to retirement (by, for example, adding more flexibility in retirement age with 'bonus-malus' systems – i.e. different accrual rates of pension rights and calculation formulae for benefits depending on whether the person retires before, at, or after the statutory retirement age), making it possible to combine income from employment while drawing a pension;

- Provide an appropriate variety of incentives to prolong working lives (by providing incentives both to employers to retain older workers and to employees to stay longer in the labour market);

- Strengthen incentives to work longer, complementing options for flexibility in retirement age;

- Make available the option of partial pension withdrawal while still working - combining pensions and earnings as well as allowing additional pension rights to be accumulated after statutory retirement age; and

- Guarantee that appropriate information is provided to beneficiaries. More complex retirement rules necessitate greater financial literacy in individuals and most Member States are developing new information tools, for instance through websites or direct individual information on pension entitlements. However, this is a difficult task that requires long term efforts, as experience suggests that even when individuals are given the information on their pension entitlements, they do not necessarily understand the consequences of different retirement choices.

The impact of flexibility in retirement age on the employment of older workers also depends on other factors, particularly the opportunities available in the labour market for older workers. These in turn depend both on the ability of employees to continue working after 55 (health status, training opportunities) and employers' attitudes towards older workers. Consequently the Commission proposed common 'flexicurity' principles for consideration at the December 2007 European Council. The Council endorsed the common principles which are based on four components: effective labour market policies, flexible and reliable

contractual arrangements, comprehensive lifelong learning strategies and modern and adequate social protection systems. Upgrading the skills of the employed and protecting people throughout their working lives rather than in particular jobs helps people to move into better paid and more satisfying jobs as well as motivating them to stay longer in the labour market.

Eligibility rules for flexibility in retirement age

The age at which individuals take their pension is linked to the design of social protection systems, but it is useful to investigate to what extent rules on early or deferred retirement affect the age at which individuals choose (or are compelled) to retire. Obvious examples of this correlation are the DK or UK systems, where it is not possible to draw a state pension prior to the State Pension age of 65, which translates into a very high take up of the pension at age 65 and over. In other Member States, such as HU or SK, relatively smooth conditions for early retirement lead to a high take-up, with nearly nobody deferring their pension beyond the statutory retirement age. These examples illustrate extremes of the effects of early and deferred retirement rules in social security schemes, but these are not the only factors to be considered in assessing an individual's decision to retire at a given age.

Member States report many different rules and regulations for early retirement within statutory pension schemes. In some Member States, early retirement is permitted for those who fulfil certain contribution requirements, also as recognition of longer work or particular 'hazardous' careers. Contribution year requirements vary from 15 to 37 contributory years, the majority reporting the number of years required to be around 30-35 years. These conditions entitle individuals to retire from 2 to 5 years before the official retirement age.

A number of other Member States list certain occupations as special cases, entitling these workers to early retirement as a result of a 'harder' working life. Member States reporting early retirement provisions related to occupation usually require a certain number of years within those occupations.

Member States report a more consistent approach to the rules relating to deferral of retirement, and generally (with some exceptions) allow unlimited deferred retirement.

A related point is how far people are fully aware of the consequences of their decisions and the extent to which flexibility in retirement needs to be complemented by minimum/maximum eligibility rules, in order to ensure adequate retirement incomes by restricting the scope for choice.

Eligibility rules for partial pensions

A second issue for the design of flexibility in retirement age concerns the conditions set for partial retirement, where individuals can draw part of their pension while continuing to work (in particular share, age and accrual conditions). This type of provision is reported in only a quarter of Member States. Such arrangements also concern only a small fraction of pensioners: at most 10% before 65 and no more than 1% around 65. It is important not to conflate the possibility of drawing a partial pension while continuing to work with early retirement paths as partial retirement can sometimes be used as a means of early exit from the labour market.

In general, more opportunities to combine a pension (possibly partial) and earnings are available for those close to the standard retirement age, while conditions are stricter for earlier ages (with often no possibility at all to combine earnings and early retirement). Furthermore, the development of a progressive phase-out of pensioners from the labour market depends on labour market conditions, in particular on opportunities for part-time work for older workers.

Another significant element in such arrangements is the choice between reducing the number of working hours and accruing further pension rights to ensure a higher pension in the future. Some Member States also provide an option to "de-retire" (to stop receiving pension) and return to work.

There are common themes across Member States in the arrangements for combining work and pensions, such as the limits placed on earnings when receiving a pension, in particular for those retiring prior to the official retirement age. However, some Member States allow individuals to continue accruing pension rights when working and drawing a pension, not stopping accrual at the moment pension is taken.

Flexibility in retirement age and incentives to work longer

Incentives to postpone retirement differ significantly between Member States, ranging from no specific incentives (while pension benefits continue to accrue during additional years at work, there are no specific supplements to reward additional years) to increases of accrual rates to about 10% a year. If economic incentives to retire later are too low, they may not have the desired effect on the postponement of retirement but, if they are too high, the cost for public finances could be significant. Furthermore, there is a risk of subsidising those who would have postponed retirement anyway. In this context, such incentives should be at least neutral to ensure sustainability.

Financial incentives may play an important role in the decision to keep working beyond the statutory retirement age, but, as concluded in the peer review on active aging in Helsinki in November 2007, non-material incentives are often perceived as more important. These include physical (e.g. pleasant environment) and mental (e.g. good attitude towards the older persons) well-being at work and preventive health care for employees. The atmosphere in the company and the management style are also frequently considered more important than the size of salary[47].

Incentives are very uneven among Member States and some schemes still incorporate relatively strong disincentives to continue working after the earliest eligible age. The strength of incentives has a direct impact on the adequacy of pensions, as an increase of a few years in the retirement age generally translates into substantial differences in pension levels. At the same time shorter life expectancies upon later result in increased replacement rates. The design of incentives is probably most important between 60 and 65. Before 60, restricting eligibility for early exit is essential to promote longer working lives. After 65, it is also important not to provide strong incentives to people who would have worked longer anyway.

Incentives to work longer seem to be lower for those on lower wages

47 T. Hussi, Maintenance and promotion of work ability – cornerstone of Finnish ative aging policies. Peer review: Active Aging Strategies to Strengthen Social Inclusion. Helsinki, 22-23/11/2007.

Incentives can be significantly different for different earnings levels, so the situation for average wage earners does not fully reflect a country's incentive structures for working longer. For lower wage earners in particular, incentives have to be coherent with minimum income provision for pensioners and the way this interacts with standard earnings related schemes.

Incentive structures for different income levels appear to be generally similar after 65. However, before that age they seem to be lower for lower wage earners (50% of the average wage) in a few Member States[48]. These relatively low levels of incentives for lower wage earners should be reviewed, for reasons of efficiency, equity and also adequacy. Firstly, incentive structures should provide comparable levels of incentive for different wage levels, thus promoting longer working equally among the entire active population. Secondly, working longer should allow increasing pension accruals and thus contribute to more favourable pension outcomes for all income groups.

Reviewing incentive structures for lower wage earners requires the re-examination of at least the design of minimum income provision for older people and its interaction with earnings-related statutory pensions.

Likely impact of flexibility of retirement options on the employment of older workers

A number of factors impact on the employment rate of older workers and it is difficult to estimate the separate impact of flexible retirement. This difficulty is compounded by the fact that Member States normally provide qualitative rather than quantitative evaluations.

One of the main factors seems to be the general positive situation of the labour market. Finland, for instance, mentions that it was the key factor in the 90's in keeping more older workers in employment than previously. In the United Kingdom, on the other hand, recent research has highlighted that the attitudes of employers and individuals affect the ability to extend working life. Where health problems and caring responsibilities are taken into account by their employer, some people are able to remain in work.

The United Kingdom has introduced generous deferral options for its statutory pension, intended to reward those who can continue to support themselves after the statutory pension age. However, it is as yet too early to determine the precise effects of these policies, and research is being conducted to understand what drives individuals to choose to defer their state pension.

It is difficult to measure how the coverage of flexible retirement age and related expenditure are likely to evolve. This depends largely on recent steps in the reform of access to retirement. In the majority of Member States, the take up of more flexible paths out of the labour market is expected to increase in the coming decades, either through an increase in part-time work (DE, SE) an increase in deferment (DE, DK, ES, SE), or a decrease in exits at earlier ages (DE, HU, PL).

48 Incentives are measured here by the change in gross replacement rate when delaying retirement age. Reviewing incentive structures for lower wage earners implies to examine at least both the design of minimum income provision for older people and interactions with earnings related statutory pensions. For further details, see SPC Study Promoting longer working lives through pension reforms - First part - Flexibility in retirement age provision (2007).

3.3. Key elements in reforms of early exits

Early exit[49] benefits (mainly special early retirement schemes for certain professions, unemployment benefits and disability benefits, but also in some Member States supplementary pensions or survivors' pensions) tend to be one of the main elements in the path out of the labour market. Such benefits are often taken up by around 20% of the population aged 55-64. Reforms to reduce the take-up of these benefits before going on to statutory pension can thus make a strong contribution to promoting longer working lives. This is a key step in achieving higher employment rates among those aged 55-59 and thus of older workers as a whole.

The recent improvement in the employment situation of those aged 55-64 coincides with a growing divergence in Member States indicating slower progress for some groups (men *versus* women, higher educated *versus* lower educated). Such slower progress could weaken future adequacy of pensions, as future pension levels will increasingly depend on pension rights accrued throughout a working life. Accordingly, the reform of early exit from the labour market should also aim to focus on these groups where progress is slower.

Coverage

In recent years, the trend in the take-up of early exit benefits has generally been downward - most Member States' reported figures decline, notably as regards early retirement (DE, FR, HU), unemployment (ES, FR, PL, UK) or disability benefits (DE, DK, LU, NL, PL, UK). On the other hand, increases have been registered in a few Member States in recent years: early retirement (BE, RO), unemployment (LU) or disability benefits (EE, LT and SE).

In most Member States, a general decline in the take–up of early exit benefits is expected in future (BE, DK, DE, FR, LU, NL, HU, AT, PL and FI), although take-up levels are expected to remain at current levels in SE and increase in IE, LT and RO. These expected trends are the result of different driving forces: recent reforms, demographic factors and the maturity of schemes. Clearly positive developments in the labour market will also have a strong influence on the future take-up of benefits, along with general reforms rising the retirement age.

While most Member States expect a decline in take-up in future decades, reforms are expected to change behaviour gradually and in the long term. It is noticeable that the evaluation of already enacted reforms is not very developed[50]. Most Member States either do not mention any assessment of future trends or provide only very general ones. There seems thus to be a clear need for more efforts to evaluate the expected effects of reforms in terms of the take-up of benefits and the employment rates of older people – which would contribute to better preparation of further steps in pension reforms. Indeed, evaluation (possibly regular) would contribute to more transparency and would highlight any additional steps necessary.

Reform dimensions of early exit schemes

Most Member States are engaged in reforms to adapt these schemes and reduce the take-up of early exit benefits. They focus on the design of unemployment and early retirement benefits

49 Early exit schemes are to be seen as a special category of pathways out of the labour force different, than flexibility provided within the statutory pension schemes discussed in the previous section.

50 Conclusion based on replies to questionnaire for the SPC study on early exits from the labour market in mid 2007.

and access to disability pensions and rehabilitation. Some Member States have also reviewed taxation and the design of private pensions.

Key dimensions in reforms are to:

- Restrict eligibility conditions while creating an adequate framework for older workers' continued participation in the labour market, allowing for exceptions in the case of particularly demanding or hazardous jobs;

- Increase incentives to work longer for employees (notably through fiscal rules) and also for employers to hire older workers and not rely on early exit schemes; and

- Enhance work opportunities for older workers and disabled workers. Important aspects include improving working conditions (notably by preventing health problems) and developing active measures such as training or specific programmes to help re-enter the labour market.

Recent reforms aim to reduce the current high level of take up of early exit benefits

Early retirement benefits are a key element in the path out of the labour market as these benefits are often taken-up by around 20% of the population aged 55-64. Reforms to reduce the take-up of various early exit benefits (or its length) before the take-up of a statutory pension can thus make a strong contribution to promoting longer working lives.

Most Member States have launched a number of reforms to adapt these measures in recent years:

- Reforms of early retirement benefits are taking place in AT (2000, 2003, 2007), BE (2008), ES (2007), IE (2007), LV (2008), PT (2007), FI (2005). Some of them aim in particular to ensure that employers bear all or at least a significant share of the costs in compensating for particularly demanding or hazardous jobs. In some other Member States, eligibility rules have been tightened or schemes closed. For most of these schemes, an important aspect in the reforms is to ameliorate working conditions so that the nature of the job is less harmful to workers' health.

- Reforms of unemployment benefits for older workers are taking place in BG (2007), CZ (2001, 2004), DK (2007), DE (2003), LT (2005), NL (2006), HU (2005), FI (2003), UK (2000). These reforms aim to reduce differences between eligibility conditions for older workers and those for the active population as a whole and to develop active measures in order to enhance labour market opportunities for older workers.

- Reforms of invalidity benefits are taking place in AT (2000, 2003, 2008), ES (2007), LU (2002), PL (2006), HU (2008), LT (2005, 2006), PT (2007), MT (2007), NL (2005), FI (2004) and UK (2007). These aim to offer more opportunities to combine benefits and work, to undergo retraining, and to improve the adaptation of enterprises, including workplaces. Incentives are also being strengthened both for employers, to employ people with a reduced capacity for work, and for beneficiaries, by reducing barriers to returning to working life. The prevention of invalidity and the professional rehabilitation of people with health

problems can also make an important contribution and has to start from an early age.

Reforms of supplementary pension benefits (occupational pensions) are taking place in a few Member States. In BE (2003) they aim to diminish or even stop early take-up of supplementary pension benefits, by tightening eligibility rules and increasing awareness of consequences of early exit on future benefit levels. Whereas in the UK (2007) they are intended to increase the flexibility of drawing a private pension while remaining in employment; increase incentives for a higher level of private provision; and increase financial education.

- Reforms of financial incentives, especially taxation are taking place in BE (2005), FR (2003, 2007), HU (2007), NL (2005), PT (2007) or SE (2007). These reforms aim to increase incentives to take-up early exit benefits later and to increase incentives for employers to hire older workers.

About half the Member States have plans for additional steps in the reform of early exit schemes from the labour market. In some cases (LV, RO, UK), reform decisions have already been taken and the implementation process is under way. Some Member States (BE, HU) have already prepared additional steps, which should soon be ready. Others are considering options for further changes (AT, EE, EL, DK, FR, NL, SI, SK, SE) to improve the design of early exit schemes, many of which are still at an early stage in political debate.

Despite these reforms, given the current high levels of take up of these benefits, it is clear that more steps will be needed in most Member States. They should achieve a more systematic assessment of the way these schemes are designed and how they could be adapted in order to reduce the length of the period between end of last job and the take-up of statutory pension.

Likely impacts of reforms

Predicting changes in the employment behaviour of older workers as a result of reforms is a complex task, as it depends on a number of variables. The difficulty of the task is acknowledged by Member States, and only a few have indicated how reforms have influenced recent or future trends.

Most Member States are expecting an increase in both the labour market participation of older people and the average exit age from the labour market as a result of past or future reforms of pensions or early exit schemes. However, the focus is mainly on short-term objectives (such as the Lisbon targets on employment levels), rather than on longer term goals (for employment rates and exit ages further in the future, beyond 2010). Despite recent reforms, some Member States still foresee difficulties in reaching the Lisbon targets (BE).

Measuring the income situation of the elderly in connection with recent reforms or planned reforms is another complex task. Some Member States project a decrease in the incomes of the elderly following reforms to early pathways from the labour market as well as more general reforms (BE, HU, RO and EE). A few Member States on the other hand see some uncertainty as to how the income level of the elderly will develop (LT, FI and SE). In Finland, for example, the effect of the life expectancy coefficient included in the pension reform will only produce results later and at the present the full effect cannot be measured.

Member States generally expect a decrease in spending on early exit schemes reflecting a decrease in the number of beneficiaries (AT, BE, DE, IE, LT, HU, NL, PL, SK, FI, SE). A few Member States however do not expect significant changes in spending on early exit compared with current levels (EE and LV). However, in constructing and evaluating policy, it must be borne in mind that financial and other incentives are just one factor affecting early exits. Other factors are far harder to quantify and affect but can have equally large impacts such as job satisfaction - those happy in their work are more likely to continue working later.

4. ENSURING ADEQUATE AND SUSTAINABLE PRIVATE PENSIONS

The 2006 Synthesis Report on Adequate and Sustainable pensions[51] noted that many Member States are increasingly placing greater emphasis on the contribution of privately funded provision to ensure adequate retirement incomes. Many encourage private pension saving, often through mandatory funded pensions. The Report thus emphasised the importance of translating private pensions into safe and secure annuities.

However, the trend towards broader use of privately managed pension provision does not signal a public policy retreat from the area. The 2005 SPC special study on privately managed pension provision stressed that, although income from privately managed pension schemes is projected to increase in the coming decades, pay-as-you-go (PAYG) pension schemes are expected to remain the principal source of income for pensioners.

The increasing role of private pension income requires an effective framework to be established by Member States in order to facilitate the setting up-of complementary old-age provision and ensure its efficacy in providing adequate incomes in retirement. Consequently the 2007 SPC work programme included a thematic focus on private pension provision. In a joint workshop organised by the Estonian Ministry of Finance and the Commission, 15 Member States discussed and presented their approaches to the transition costs of pension reform and the design of the pay-out phase of funded schemes.

The workshop concluded that the development of private pension provision requires appropriate and careful design of public regulation. The transfer of risk from governments to pension funds and individuals needs to be well evaluated and accompanied by appropriate regulation. Thus monitoring and regulating private pension provision is becoming an important and complex task for public policy. The state has to organise the proper financing of transition costs as well as providing the public with information and raising the overall level of financial literacy. In particular it is important for the government to monitor, whether the actual development of private pension provision matches the needs of the country by assessing levels of coverage and benefits and their distribution by age and socio-economic status.

4.1. Public regulation: financing and information provision

Transition costs

In any reform of a public system transition costs are incurred and pension reforms typically reveal, or even create, pension deficits.

Transition costs generally occur on two levels: the macro and the micro level. On the macro level, transition costs occur due to the re-allocation of some contributions from PAYG schemes to individuals' private pensions. Pensions of current beneficiaries must then be financed from lower contribution revenues, resulting in additional costs borne by the State - a situation exacerbated by demographic ageing. Micro costs, on the other hand, are the ones directly shifted onto individuals to share the burden of transition.

51 SEC(2006)304 of 27/02/2006

From the PAYG pension scheme's perspective, transition costs could be divided into:

- gross transition costs, expressed as the amount of pension contributions diverted to the funded tier; and

- net transition costs, which include the gross transition costs but, in terms of compensation for the loss, also take into account potential PAYG pension level reductions accompanying the funded tier's phasing-in and/or additional state subsidies to the PAYG scheme.

The size of the gross transition costs is mainly influenced by the share of contributions diverted to the new funded scheme, the level of coverage of the funded scheme and the ratio of the average earnings of switchers to the average earnings of all insured persons in the system. The size of net transition costs is often lower than the gross costs because governments use various means to reduce the burden.

Governments are responsible for developing mechanisms to finance the transition costs as the creation of new mandatory private pension schemes. Both the size of the transition costs as and the strategy for financing them have a great impact on the well-being of current and future pensioners.

Governments have used different strategies to shoulder the net costs, including transfers from the state budget (from general tax revenues); increasing total contribution rates (e.g. EE, LT, where the total contribution rate for PAYG and mandatory funded pension schemes has increased); use of revenues from privatising state enterprises or other property; use of reserves; and debt financing. Other means of financing include:

- shifting part of the cost to current pensioners (e.g. less favourable pension indexation rules);

- restricting access to the statutory pension system by modifying eligibility rules (e.g. increasing pension age and contributory periods or the average effective pension age by restricting access to early pensions);

- for switchers to a mix of private pension and PAYG modifying the principles for the acquisition of pension rights and/or the PAYG pension formula.

In some Member States transition costs have also been reduced by other factors. In a number of cases (BG, EE, HU, LV and SK[52]) pension reform is considered to have had a positive influence on tax and contribution compliance, thus increasing post-reform revenues and shrinking the size of the grey economy. It should also be noted that in most new Member States the high economic growth rates of recent years have boosted employment and wage levels, positively influencing PAYG revenues and easing the transition.

Financial literacy and degrees of freedom

Another topic meriting particular attention in public policies is the need to improve financial literacy. There is a greater element of choice and therefore complexity, in private pensions than in PAYG schemes, which requires a better understanding of financial issues in order to make informed choices. Most Member States recognise the current insufficient level of public

52 L. Leppik, A. Vork. Transition costs of reformed pension systems. Tallinn 2007. Table 2.9.

financial literacy in their countries and the lack of information for people covered by mandatory funded schemes. Improving these levels is integral to the success of private pensions.

A further subject of debate is whether there is a need for legal restrictions on individual choice (e.g. eligibility for the mandatory funded scheme, fund choice etc), or whether more freedom could be given to customise options in pension systems to individual needs (though the latter also requires a good understanding by individuals of their choices). One should note here that adequacy does not depend on compulsion or freedom of choice, but rather on the relationship between risk and return. A higher return normally goes together with a higher risk and *vice versa*. In systems with mandatory saving provisions, it is up to state regulation to find a balance between the two parameters in order to ensure a sufficient level of adequacy without incurring unjustified levels of risk (higher risk may be left to the supplementary, voluntary funded pension schemes). To protect members of mandatory funded schemes from high investment risks all Member States have imposed restrictions on the schemes (types of instrument, portfolio structure, geographical and currency restrictions etc.) Normally individuals still retain a certain degree of freedom in the actual choice of fund and in switching from one fund to another. In addition, EE, BG, HU, LV, LT, SK and SE provide mandatory pension funds with a choice of investment strategies (fund management companies are required by law to provide pension funds with different investment strategies) and thus various risk levels (fixing the maximum share of portfolio that can be invested into stocks). As part of its information provision and public education policy, the state can suggest investing in less volatile instruments (higher share of bonds in the portfolio) when close to retirement. In Slovakia for example, the state has made it compulsory to change to less risky funds a certain number of years before statutory retirement age.

4.2. Public regulation: ensuring adequacy

Increased reliance on retirement incomes from private pensions implies a transfer of risk from the State or employer to the individual (DC schemes), particularly where a retirement is longer than expected. A number of factors affect this: primarily coverage (not only PAYG but also private funded schemes), costs, performance of private pension providers and design of the decumulation phase. Member States clearly have a role to play in ensuring that these factors do not result in inadequate pensions.

Coverage

The coverage of mandatory funded pension schemes is currently estimated at around 50-60% in most Member States and will approach 100% as schemes mature. Where participation is not mandatory, the degree of reliance on private pension provision in the country must also be taken into account. OECD data for voluntary schemes[53] shows that lower income groups are less likely to save privately for their pension than higher income groups, so greater reliance on private pensions could disadvantage certain socio-economic groups.

One characteristic of private pension provision is also the (generally) low degree of progressive redistribution in comparison to PAYG scheme, which could also result in a greater incidence of pensioner poverty. However, some countries have introduced solidarity elements into the funded schemes, for example, by compensating for certain periods outside

53 Pablo Antolin. "Different types of annuities", presentation on seminar Private Pension Provision: Transition costs and Decumulation Phase, in Tallinn 07/09/2007.

active employment, e.g. with the state paying contributions during periods of childcare or unemployment (SE, PL, LV, EE).

Costs and performance

Depending on the institutional set-up of the funded scheme in a Member State, the costs and fees charged by various pension institutions (mainly pension funds and insurance companies) can have a great impact on future benefits. The impact is greatest on lower earners as charges reduce their marginal contributions even further. Real returns on accumulated capital also heavily influence adequacy levels. Calculations by the Social Protection Committee (ISG) and Economic Policy Committee (AWG) assume a common long-run rate of return for the whole EU of 2.5%, corresponding to a 3% of gross real rate of return, minus 0.5% in administrative charges. However, economic growth differs among individual Member States and there can be significant national variations as to the actual long term gross and net rates of return.

Design of the decumulation phase: the importance of annuities

The payout phase of private, funded pensions requires very careful design to ensure the adequacy and sustainability of pension systems. Decumulation design can protect beneficiaries against fluctuations on financial markets (by predetermining payments), against inflation (through index linking) and various biometric risks (longevity, invalidity and income protection for survivors). There are three broad groups of payout products: annuities, phased withdrawals and lump sums. Annuities provide periodical payments to beneficiaries (with insurance against biometric risks such as longevity and survivors' protection in the event of death, based on the use of life expectancy tables), while lump-sums provide a single payment to beneficiaries, leaving it to them to ensure that this provides sufficient income during retirement. Phased withdrawals provide periodic payments, but without any insurance against the longevity risk, progressively diminishing the capital available. The choice between them can depend on the size of the statutory pension scheme (large PAYG schemes leave more room for manoeuvre in funded schemes), the general level of financial education, and the present and future financial and demographic situation in the country.

Annuities guarantee an income for life regardless of its eventual length and, as such, are the most secure means of providing an income in retirement. While they are common in many countries (and are the only option in some), they are not as prevalent as might be hoped due to individuals' myopia regarding their financial future. People tend to underestimate their life expectancy and often opt for phased withdrawals as this enables them to bequeath any remaining money. With annuities, the remaining stream of payments can only be inherited during a guaranteed period (if that option is chosen) and so can be less attractive. However, with other income streams, including phased withdrawals, there is a risk that the beneficiary will outlive the money available (particularly likely with increased life expectancies) and so greatly increases the risk of poverty in retirement. Although phased withdrawals or lump sums can sometimes be converted into annuities, this is left up to the individual beneficiary and is rarely undertaken without compulsion.

The ability to choose between annuities, phased withdrawals and lump sum payments currently varies greatly among the Member States. Funded pension schemes normally provide either annuities or lump sums. In some Member States the lump sum part is restricted either by direct legislation or by tax rules (as in DE, IE, LU, HU, PT or UK). Lump sum payments represent the largest share of pay-outs in BE, ES and CZ. Conversely, they are not common in NL, PT, SI and FI. Some Member States have introduced restrictions on the amount of

retirement savings that may be taken as a lump-sum payment (e.g. IE, IT, LT, EE or UK), while in others only annuities are available (NL and planned in PL). In some countries all three options are available, but access is subject to different requirements and conditions (EE, LT).

As the use of annuities for payouts spreads, so does the definition of annuity itself. Annuities must be purchased by those with a DC scheme from their individual account but are provided directly by providers of DB pensions (the ultimate level depending on time in work, salary etc). However changes to former DB schemes increasingly require the purchase of annuities, as in the case of NL where CDC (Collective Defined Contribution) schemes are developing. These schemes are hybrid in nature, as employers' contributions to the scheme are fixed for at least 5 years while the annual accrual of pension rights is based on the average or final wage.

The concrete design of annuities is also essential in determining the extent of risk sharing, for instance as regards longevity, inflation, developments on financial markets and other factors. The range of different products is large with joint annuities and flat-rate or indexed annuities with different guaranteed periods and risks covered (UK), whereas in some others only a basic single annuity is allowed (EE).

These developments require institutions capable of delivering annuities. The private sector cannot yet respond to that need in all Member States as markets for annuities have yet to emerge. Thus there is a role for governments to prepare the sector before legislating on the various payout products necessary for a mandatory funded pension. Furthermore, there is a need to guarantee the provision of payout products, especially annuities. The guarantee system could be similar to that used in the accumulation phase, where compensation schemes have been established in several countries (EE, UK) to reduce the risk of default of the provider.

The greater prevalence of funded pensions calls for an equivalent take up of annuities rather than other payout products of definite streams because of their guarantee of a life time income. In order to ensure adequate pensions, annuities need to protect beneficiaries against fluctuations on financial markets and inflation, for instance by being index linked.

Without this protection, the value of an annuity can fall drastically in a matter of years. This has led to increasing calls for financial service providers to build up guarantee funds of pooled resources, in the decumulation phase, as a last resort.

The increased role of private pensions in ensuring long term pension adequacy requires a more clearly defined role for governments. This involves defining pay-out conditions, appropriate supervision, public information and financial literacy, along with the definition of new instruments. Without such action, the increasing reliance on private pensions raises serious doubts about future adequacy.

5. ADDRESSING HEALTH INEQUALITIES AND PROMOTING ACCESS TO HEALTH CARE

5.1. Introduction

Striking differences in health outcomes can be observed not only across Member States but also within each country between different sections of the population according to socio-economic status, place of residence and ethnic group. Moreover, these inequalities widened during the last decades of the 20th century for a large number of EU countries.

Health inequalities or inequalities in health outcomes have been identified as an important policy area by Member States in their National Reports and in the 2007 Joint Report on Social Protection and Social Inclusion and, moreover, as an area for future more detailed analysis. The analysis is related to agreed common objectives of ensuring access for all to adequate health and long-term care and addressing inequities in access to care and inequalities in health outcomes. This chapter is based on the 2006 National Strategy Reports on Social protection and Social inclusion, the November 2006 in-depth discussion on health care and long-term care, the January 2007 Peer review in Budapest on health inequalities in the context of health care reform, the work of the Expert Group on Social Determinants of Health Inequalities (a subgroup of the High Level Group on Public Health), a number of related analytical studies notably those used in the 2007 Peer review and commissioned by previous presidencies (e.g. 2005 UK Presidency), and the 2007 Joint Report.

Health care systems, as part of social protection systems, have significantly contributed over time to major improvements in the health status of the population by reducing ill-health and maintaining good health. Overall, the coverage and quality of care in Europe is of a high standard. However the actual health status of the population is far from as good as it could be. Indeed, despite all Member States having in place systems that aim to provide access to care for everyone regardless of social status or income, health inequalities are substantial across and within EU Member States. The National Strategy Reports document striking differences in health outcomes across Member States (e.g. life expectancy varies between Member States from 65.4 to 78 years for men and from 75.4 to 83.9 for women). Within each country, there are also major differences in health outcomes between different sections of the population related to socio-economic status, place of residence and ethnic group.

However, health policy is only one of the aspects that determine health outcomes. Besides differences in access to health services, health inequalities are associated with a range of factors including social support systems, living and working conditions and differences in health related behaviour. Addressing health inequalities requires action to increase social protection and tackle social exclusion, to ensure that socio-economically disadvantaged people are not subject to additional disadvantages in relation to the quality of their education, living and working environments and access to health services, and through specific targeted action to protect and promote health, particularly in disadvantaged groups.

5.2. Background and stylised facts

Inequalities in health between social groups

Available information suggests that all EU countries are faced with substantial inequalities in health within their populations. Indeed, on average disadvantaged social groups are shown to have shorter lives, suffer more disease and illness and feel their health to be worse than more

well-off groups. For most measures of health a gradient exists in which people with higher levels of education or wealth or in professional occupations have better health on average than their counterparts. Moreover, socio-economic health inequalities have widened during the last decades of the 20th century for many countries. Inequalities start early in life (e.g. children of manual workers have lower birth-weights on average and infant mortality is higher) and persist into old age[54]. As is evident from the 2006 National Strategy Reports, in some countries ethnic minority groups such as Roma and migrants report a much lower health status than the population as a whole.

The literature on socio-economic inequalities in health in the various EU countries is extensive (see the 2005 Annual Report of the European Observatory on the Social Situation: Health status and living conditions[55] and 'The Role of the Health Care Sector in Tackling Poverty and social Exclusion in Europe'[56]. A recent analysis[57] found significant differences in life expectancy at birth between the lowest and highest socio-economic groups, e.g. between individuals in manual versus professional occupations and people with primary school versus post-secondary education. These amounted to 4 to 6 years among men and 2 to 4 years among women. In some countries these differences are considerably higher, representing a gap of up to 10 years, and in many countries the gap appears to have widened over the last 3 decades. Despite a general increase in life expectancy in all groups of the population, those in the highest socio-economic groups have in some cases registered a larger increase in life expectancy than those in the lowest socio-economic groups, thus widening the gap.

54 SHARE – Survey on Health Ageing and Retirement in Europe. For more information see http://www.share-project.org/. SHARE is a survey of the population of 50 years and older in 14 European countries and is fully comparable with similar surveys in England, USA, Korea and Japan. Two waves of data have now been collected.

55 The report is available at:

http://ec.europa.eu/employment_social /social_situation/docs/sso2005_healthlc_report.pdf

56 Tamsma, N. and Berman, P.C., 2004. Available at:http://www.eurohealthnet.eu/content/blogcategory/101/137

57 Health inequalities: Europe in Profile carried out for the EU supported project 'Health Inequalities, Governing for Health', for the conference on health inequalities organized by the UK Council Presidency in 2005. For more information see:

http://www.dh.gov.uk/PolicyAndGuidance/International/EuropeanUnion/EUPresidency2005/EUPresidencyArticle/fs/en?CONTENT_ID=4119613&chk=Xa2sOh. Other European Commission reports where the issue of health inequalities is highlighted include: the Social Situation Report 2003, the Joint Report on Social Inclusion 2004 and the Joint Report on Social Protection and Social Inclusion 2006. Presidency summits regarding the topic of health determinants and health inequalities included those of Portugal (2000), Belgium (2001) and the UK (2005).

Table 4

Inequalities in mortality by socio-economic position in 21 European countries[a].

Country	Indicator of socio-economic position	Period	Age-group	Rate Ratio[b] Men	Rate Ratio[b] Women	Source
Austria	Education[2]	1991–1992	45+	1.43*	1.32*	National census-linked mortality follow-up
Belgium	Education[2]	1991–1995	45+	1.34*	1.29*	National census-linked mortality follow-up
	Housing tenure[1]	1991–1995	60–69	1.44*	1.43*	
Czech Republic	Education[6]	End 1990s	20–64	1.66*	1.09*	Unlinked cross-sectional study
Denmark	Education[1]	1991–1995	60–69	1.28*	1.26*	National census-linked mortality follow-up
	Housing tenure[1]	1991–1995	60–69	1.64*	1.47*	
	Occupation[3]	1981–1990	45–59	1.33*	n.a.	National census-linked mortality follow-up
England/Wales	Education[2]	1991–1996	45+	1.35*	1.22*	National census-linked mortality follow-up
	Housing tenure[1]	1991–1996	60–69	1.65*	1.58*	
	Occupation[3]	1981–1989	45–59	1.61*	n.a.	National census-linked mortality follow-up; representative sample
Estonia	Education[11]	2000	20+	2.38*	2.23*	National cross-sectional study
	Education[6]	1988	20–74	1.50*	1.31*	National cross-sectional study
Finland	Education[2]	1991–1995	45+	1.33*	1.24*	National census-linked mortality follow-up
	Housing tenure[1]	1991–1995	60–69	1.90*	1.73*	
France	Education[1]	1990–1994	60–69	1.31*	1.14	National census-linked mortality follow-up
	Housing tenure[1]	1990–1994	60–69	1.27*	1.25*	
	Occupation[3]	1980–1989	45–59	2.15*	n.a.	National census-linked mortality follow-up; representative sample
Hungary	Education[9]	2002	45–64	1.97*	1.58*	Cross-sectional ecological analysis
	Occupation[10]	1984–1985	45–64	1.61	1.33	National cross-sectional study
Ireland	Occupation[3]	1980–1982	45–59	1.38*	n.a.	National cross-sectional study
Italy	Education[2]	1991–1996	45+	1.22*	1.20*	Urban census-linked mortality follow-up (Turin)
	Housing tenure[1]	1991–1996	60–69	1.37*	1.33*	
	Education[4]	1981–1982	18–54	1.85*	n.a.	National census-linked mortality follow-up
	Occupation[3]	1981–1982	45–59	1.35*	n.a.	National census-linked mortality follow-up
Latvia	Education[7]	1988–1989		1.50	1.20	National cross-sectional study
Lithuania	Education[5]	2001	25+	2.40*	2.90*	Unlinked cross-sectional analysis
Netherlands	Education[23]	1991–1997	25–74	1.92*	1.28	GLOBE Longitudinal study (Eindhoven)
Norway	Education[2]	1990–1995	45+	1.36*	1.27*	National census-linked mortality follow-up
	Housing tenure[1]	1990–1995	60–69	1.44*	1.36*	
	Occupation[3]	1980–1990	45–59	1.47*	n.a.	National census-linked mortality follow-up
Poland	Education[8]	1988–1989	50–64	2.24	1.78	National cross-sectional study
Portugal	Occupation[3]	1980–1982	45–59	1.36*	n.a.	National cross-sectional study
Slovenia	Education	1991 & 2002	25–64	2.44	2.66	Unlinked cross-sectional study
Spain	Education[2]	1992–1996	45+	1.24*	1.27*	Urban and regional census-linked mortality follow-up (Barcelona & Madrid)
	Occupation[3]	1980–1982	45–59	1.37*	n.a.	National cross-sectional study
Sweden	Occupation[3]	1980–1986	45–59	1.59*	n.a.	National census-linked mortality follow-up
Switzerland	Education[2]	1991–1995	45+	1.33*	1.27*	National census-linked mortality follow-up
	Occupation[3]	1979–1982	45–59	1.37*	n.a.	National cross-sectional study

a Because of differences in data collection and classification, the magnitude of inequalities in health cannot always directly be compared between countries.

b Rate Ratio: ratio of mortality rate in lower socio-economic groups as compared to that in higher socio-economic groups. Asterisk (*) indicates that difference in mortality between socio-economic groups is statistically significant. Notes refer to references given in the back of this report. N.a. indicates 'not available'.

Source: 'Health inequalities: Europe in Profile 2005': Study undertaken for the European Commission and the UK EU Presidency by Prof. Dr Johan P. Mackenbach, Erasmus MC, Rotterdam[58]

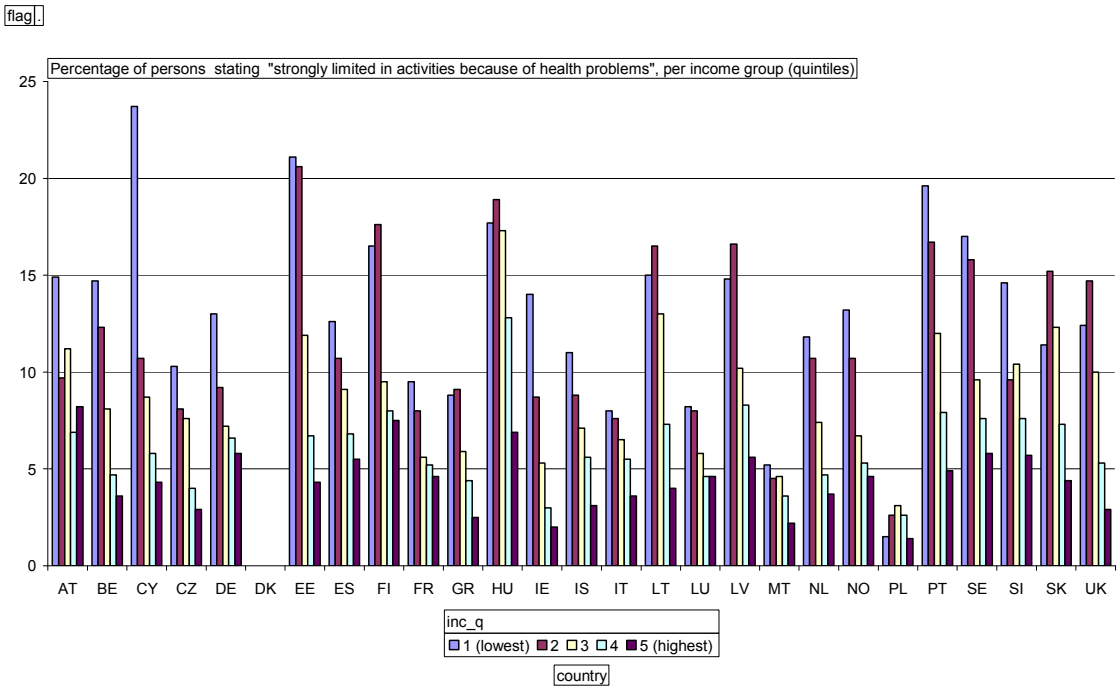
As regards mortality, the risk of dying in the lowest socio-economic groups identified in table 4 was found to be significantly higher than in the upper groups. Taking the education level as a key variable, Lithuania has a comparative mortality rate per 100,000 between the lower and higher socio economic groups of 2.4 for men and 2.9 for women, i.e. the number of deaths per 100,000 for women with a lower educational background is 2.9 times higher than for their counterparts with a higher level of education. The study also found that inequalities in deaths due to cardio-vascular diseases account for about half of the excess mortality in lower socio-economic groups, that injury mortality is higher for men in lower socio-economic groups and that cancer survival is higher in upper socio-economic groups. Moreover, despite substantial declines in infant mortality, the lower social classes continue to be more at risk.

Similarly, the 'Europe in Profile' study shows that rates of disease and disability vary substantially between socio-economic groups. People with lower education not only live shorter lives but also spend more time in poorer health. Results from the SHARE survey[59] found that both men and women with lower education and income levels have a higher risk of reporting less than good self-perceived health, long-term problems and activity limitations. Moreover, individuals with a lower educational level or income are more likely to experience limitations with mobility, arm or fine motor functions and have a higher prevalence of eyesight, hearing and chewing problems than individuals with a higher educational level. The 2005 Annual Report by the Health Status and Living Conditions network of the Social Situation Observatory and 2005 data from the European Union Survey on Income and Living Conditions (EU-SILC) (see Figure 17) confirms that those in the lower income quintiles are more likely to report ill health than those in the higher economic quintiles.

58 The study is available at http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd06_en.pdf. The numbered reference notes for the national indicators are explained on page 45 of that study.

59 For more information see http://www.share-project.org/.

Figure 18



Source: Eurostat, EU-SILC 2005

Finally, according to the 'Health Inequalities: Europe in Profile 2005' report, people with higher education are 1 to 3 centimetres taller. Another study showed that there was a difference in height between higher and lower educational groups which, ranging from 1.6 centimetres in Finland to 3 centimetres in Spain and, amongst women, from 1.2 centimetres in Norway to 2.2 centimetres in Germany[60]. Despite this evidence, however, health indicators at EU level are in general very patchy and need to be improved.

5.3. Causes of health inequalities

Health inequalities are not randomly distributed, but arise because of systematic differences between people depending on social group, physical and social environments, material conditions, exposure to positive and negative factors, and differences in access to health services.

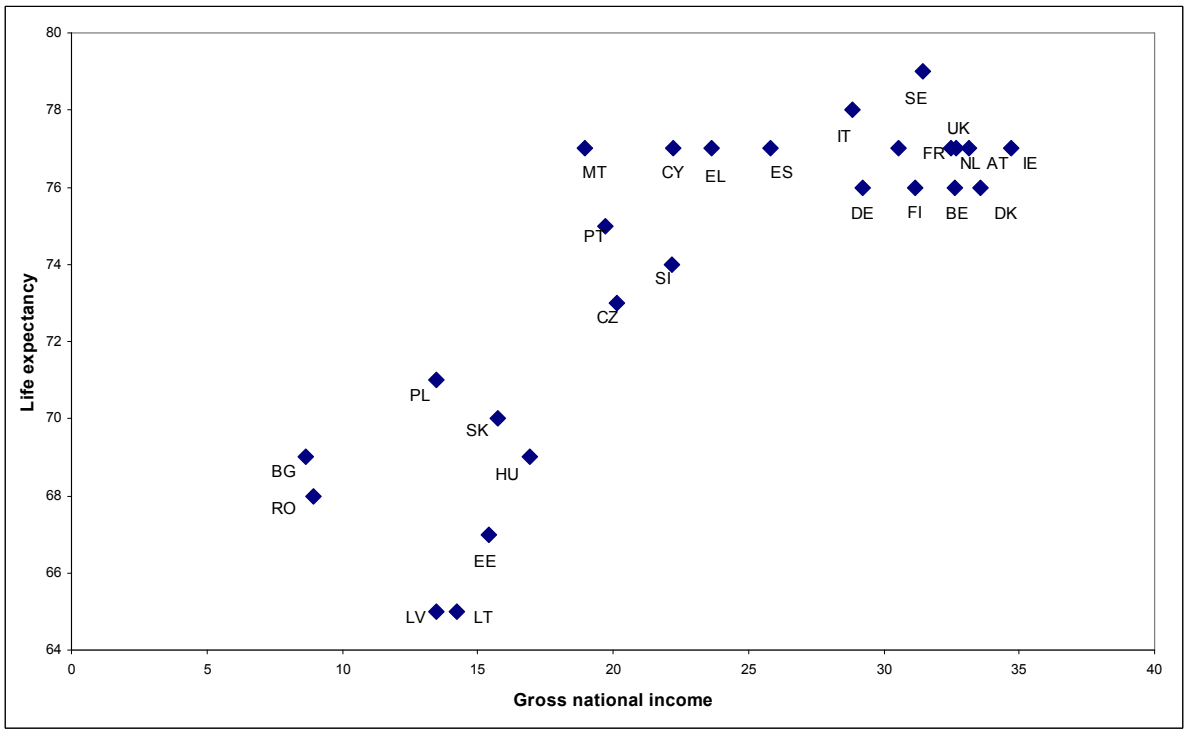
The physical and social environment of the individual, for example factors related to housing such as central heating, insulation, dampness and crowding as well as conditions in schools and at the workplace (such as exposure to chemicals, accidents and physically hard work), relevancies highly relevant to health. Where housing is concerned, it has been shown that people are significantly more likely to be in poor health when they live in housing characterised by: insufficient protection against noise, vibrations, damp, droughts, mould and cold in winter; overcrowding, lack of light or no view of the outside environment; the absence of parks and gardens (thus impeding socialisation), or being located in areas prone to

60 Cavelaars AEJM, Kunst AE, Geurts JJM et al. Persistent variations in average height between countries and between socio-economic groups: an overview of 10 European countries. Ann Hum Biol 2000;27(4): 407-421

vandalism. Other factors related to housing and low socioeconomic status include fear of losing the dwelling and having a poor perception of neighbours.

Material conditions, in the sense of having a stable income and a job as opposed to experiencing poverty and material deprivation, are of vital importance. While genetic predispositions may have a role in determining why a particular person is more likely to get ill than another, material circumstances affect health directly and, in consequence, starting early in life and continuing throughout, also affect psychological and health behaviour. As illustrated in Figure 18, average health status is also closely associated with the general macroeconomic situation, which suggests that rapid economic growth may lead to an improvement in general health status in the currently less wealthy EU Member States.

Figure 19 - Relation between male life expectancy and gross national income per capita in PPP ($), 2005



Source: OECD 2004

However, recent data[61] suggest that developments in general health status (e.g. life expectancy) and health status inequalities can be attributed to an even higher degree to changes in rates of poverty and income inequality. Poverty has a negative impact on health: living in poverty is associated with lower life expectancy, higher mortality (including infant mortality) and morbidity. Poverty is related to poor diet, sanitation and housing, a higher prevalence of smoking, alcohol and drug use, greater violence and lack of access to care. In the EU the proportion of the population at risk of poverty (at or below a threshold equal to 60% of the median income) is still quite high: 16% on average for the whole population and even higher for children, young people and the elderly.

61 'Health inequalities: Europe in Profile': Study undertaken for the European Commission and the UK EU Presidency 2005 by Prof. Dr Johan P. Mackenbach, Erasmus MC, Rotterdam

Also in this connection, some of the most important social determinants of health include unemployment, stress, and work. Unemployment, for example, is associated with poor health status and increased chance of poor mental health and social exclusion. It is largely agreed that the relationship between unemployment and mental health problems is bidirectional, or more likely, circular and reinforcing. Unemployment remains a concern for most EU Member States, with 7.9% of the EU27 labour force unemployed in 2006 and long-term unemployment reaching 3.6%.

Exposure to positive and negative factors that influence health, for example, the quality of nutrition, levels of physical activity, tobacco and alcohol use, sexual behaviour and psychosocial factors such as negative life events or a combination of high effort and demands with low reward and low control, is another major determining factor. Data (see "Health inequalities: Europe in Profile 2005") shows that smoking is usually higher in lower socio-economic groups and particularly among men. In northern Europe, findings show that higher educated women smoke less than their lower educated counterparts and that infrequent consumption of fresh vegetables is much more prevalent in lower socioeconomic groups. Women with lower socio-economic status are more likely to be overweight. These results therefore suggest that improvements in health–related behaviours are relatively more widespread in higher socio-economic groups. Negative factors such as obesity and smoking not only influence health but can also lessen the individual's chance of obtaining a job thus exacerbating the relationship between poor health and unemployment.

Finally, and importantly in the context of social protection, differences in access to health services are pronounced across socio-economic groups and also play a role in explaining health inequalities**.** While Member States have agreed on universality, equity and solidarity as common values and principles for health systems, and indeed universal or nearly universal rights to care are basic principles in all Member States, they do not always translate into equal access to care. There are differences in the individual ability to benefit from care depending on socio-economic status, age, and gender which result in unequal health outcomes. Furthermore, not all health care systems take sufficient account of the fact that the need for health care is higher in less advantaged social groups because of higher rates of disease and disability.

The 2006 National Reports identified a number of notable barriers to access that can hinder the use of care by more vulnerable groups. These include, for example, lack of coverage for certain types of care, high financial costs of care for individual, variation in service availability and geographical disparities in supply, waiting times, lack of information and knowledge, and beliefs and preferences. Hence, legislating for universal access to care services does not necessarily eliminate inequalities. Equitable health care must enable everyone to access and use appropriate health services in practice and not just in theory and equal access should be assured for equal need.

For example, access to health care and proximity to hospitals or primary care should not depend on individual socio-economic characteristics such as income. Table 5 shows self-reported unmet need for medical treatment due to the three reasons assumed to be closely related to social protection: affordability, waiting times and distance to care. While the available data do not allow cross-country comparisons because of cultural differences and different organisation of healthcare systems, a social gradient evidently exists in most EU countries for self-reported unmet need i.e. those in lower quintiles more often report an unmet need than those in higher quintiles. This is quite independent of the frequency of doctors'

consultations, i.e. the fact that in some countries people tend to visit the doctor more often than in others.

Table 5 - Doctors consultations per capita[62] and self-reported unmet need[63] for medical examination or treatment due to affordability, waiting times and distance to care, by income quintile

		Self reported unmet need for medical examination or treatment by income quintile				
	Consultations	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Austria	6,7	1	0,2	0,4	0,5	0,2
Belgium	7,5	2,4	0,8	0,2	0,2	0,1
Cyprus	2	6,2	5,2	2,7	1,4	0,4
Czech Republik	13,2	1,9	1,2	1,1	1,1	0,8
Denmark	7,5	0,5	0,3	0,5	0,3	0,1
Germany	7	na	na	na	na	na
Estonia	6,9	11,7	7,2	5,5	4	3,6
Spain	na	2	1,4	1,1	0,7	0,7
Finland	4,3	5,5	3,6	2,4	1,8	1,3
France	6,6	3,9	1,8	1,5	0,4	0,5
Greece	na	8,5	6	4,4	2,9	0,8
Hungary	12,8	6,5	4,5	2,6	2,8	2,5
Irland	na	2,4	2,7	3	1	0,7
Italy	7	9,9	5,4	4,4	2,7	1,9
Lithuania	6,8	10,3	7,8	7,2	4,5	4,9
Luxembourg	6,1	0,8	0,2	0,4	0,2	0,3
Latvia	5,2	30,2	24,5	18,6	13,3	7
Malta	2,6	2,1	1,7	2	1,5	0,7
Netherlands	5,4	1	0,6	0,7	0,1	0
Poland	6,3	13,5	11	9,4	8,2	6,2
Portugal	3,9	10	5	4,4	2,3	1,4
Sweden	2,3	2,9	4	2,4	2,4	1,3
Slovenia	7,2	0,5	0,4	0,3	0,1	0,3
Slovakia	11,3	5,4	4,2	2,9	1,9	1,3
United Kingdom	5,1	2,4	2,2	2,5	2,1	2,3

Socio-economic inequalities in health care use have also been detected. A 2004 OECD study looking at "Income-related inequality in the use of medical care in 21 OECD countries", conducted by van Doorslaer, Masseria and the OECD Health Equity Research Group

62 Source: OECD Health Data. Doctor's consultations are the number of contacts with an ambulatory care physician divided by the population. Contacts in out-patient wards should be included. The number of contacts includes: a) visits/ consultations of patients at the physician's office, b) physician's visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or nursing home with the intent of planning for the future delivery of service at home, c) telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home, d) visits made to the patient's home.

63 Source: Eurostat: EU-SILC. The table's figures represent the frequency of respondents replying 'yes, there was at least one occasion when the person really needed medical examination or treatment but did not'. The reference period is the previous 12 months. The three categories included in the table are 'Could not afford to (too expensive)' 'Waiting list' and 'Too far to travel/no means of transportation'. Eurostat has identified some discrepancies in the interpretation of the guidelines and the translation of the questions for the "Unmet need" SILC variables that hamper cross-country comparability of the 2005 SILC results. Eurostat is currently working with MS to better harmonise the national questionnaires.

Members[64] finds significant income-biased inequalities in the use of doctors: the rich or more educated are significantly more likely to see a specialist or a dentist, and on a more regular basis, than the poor or less educated.

From an equity perspective, it is also important to see how out-of-pocket payments for health care services are related to household ability to pay. Are they progressive in that they account for an increasing proportion of ability to pay as the latter rises or are they regressive in the sense that payments comprise a decreasing share of ability to pay? The SHARE study calculates for each country out-of-pocket payments for health care as a percentage of income by quintile groups of income. Across all countries, there is a clear trend for this share to decrease with total income, thus revealing a regressive relationship[65].

5.4. Importance of health inequalities

The 1946 WHO constitution stated that "the highest standard of health should be within reach of all without distinction of race, religion, political belief and economic and social condition". The 2006 National Reports and the 2006 in-depth discussion have put forward arguments as to why it is important to look at health inequalities:

- Inequalities are not unavoidable and, as such, are not ethically acceptable.
- For the most vulnerable groups poor health is an additional factor contributing to social exclusion and an economic gap.
- Socio-economic differences in health translate to avoidable and premature mortality and a high prevalence of disability, representing a loss of human and economic potential.

Care services can play a crucial role in preventing and combating disease, particularly in terms of reducing the so-called avoidable or amenable causes of disease and mortality i.e. those that are responsive to medical intervention in the form of treatment and prevention.[66] Here, improved access to timely and effective health care can have a significant impact in reducing mortality and improving the health status of the general population and the more vulnerable groups in particular, for which treatable and preventable mortality is typically higher. Health care has been shown to be of significant importance in reducing preventable and treatable mortality: studies (e.g. Mackenbach, 1988, 1996; Velkova et al. 1997; Newey et al. 2003) suggest that health care accounted for 18% of the decline in mortality in the Netherlands between 1875 and 1970 and is responsible for 24% and 39%, respectively, of the differences in male and female life expectancy between Eastern and Western Europe.

Inequalities have a considerable impact on labour policy. If overall levels of mortality, disease and disability of all social groups could be brought closer to those enjoyed by the most privileged groups, this would result in a huge reduction in the number of people lost to the labour market due to disability or mortality and an overall increase in human capital. Current evidence suggests that health care systems are failing to improve the health status of those with accumulated ill-health.

64 For more information see http://www.oecd.org/dataoecd/14/0/31743034.pdf

65 Ibid.

66 Examples of treatable mortality include infant mortality, cerebrovascular disease, and testicular cancer, while examples of and preventable mortality include lung cancer, motor vehicle and traffic accidents, and cirrhosis of the liver.

5.5. Policies to reduce heath inequalities

5.5.1. Current action by Member States

In the National Reports and during the November 2006 in-depth review, Member States emphasised that, given the existing evidence, it was now time to go a step further and implement effective policy to reduce health inequalities. The majority of countries have already taken initiatives along these lines. For example, some countries explicitly underline the reduction of health inequalities as a goal (FI, IE, PT, UK, SI, HU, LV, and EL). Others propose a variety of accompanying measures, including promotion of initiatives relating to risk factors, disease prevention, delivering services in a variety of settings, and developing information systems to monitor data. Initiatives aimed at combating risk factors target, amongst other problems, tobacco use, obesity and alcohol consumption while disease prevention measures are aimed at a variety of ailments including cancer, cardiovascular disease, respiratory ailments, HIV/AIDS and mental disorders. There are attempts under way to extend the provision of services to day care, schools and community centres, preventive measures include screening and vaccination programmes. Importantly, many Member States (UK, ES, IE, FI, CY, LT, PL, DK) have identified (in the reports, in the 2006 in-depth review and in the 2007 Peer review on access to care and health status inequalities) the need to develop information systems and monitor data on health status.

5.5.2. Areas identified for improvement

The National Reports and the 2006 in-depth review (as well as academic studies) recognise that ensuring equitable access to care – notably preventive and primary care provision and more specifically effective prevention and treatment of cardiovascular diseases and cancer – for lower socio-economic groups can contribute to reducing the gap. Ensuring greater cooperation between local authorities and regions and defining nationwide minimum provision requirements and national harmonised access criteria can also tackle regional differences in access and health status inequalities. It is however noted that improved access should be coupled with public health policies to address risk factors, including hazardous physical, chemical and biological factors and accompanied by policies that are disease specific.

Better coordination of the promotion policies pursued in conjunction with a range of stakeholders within and outside the health services (including other government departments, industry and the community - notably through NGOs and patients' organisations) and the refocusing of promotion policies on reducing health inequalities are also necessary to tackle health inequalities and improve the health of the general population. Health and social policies coupled with initiatives in other sectors must aim to prolong healthy and active lives for all, safeguard quality of life and reduce health inequalities and premature mortality. Finally, a combination of general policies and policies targeting at lower socio-economic groups (e.g. changes in the delivery of health care to more vulnerable groups) is necessary to tackle health inequalities.

The 2007 Peer review on access to care and health status inequalities also identified several areas as requiring more in-depth attention on the part of policy makers:

- Population coverage should be increased by extending social health insurance coverage to groups not yet covered by insurance. However, increasing population coverage in legal terms may not be sufficient to ensure access to services. Countries want to ensure that

people reach the services available or that services reach the people who most need them. For example, France has highlighted some of the problems faced by the Couverture Maladie Universelle Complementaire such as refusal by doctors to participate and fear of stigmatisation among potential beneficiaries. This is a "managerial or organisational" challenge that all Member States face: to ensure that existing and often cost-effective and free services are indeed used by those in need - which has to be a common EU goal. Policies aimed at increasing coverage include: identifying and addressing administrative hurdles that can negatively affect coverage (e.g. changes in marital and employment status, lack of a fixed residence) and better defining the basic care package that is available to all.

- Tackling existing geographic disparities in the supply of care (notably basic primary and hospital care) between regions, between rural and urban areas and within urban areas. Evidence suggests the existence of an “inverse care law”: a perverse relationship between the need for health care and its actual take-up (which in essence says that those who most need medical care are least likely to receive it, while those with least need of health care tend to use health services more and more effectively). Defining catchment areas, defining the minimum level of provision everywhere in the country, reducing the distance to health facilities (health centres and hospitals), introducing equalisation funds, organising outreach services to serve more remote populations, using e-health solutions and using cross-border care are some of the possible policies available to Member States.

- Reorganising services so that promotion and prevention activities (in particular for primary care provision) are enhanced vis-à-vis curative care. Investment in prevention is currently low compared to that spent on treatment and this needs to change. A number of health promotion and disease prevention activities, which can be cost-effective in postponing or reducing the burden of disease, are receiving less attention than curative care and, importantly, are not being accessed or used by the more vulnerable groups who could benefit the most. Public health priorities should take into account the main causes of mortality by focusing on effective (general and targeted) promotion and prevention activities for example to deal with tobacco use. Early diagnosis and detection of disease could also be improved. Safety at the workplace may also contribute to reducing accidents and other preventable forms of mortality and morbidity.

- Reducing waiting times for outpatient and inpatient care by introducing management changes in hospital organisation.

- Understanding the needs of specific groups and adapting the provision of services to them: e.g. an elderly population may require very different services than a young urban population. Addressing cultural, language and attitude barriers to the use of services can also improve access for certain groups. This can be done through improved education, increasing awareness and information on access to services.

- Addressing financial barriers to care. A number of Member States consider that co-payments, while raising some revenue, have not been able to restrict unnecessary care consumption, while they may hinder access for vulnerable groups. Other Member States view co-payments as a helpful instrument in reducing unnecessary care consumption. In any case, co-payment systems have to be carefully designed to avoid social bias and give the right incentives to reduce unnecessary care consumption. Important for comprehensive health care in this context is the exemption of preventive measures and measures for the early detection of chronic diseases. The exemption mechanisms necessary to maintain

equity of access render the system more complex. Moreover, co-payment systems entail considerable administrative running costs, which need to be offset against the savings generated from deterring unnecessary care use. Critics say that they reduce health care access for people who most need it, and that the cost of administering such systems will in any case seriously reduce the revenue they generate.

- Improving access by reducing waste and thus releasing resources to improve equity of access. Measures suggested to increase efficiency include: addressing the medical imbalance between primary care and specialist and hospital care improving the supply of long-term care services to reduce use unnecessary of acute care services, improving care coordination, improving collaboration between providers to avoid duplication of services, increasing transparency, increasing competition between providers and increasing competition between insurers by developing a multi-insurer environment. Some participants argued for caution when using competition as a means to improve efficiency. Where markets are not complete, competition does not necessarily lead to increased efficiency. Hence, while not to be disregarded, market forces have to be carefully evaluated, in relation to the conditions of the market where they are to be used, before a decision is taken. Sometimes coordination between providers can prove more effective in reducing waste and increasing resource efficiency. The search for efficiency should therefore not be restricted to the use of market forces but should encompass a whole range of policies. Regarding a multi-insurer setting, it is strongly argued that to ensure equity of access governments need to regulate the sector. This includes clearly defining the basic package of care available to all, applying appropriate risk equalisation and risk adjustment schemes and checking for unfair or unlawful competition practices. The need for strong regulation requires a strong administrative capacity which in turn implies significant administrative costs.

5.6. Conclusions

Health inequalities can be clearly observed within Member States across socio-economic groups. They are associated with living and working conditions, differences in health related behaviour, and differences in access to health services. This shows that addressing health inequalities requires action to increase social protection and tackle social exclusion. Though virtually all Member States have implemented universal or almost universal rights to care and have put in place measures to adapt services to reach those who have difficulties accessing conventional services because of physical or mental disability or because of linguistic or cultural differences, few Member States have begun to systematically address health inequalities through actions that address the full spectrum of the problem from reducing social differences, through preventing the health differences that these differences cause, to actions to address the poor health that results and ensuring, in practice, equal access for equal need, or in other words that care reaches those who need it the most. Indeed, it is important to treat the very causes of ill-health conditions as well as treating the conditions themselves. Thus, it is important to address the issue of health inequalities in a "health in all policies" approach: we need to tackle not only inequalities in access to care services but also, for example, inequalities in access to education, employment, housing, and income as well as differences in health behaviour and working practices.

Evidence suggests that appropriate policies can range from better data collection and reporting to general and specific action involving key sectors such as social inclusion, employment, education, economic development and the environment as well as health services themselves. Measurement and monitoring, however, require information systems to

allow the measurement of population health according to social variables. Efforts are now being made with the support of the Indicators Sub-Group of the Social Protection Committee to produce mortality and life expectancy information by socio-economic status. A task Force has been established to prepare a methodology for the regular provision of mortality data by socio-economic determinants. It is expected that by the 2010 census significant progress can be made in this regard. Under the European Statistical System (ESS), EU-level surveys such as EU- SILC[67] and EU-EHIS[68] have been agreed and are now up and running; they will help to obtain, on a more regular basis, available information on health status (including disability and specific diseases), health-related behaviour and care use by socio-economic groups.

It is important to understand how the home, school and work environments can be improved to enhance health and reduce risks. This means addressing not only physical factors but also people factors, which are so important in influencing behaviour. Disadvantaged groups are subject to the worst physical environments with the highest levels of pollution. Poorer areas frequently experience less protection from the location of activities that have unpleasant or harmful outputs. Positive policies aimed at altering these historical practices therefore have an important role to play in redressing such imbalances. Comprehensive promotion and prevention strategies (tobacco, alcohol, nutrition and physical activity, screening) were advocated as important in reducing health inequalities, with Member States putting forward a variety of programmes. In relation to tobacco, for example, most Member States have not yet implemented the full package of effective tobacco control policies which can impact on health inequalities, including smoke free public spaces, the prohibition of advertising and promotion, and significant and sustained price increases. Such strategies need to take account of the fact that different social groups react differently to particular interventions. For example education and information programmes have a much bigger impact on well educated social groups. By contrast, poorer groups are more sensitive to strategies based on price and availability. Nutrition and healthy eating programmes need to address the availability and cost of food if they are going to be successful in less affluent groups.

As health inequalities remain in old age, pension policy may play an important role in tackling health inequalities. Member States are focusing on ensuring higher employment rates among older people and adequate retirement incomes which can be important in reducing social and income inequalities and in ensuring access to services for the elderly.

Moreover, although important efforts have been made in fighting and reducing poverty and exclusion, the risk of poverty is still high in general. There are still considerable challenges: slow economic growth, high unemployment, disadvantages in education and training for some population groups, and high child poverty, leading to differences in opportunities and early differences in health. Multiple disadvantages can be found in certain urban and rural communities as well as among ethnic minorities and immigrants, whose numbers have been swollen by increasing immigration. Other challenges comprise rising health and insurance costs and the lack of affordable care for children and for disabled and elderly dependants in the light of both demographic change and increasing female labour force participation. Member States want to increase the integration of disadvantaged groups and improve access

67 Statistics on Income and Living Conditions (SILC), conducted in accordance with a set of EU Regulations, based on the Framework Regulation CE 1177/2003 of European Parliament and Council adopted on 16 June 2003 and published in the OJ on 3 July 2003.

68 European Health Interview Survey (EHIS): questionnaire adopted in November 2006 by the Eurostat Working Group on Public Health statistics ; the first round of the EHIS will be implemented in the period 2007-2009

to employment, training, education, housing, health care and social security by mainstreaming provision and, where necessary, implementing targeted measures.

Health inequalities and their accompanying social inequities are being addressed through the OMC on social inclusion and social protection. The OMC and other EU level exchanges such as the EU Expert Group on Social Determinants and Health Inequalities as well as the High Level Group on Health Services and Medical care can play a role in exchanging best practices to help countries reduce the health gradient that currently exists.

6. ADDRESSING LONG-TERM CARE

6.1. Introduction

One of the principal aims of social protection systems in the Member States is to ensure access to high quality care for all. The widespread extension of coverage against sickness and invalidity, along with other factors such as the rise in the per capita standard of living, improved living conditions and enhanced health education, are the main reasons for the improved health status of the European population as a whole. The development of social protection systems has considerably reduced the risk of poverty, often associated with ill health, old age or accident, and has made a significant contribution to improving the health of the people of Europe over recent decades. The development of social protection systems has made it possible to shield people from the financial consequences of ill-health and, at the same time, sustain the rapid, ongoing advancement in medicine and treatment.

The improvement in the health status of the European population is exemplified by the increases in life and healthy life expectancies. High levels of protection against the risk of illness and dependence are vital assets that must be preserved and adapted to the concerns of the modern world, particularly demographic ageing. It is in light of these developments and the concerns over expanding expenditure that Member States have embarked upon the modernisation of their social protection systems. Social protection is intended to cover, at the level of an entire society, costs that often exceed the means of an individual or his/her family, ensuring that paying for healthcare does not lead to impoverishment and that even those on a low income have reasonable access to care. This has been achieved using a wide range of systems – based on insurance or the direct provision of services – the prime responsibility for which, under the Treaty, falls to the Member States.

Expenditure on Health and Long-term care accounts for a substantial share of overall social protection expenditure, the second largest after retirement and survivors' pensions. Demographic ageing in itself does not necessarily translate into increased demand for Long-term care services. It is the incidence of invalidity and dependency associated with increases in life expectancy that drive increases in demand for Long-term care.

The Lisbon European Council of March 2000 stressed that social protection systems needed to be reformed in order to be able to continue providing good quality health services in the face of the demographic challenges and prospective increases in Health and Long-term care expenditure. The 2005 Luxembourg Presidency Conference "Long-term care for older persons", emphasised that, despite the multiple ways of addressing this social risk, it is inherently a public responsibility and therefore a role for the Member States. The Joint European Commission and AARP Conference "The Cross Atlantic Exchange to Advance

Long-Term Care" in September 2006, emphasised that, given the extended longevity in the EU and the United States, an increasing demand for long-term care can be expected.

The increased demand for long-term care represents a policy challenge for many countries as current supply is considered to be insufficient and inadequate to meet current and especially future needs and thus to ensure adequate living conditions for long-term care recipients. However, recognition that there is no comprehensive system for the provision of long-term services in the US and in large parts of the EU is now, coupled with a firm commitment on the part of EU countries to ensure universal access to high quality and affordable long-term care.

The role of health care systems in combating the risk of disease and contributing to social cohesion and employment has been acknowledged by the European Union for some time. The Open Method of Coordination (OMC) was extended to the areas of health care and long-term care in 2004 establishing a common framework to support Member States in the modernisation of their social protection systems. The November 2005 Memorandum of the Social Protection Committee highlighted the main issues, raised by the Member States, and contributed to the definition of the new streamlined common objectives. Member States submitted national reports on health care and long-term care in September 2006. This chapter reviews the 2006 national reports in relation to long-term care. It analyses the main challenges Member States face and their strategies to tackle these challenges in the fields of long-term care in the light of the agreed common objectives. With regard to the data used here, the Indicators Sub-Group of the Social Protection Committee is currently working on the development of common indicators for the Healthcare and Long-term Care strand of the OMC, so the tables and graphs presented in this chapter are for illustrative purposes only.

6.2. Background and stylised facts

6.2.1. Definition of Long-term Care and current developments

The OECD has defined long-term care as "a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living[69] (ADLs) over an extended period of time."[70] Elements of long-term care include rehabilitation, basic medical services, home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with Instrumental activities of daily living (IADLs).[71] Long-term care is usually provided to persons with physical or mental disabilities, the frail elderly and particular groups that need support in conducting their daily life activities. "Long-term care needs are most prevalent in the oldest age groups […] who are most at risk of long-standing chronic conditions causing physical or mental disability."[72]

However, individual Member States use a variety of definitions that do not always concur. There are variations in the determination of the length of stay, the identification of the care recipient and the available taxonomies defining the long-term care services provided.

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

70 OECD 2005 Long-Term Care for Older People

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

72 OECD 2005 Long-Term Care for Older People

Additionally, the demarcation between healthcare (medical component) and social care (non-medical component) is often blurred. The same can be said with regard to rehabilitative services and the length of time spent in hospital (acute care) or in an institution before discharge with some countries clearly favouring lengthier rehabilitation rather than hospital or institutional stays. Additionally, differences in the evaluation of 'dependency' and its scope, whether support should be provided in kind or in the form of financial benefits, who receives that support, and the general demarcation between the role of the public sector, the private sector, and the family are prevalent. Long-term care is often defined as a variety of health and social services provided for an ongoing or extended period to individuals who need assistance on a continuing basis due to physical or mental disability[73].

These differences have resulted in a great variation in long-term care services, their organisation and their role within social protection systems. In certain countries, long-term care is often associated with the notion of a 'care continuum' or an integrated approach including elements of other public health policies such as preventive measures, active ageing, autonomy promotion and empowerment, social assistance, healthcare and end-of-life or palliative care. Long-term care is often intertwined with other public policy fields such as the combating of social exclusion, the provision of social security for formal and informal carers, employment and education/training policies. The definition of long-term care, the services and benefits provided and the population coverage thus vary between Member States.

6.2.2. Demographic ageing and the incidence of dependency

The demographic developments in Europe are well documented. Population ageing results in an increasing share of old and very old people in the population, leading to new patterns of morbidity and mortality, such as an increase in (often multiple and reinforcing) degenerative and chronic diseases. The self-reported need for long-term care tends to increase significantly with age, showing a greater incidence of dependency and disability as people get older. Demographic ageing, coupled with deteriorating replacement rates and a prevalence of chronic disease in the older age groups, clearly affects the future demand for long-term care.

The most important element in addressing future needs for long-term care services (both formal and informal) is the degree of additional life-years spent in good health or the health status of the elderly population. Indeed, since demographic developments point to increasing longevity of the population, a serious challenge, or opportunity, in terms of public health is the prevention of ill-health in old age, i.e. delaying the onset of disability or dependence. Demographic developments increase the pressure on long-term care systems to provide more and better curative medical care but also more rehabilitative, nursing and social care.

6.2.3. Projected expenditure on long-term care

The 2006 EPC/EC projections predict an increase in public long-term care expenditure of 0.6 percentage points of GDP (with FI, SE and SI increases of 1.8, 1.7 and 1.2 p.p.) due to population ageing[74]. It must be noted, however, that this increase may be higher as the projections are based on current institutional and policy settings, while many Member States are only starting to develop a comprehensive framework for long-term care provision.

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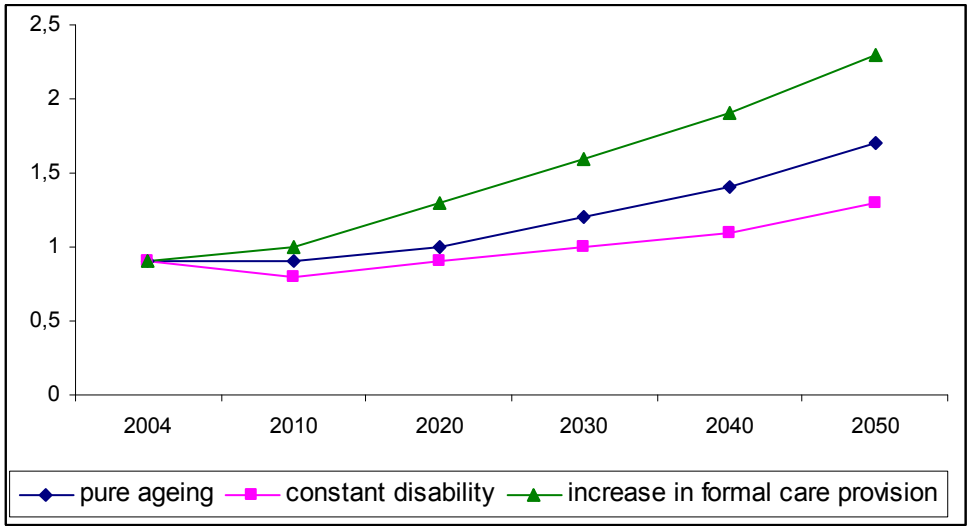
73 OECD Observer 2007, Long-term care: a complex challenge

74 Economic 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.

Figure 20: Three scenarios for public spending on long-term care, EU25 (percentage of GDP)



In some Member States, the projected increase in demand for long-term care, coupled with the increased labour participation of women involves an increase in the demand for formal long-term care services, since women will be less available for informal care provision. Figure 19 sets out the two scenarios projected by the AWG for public spending on long-term care in 2050: i) pure ageing (no change in age-specific disability/dependency rates which, given expected increase in life expectancy, means a relative increase in the share of lifespan spent with disability/dependency); and ii) constant disability (contraction of age-specific disability/dependency incidence such that the share of lifespan spent with disability/dependency remains constant). Moreover, a sensitivity test which has been applied to the two pure ageing scenarios shows that a 1% yearly shift of informal care recipients to the formal care sector may result in an additional expenditure of 0.6% of GDP at the end of the projection period**.** It can thus be assumed that even in the case of a contraction of the age-specific disability/dependency incidence, the trend would be towards an increase in public spending on long-term care. While these assumptions are necessary for the projection exercise, they do not reflect the reality of formal care provision nor do they take into account possible policy changes that could occur in the organisation and financing of formal long-term care provision.

6.2.4. Responsibility for provision and trends

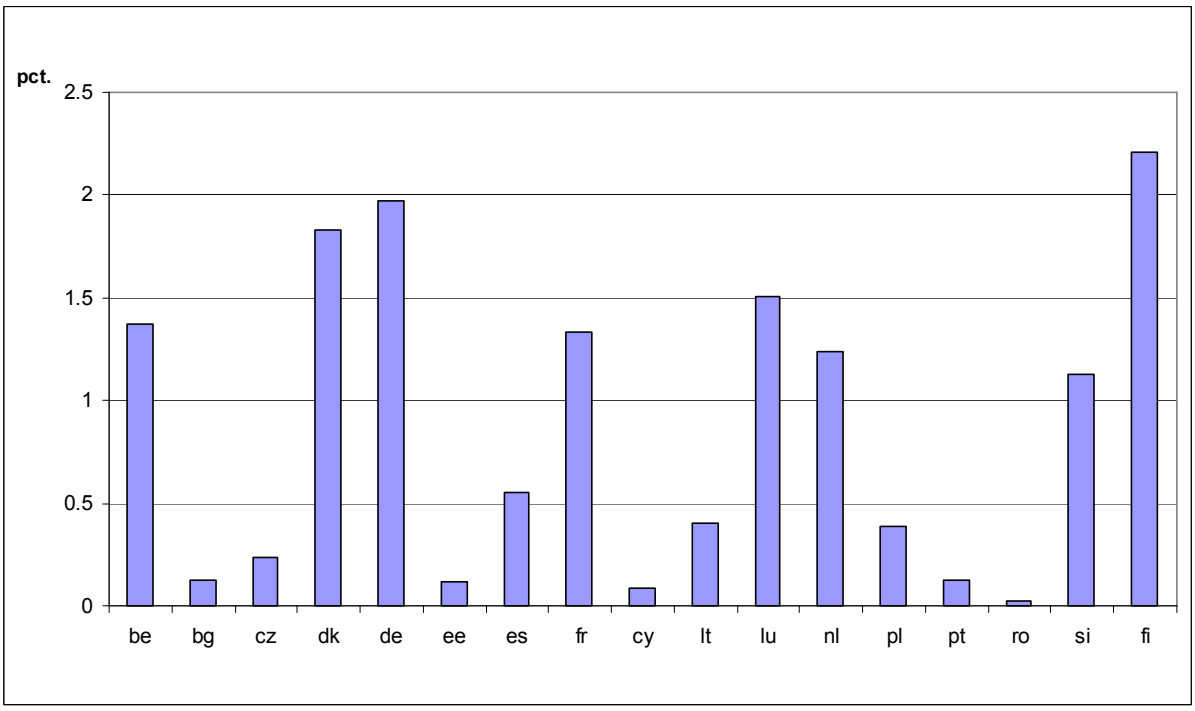
While long-term care provision varies across Member States in terms of coverage, countries are firmly focused on enhancing tailored home and community care services and moving away from institutional care. This does not mean that institutional care provision is to be dismantled. Rather, institutional care must be maintained for those with severe disabilities or conditions, for whom home care is not the most appropriate alternative. According to the OECD, a majority of countries are primarily concerned by the need to develop and expand home or community care, with the development of an appropriate quality level for long-term care receiving the same degree of attention throughout the countries studied[75]. Where

75 S. Jacobzone (1999),Ageing and Care for Frail Elderly Persons: an overview of international perspectives, OECD Labour Market and Social Policy Occasional Paper No. 38

available, home or community care is preferred to institutional care. Moreover, even where provided, care in institutions should be provided within a community setting ensuring the social inclusion and participation of their residents in accordance with the prevailing societal values and norms[76]. The goal is to help individuals remain at home for as long as possible, while providing institutional care when needed. This also supports individual choice and preferences: in general people want to live for as long as possible in their own homes, close to their family and friends. This is also considered to be a cheaper or budget-neutral alternative to institutional care[77].

Some countries favour longer lengths of stay in institutions than others. Some countries focus on the provision of a medical care continuum whereas others discharge patients from institutional care faster, whilst emphasising rehabilitative or preventive follow–up care. Finally, some countries lack a specialised infrastructure, so acute care beds are often used as long-term care beds, which is a highly inefficient way of using available resources and artificially reduces the reported level of long-term care provided to the elderly population. What is important to note is that the structure and organisation of the different Long-term care schemes vary between European countries, reflecting more the organisational features of each system rather than population structure and demographic developments. The variations reflect the differing national approaches to familial solidarity (incidence of informal care and support for carers) as well as identifiable disparities between the demand for and the provision of publicly funded long-term care services.

Figure 21: Expenditure on long-term care as pct. of GDP, 2004.



Source: Eurostat Health expenditure data

Figure 21 shows the degree of variation in long-term care expenditure. Although home care or community services are less expensive than acute care in an institutional setting, the resources

76 Ethical choices in long-term care: what does justice require? World Health Organization collection on long-term care, WHO 2002

77 The OECD Health Project, Long-term Care for Older People, OECD 2005

allocated to the home care sector vary between countries. In the majority of countries, publicly funded institutional care still accounts for more than half of long-term care expenditure. Despite the fact that most countries wish to expand community and home care, either for financial reasons or in order to provide patient-centred services, the share of home care as a component of public spending on long-term care varies. In the countries with the least developed long-term care systems, the share of public spending on home care as a proportion of total long-term care expenditure is minimal. Other countries have made significant steps towards increasing the public spending dedicated to home and/or community care. The schemes included in the definition of long-term care and the legal status of the providers of such care will affect the degree of comparability between the various schemes and their levels of expenditure.

6.3. National policy developments

6.3.1. Access to adequate long-term car

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

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

However, universal rights do not necessarily translate into universal access and there remain significant sources of inequalities in access that demand further attention. The supply of Long-term care is considered to be inadequate to meet current and especially future needs given demographic developments. Despite the formal provision of universal access, barriers to access still persist, unevenly distributed across the population. These include lack of insurance coverage, lack of coverage/provision of certain types of care, high individual financial costs of care and geographical disparities in supply. They also include lengthy waiting times for certain treatments, lack of knowledge or information and complex administrative procedures.

Increase in population coverage

Differences in access to a range of long-term care services can be observed for various population groups, some of which are not yet fully covered by social insurance schemes. Indeed, long-term care offers especially limited coverage. In this context, Member States want to expand long-term care services. This includes increasing population and care coverage under health insurance schemes and enhancing the availability of specialised services, home or community (close to home) care (medical, nursing and social care) and residential care

when the alternative is no longer medically appropriate or adequate (e.g. BE, CZ, EL, HU, ES, LT).

Content of the health benefit package

Long-term care does not refer to the same range of services in all countries. Some countries focus on the medical component, separating medical from social care. The provision of integrated services for dependent and elderly persons, albeit accepted as an overall goal to be pursued by the various responsible authorities for long-term care, is not available everywhere. This, in turn, limits and undermines the provision of a continuum of care with adequate follow-up of the care given to dependent and elderly persons. Many Member States wish to promote rehabilitative care (PT, CZ, EL, FI, FR, DE) with a view to restoring patients' skills that they as to regain maximum self-sufficiency in order to function in a normal or as near a normal manner as possible. Rehabilitative care can be provided in an institutional or community setting. More importantly, rehabilitative services should be provided in order to allow, where possible, the patient's reintegration within the labour market. In social health insurance based systems, however, some components of long-term care can be excluded from reimbursement or may not be included as part of the long-term care benefits available. This often has implications either for cost-sharing (not reimbursable services) or for direct payments (out-of-pocket payments). Indeed, cost-sharing, direct payments and informal payments are the main administrative and organisational hurdles faced by vulnerable groups when seeking access to long-term care services.

Ability to pay and cost sharing for Long-term care

High private costs, which are seemingly higher than in health care (out-of-pocket payments and voluntary private insurance), impose a major financial burden on users and their relatives and act as a barrier to access, particularly for low-income groups. Indeed, it is often the case that elements of medical and social care provided to dependent or elderly persons, are not covered by the basic insurance packages, leading to a high incidence of co-payments and out-of-pocket payments. This is associated with recourse to private provision resulting from either the inadequacy of public provision/insurance and/or the country's organisational structure and financing. Several countries have introduced co-payments, insurance premiums or means-tested systems for long-term care provision (e.g. CY, EE, IE). Policies to reduce the individual direct costs of care include: co-payment exemptions and co-payments based on income; extra financial aid/welfare benefits granted to the elderly dependent, disabled and chronically ill; state coverage of social long-term care for low-income households within a Social Assistance framework (e.g. FR, NL, BE, HU, DE); nationwide standardisation of co-payments; and state subsidies to use private services.

Out-of pocket payments are, to varying degrees, borne by the majority of people both in health and long-term care services, with varying consequences in terms of accessibility of the services and equity issues. The incidence of Out-of-pocket payments and the degree to which they are regressive depends in turn on the organisational features of each long-term care system and the availability of supplementary insurance coverage.

Waiting times and regional diversity

The shortage of publicly funded long-term care services has resulted in substantial waiting times for existing care, particularly residential care. Uneven geographical provision (across regions, urban versus rural, within cities) can also be observed as social services are typically

the responsibility of local authorities or regions. To tackle this, Spain, for example, is planning the implementation of a uniform basket of long-term care services across the autonomous regions making long-term care accessibility a priority for social inclusion policy. Additional factors influencing waiting times and lists include the availability of medical and nursing staff as well as their level of pay and working conditions and the infrastructure capacity of the country.

Tailored community and home care services and integrated long-term care provision

Countries are firmly focused on enhancing tailored home and community care services and moving away from institutional care (which has to be maintained for those with severe disabilities or conditions, for whom home care is no longer the most appropriate alternative). Information and communication technology (e-health solutions such as tele-monitoring, tele-medicine and independent living systems) can help to ensure independent living and more user-oriented services. For example, such technology can enable better self-management of chronic conditions and can support informal carers in their role. The goal is to help individuals to remain at home for as long as possible, while providing institutional care where needed. This also supports individuals' choice and preferences. The provision of home care services in conjunction with enhanced information and communication technology depends on resource availability and the degree to which long-term care is provided in an integrated framework.

As highlighted in the National Reports, provision is to be expanded through coordination between the national, regional and local levels of government and in partnership with the private and notably the voluntary sector. In Finland, the authorities are also planning joint municipal-level provision. The fragmented provision of long-term care services (between different levels of care and between different administrative levels) can reduce the accessibility of long-term care services. For example, hospital discharge ought to be followed by tailored home care provision or care within a community setting. In Germany, patients are entitled to "transfer care" from hospital to the subsequent care setting (at home or institutional) which is organised by case managers. When such follow-up provision is neither available nor planned, the accessibility of long-term care services is threatened. Indeed different patients have disparate and often multiple needs for long-term care services. The assessment of those needs and the provision of the various services must be carried out in a way that respects the choice and dignity of the person in need of care. The uniform and tailored provision of long-term care services depends in turn on the organisational features of each system and the degree of coordination between the different services operating within these systems.

6.3.2. High level of quality in long-term care services

The quality of long-term care services for dependent persons, varies widely both between and within countries. Patient satisfaction surveys and reports of poor quality have raised concerns and prompted public, private and national initiatives to improve the quality of care services and enhance quality reporting and assessment mechanisms. Examples of poor or inadequate care quality in both institutional and community settings include: inadequate housing (nursing homes), lack of privacy, poor social relationships and use of restraints, amongst others. Many Member States have introduced or improved regulation and legislation for assessing and enhancing the quality of long-term care services.

The increasingly pervasive and all-encompassing nature of long-term care services renders quality definition and measurement a difficult and complex task. Indicators of the quality of care are used to assess and evaluate the quality of the services provided in both institutional and community settings. Such indicators have been developed over time and used extensively for nursing homes and home care settings. Inevitably, they refer to formal long-term care services rather than informal provision, which is much more difficult to measure and evaluate. The OECD classifies indicators along the dimensions of *structure, process* and *outcome*. This classification is used to encompass the wide range of possible quality indicators and to identify trends over time in quality assessment and control procedures. An upward trend in quality indicator development has been observed[78]. In addition, outcome related measures are being developed to provide a more comprehensive assessment of the level of quality of long-term care services. This does not mean that structure and process quality indicators are unimportant, but rather that some assessment of the actual health impact on the dependent population is also necessary and complementary.

Increasingly, quality regulations for long-term care are evolving from basic or minimum requirements for the structure and process of care into more comprehensive and complex quality assurance mechanisms combining procedural, structural and outcome oriented indicators such as continuous staff training requirements coupled with patient rights mechanisms allowing greater patient participation and consultation. Quality in long-term care services can be addressed through formal regulatory and licensing mechanisms. The increased emphasis on the provision of long-term care services in a community or home setting has brought about the challenge of implementing quality assurance within a different framework for which structural and process indicators are often inadequate. Considering that the bulk of care in a home setting is provided by informal carers, structural indicators of staff ratios and adequate training do not reflect this situation.

Despite the upward trend in quality of care indicator development, the use of outcome indicators for quality monitoring still remains in its infancy in the majority of Member States. Moreover, quality and its evaluation, is increasingly viewed as encompassing other important factors such as the support given to family caregivers, increasing consumer choice through the promotion of consumer-directed care, ensuring the capacity of the long-term care workforce and assistive technologies[79]. Measuring the quality of long-term care services along these various dimensions is a complex task. Whereas there are accreditation and evaluation mechanisms for formal institutional and community-provided care, the monitoring of quality in an informal setting is much more difficult and is often based on measures of satisfaction and unmet needs rather than quality measures stricto sensu. One basic requirement for quality assurance, of particular relevance to long-term care, is also the active deterrence of patient maltreatment or abuse.

6.4. Long-term sustainability

6.4.1. Financial sustainability

The majority of European countries are concerned with the future financial sustainability of their long-term care systems and their ability to cope with demographic developments. Ageing is expected to bring about increases in public spending on healthcare and long-term

78 The OECD Health Project, Long-term Care for Older People, OECD 2005, p.67

79 The Cross-Atlantic Exchange to Advance Long-term Care, Special CEPS Report, S. Tsolova, J. Mortensen, 2006

care in particular. However, "considerable budgetary savings on health-care expenditure may be realised if the projected increase in life expectancy over the long-term is accompanied by an increase in healthy life years and an improvement in the health status.[80]" A preventive approach and the integrated provision of health and long-term care services, which may be enhanced by the use of information and communication technologies, could bring about savings in terms of ageing-related costs and an improvement in the health status of the elderly population.

Long-term care funding and expenditure varies across the EU. Differing funding arrangements have developed over time reflecting, in most cases the various social philosophies in addressing the risk of dependency (risk pooling). Four elements are important when analysing how long-term care expenditure is organised in the different member states: the schemes and population coverage of the provision of long-term care; the welfare funding arrangements of a given country; the degree of incidence or involvement of private sources of finance; and the prevalent demarcation of responsibility between the public and private spheres.

There is increasing recognition of the need to create a solid financing basis for long-term care and ensure the availability of much needed resources. Several Member States are moving in this direction, either by establishing dedicated universal social insurance schemes and contributions (e.g. DE, LU, NL, SI) or through taxation (AT, SE) in order to put long-term care on a sound financial footing.

Both the EU and the USA recognise the need to find an adequate mix between public and private sources of finance. Independent of a country's public financial arrangements, private direct payments will also play a role, although EU Member States are committed to designing funding schemes that do not hinder universal and comprehensive access to quality long-term care. The 2005 Luxembourg Presidency Conference concluded that a social insurance or tax-based system appeared to be more efficient than private financing solutions[81]. In terms of provision, the national reports and both conferences on this issue point to a potential mix of public and private (notably social sector) provision. Private sources of finance refer to two separate elements. Firstly, private health insurance covering long-term care may be available but is often offered on a supplementary basis or for high income groups. Secondly, and most importantly, private household payments are often requested either in the form of co-payments for publicly provided care, and/or out-of-pocket payments for which very little or no reimbursement is offered.

A multitude of driving factors can explain the variation in the level of expenditure on long-term care. Some countries have more comprehensive and developed long-term care systems than others. Some countries provide the bulk of long-term care in a residential or home setting, which is often cheaper than acute care settings. Additionally, some countries rely more or less on informal care provision with varying levels of subsidies for informal carers.

80 Communication from the Commission – The long-term sustainability of public finances in the EU – COM(2006) 574, 12.10.2006

81 "A market system may not in practice provide enough long-term care services which are available in a timely way and of adequate quality." Long-term Care for Older People – Conference organised by the Luxembourg Presidency with the Social Protection Committee of the European Union – Luxembourg, 12 and 13 May 2005, PP.92

6.4.2. Systemic sustainability

Care coordination

Care coordination is seen as crucial in enabling a high level of quality and efficient use of resources in the provision of long-term care services in an institutional or community setting, thus ensuring an adequate continuum of care irrespective of the different levels of long-term care provision (local, regional, national) and organisation. Coordination problems in the interface between medical care, social services and informal care can result in negative outcomes for users and inefficient use of resources. Coordination problems affect both the financing of the system (coordination or lack of it between the different budgets involved), and the organisation of service delivery (coordination or lack of between the different levels of organisation and between the various bodies involved - health versus social services).

Multiple and often mutually reinforcing chronic ailments need some degree of care integration, as they require the provision of different types of care and access to specialised treatments. Care professionals must ensure that patients follow a coherent path of care with the appropriate treatment provided in the appropriate setting irrespective of the organisational features of the long-term care systems. Better coordination between health and social services can also avoid duplication of action and service provision. Transferring long-term care patients from acute care settings to ensure that care is provided in more appropriate settings can reduce the financial burden associated with expensive acute care while enhancing the quality of the care provided.

Care coordination is crucial in ensuring a care continuum for individual patients. Each patient has specific needs that require a combination of medical, nursing and social services. It is often the role of the service providers to offer a coordinated, tailored and patient specific continuum of care based on an assessment of each individuals' needs. It is reasonable to argue that there is no model for providing a continuum of care since each patient will require individualised provision tailored to his needs. The care continuum approach aims to promote a uniform and coordinated provision of services. Two elements are important: the coordinated provision of a range of services (particularly for the home care setting where patients may require different services to be provided at the same time in one place) and better management of the transitions between services and settings (the patient's home, the acute hospital and the nursing home). Member States have or are introducing "measures designed to make services work together more effectively and to manage transitions between services more efficiently, both for benefit of the user and for a better use of resources."[82]

Some Member States have sought to encourage coordination and integrated long-term care provision by setting up national strategies and priorities. National guidelines and targets can ensure uniform provision across the wide spectrum of service providers and the different levels of government involved in the management and financing of long-term care services. Since long-term care is usually provided in a devolved context and run by sub-national levels of government, national standards can ensure uniform provision and financing for all the regions of the country (ES, SE, UK). Another mechanism relies on framework contracts between long-term care insurers and providers (DE). Such an approach allows greater involvement of all these stakeholders so that different services are well informed about each other and can provide similar information to patients.. In addition to national strategies, the

82 Ibid, p.35

integration of long-term care delivery and the alignment of long-term care finance with health and social care components are also aim to improve the continuum of care.

The integration of long-term care delivery involves creating single entry points or local assessment teams (NL, PT, UK) on one hand and the devolution and integration of long-term care services at regional or local level (ES, PT, SE, UK) on the other. Many countries have sought to align the financing of long-term care with its health and social care components.

6.4.3. Workforce shortages and training

In a home or community care setting, the problem of insufficient and inadequately trained formal or informal caregivers is more difficult to tackle than in institutional settings. The support of relatives (as care providers) is and will remain an indispensable part of long-term care provision. It is important to ensure that family caregivers receive adequate training and guidance. In Germany, for example, consultancy services are provided regularly through mandatory home visits by long-term care – counsellors. Supply shortages in the homecare sector cannot be viewed in isolation, but are related to the labour situation in other care settings. Indeed, it is often the case that staff employed in nursing homes will be employed in the home care sector as well.

Formal and Informal care provision

Traditionally, Long-term care needs have been met within the private sphere or the extended network of families: "maintenance obligations have traditionally been met in kind by women within the family."[83] Considering that women are increasingly participating in the formal labour market, the sustainability of informal provision of long-term care, provided by family members and friends, poses a serious challenge. From an equal opportunities perspective, one solution would be an increased share of men taking responsibility for the care of family members. Recognition that the bulk of long-term care is provided within informal settings has prompted national concerns regarding the availability and role of informal carers. Formal home or community care tends to be cheaper than acute institutional care. While informal home care is not included in cost calculations, the lack of support for informal carers does not mean that it is a budget-neutral option. Informal carers are often relied upon heavily without necessarily receiving compensation.

The expected increase in the demand for formal long-term care services can be explained by the following interdependent factors: firstly the number of working age women able to provide family or informal care will decrease at a time when the number of elderly dependent people is increasing; secondly the increased labour market participation of women means less time at their disposal to devote to providing care as well as a change in their social care role; thirdly the changing family structures such as smaller families and an increase in the prevalence of single-parent families means that family members are further apart and less able to care for dependent family members in an informal, unsupported setting. Demographic developments (ageing) and changing family structures (family breakdowns, etc) pose serious challenges for the future financial and systemic sustainability of the long-term care sector.

In both the institutional and home care settings, the main concern for policy-makers is recruiting and retaining an adequately qualified and skilled workforce[84]. In an institutional

83 Luxembourg proceedings, p.62

84 The OECD Health Project, Long-term Care for Older People, OECD 2005, p.69-70

setting (nursing homes and institutions), developments in medical and assistive technologies require almost constant upgrading of workforce skills and qualifications as well as measures to ensure their retention in the long-term care sector. In addition to the structural and process quality deficits in institutional long-term care services, the earmarking of specific funds to upgrade working conditions and training is all the more difficult in light of existing budgetary constraints. The increased prevalence of cost-sharing mechanisms and co-payments coupled with the limited financial resources dedicated to long-term care inevitably limit the possibilities for upgrading working conditions and raising pay for the staff formally employed in the sector.

6.5. Conclusions

Member States are looking at various mechanisms to address the expected increase in demand for Long-term care services in light of the demographic ageing of the population and the incidence of disability and dependence, particularly among the elderly. Despite the recognised need and desire to provide accessible, high quality long-term care services, this does not necessarily translate into a comprehensive and universal framework for long-term care provision. What is evident throughout the national reports is that the promotion of provision catering for consumers/patients/dependents in a home or residential setting is the preferred alternative to institutional care. Additionally, there is a widespread consensus on the need to address the expected workforce shortages in the long-term care sector (formal care) as well as devising new ways to support family or informal carers.

In order to meet the foreseen increase in demand for accessible, resource-efficient and high-quality long-term care provision, Member States are striving to ensure a sustainable mix of public and private sources of finance. Secure long-term care financing is still to be achieved in many countries and changes to financing mechanisms are required. Another issue of concern is the degree of care coordination existing within the various long-term care systems. Care coordination encompasses the search for financial and systemic sustainability of long-term care systems whist affecting the degree of accessibility and the quality of the care provided within each national setting. Care coordination is seen as crucial in enabling a high level of quality and efficient use of resources in the provision of long-term care services in an institutional or community setting and thus ensuring an adequate continuum of care.

In addition to the sustainability of the financing mix, determined by the organisational features of long-term care systems, Member States are committed to ensuring near universal access to long-term care. One important element is that, the individual ability to pay or the share of private sources of financing should not hinder that accessibility. It remains to be seen how this principle can be implemented in practice. In terms of quality, the trend highlighted in the report is that, where available, care in a community or residential setting is preferred to care provided in an institutional setting. Member States are committed to a high level of quality in the care provided in a residential or community setting and are striving to ensure such a level. Measures include uniform standards and quality accreditation mechanisms coupled with legally enforced evaluation methods. Where they do not currently exist, efforts are being made to implement equivalent quality assurance and accreditation mechanisms.

Equally important is the issue of the long-term care workforce. Particularly in countries facing long-term care worker and nursing staff shortages, adequately recruiting, training, and retraining long-term care workers remains a challenge. Several measures are being implemented including higher wages, the improvement of training and working conditions and the formalisation, where possible, of informal carers into social security schemes. The

amelioration of working conditions and social security formalisation schemes, which pose problems for quality assurance in long-term care provision, remain a challenge.

7. CONTRIBUTION OF THE STRUCTURAL FUNDS TO THE OMC OBJECTIVES IN 2007-2013

7.1. Introduction

This chapter assesses the integration of the social dimension in the 2007-2013 structural funds operational programmes of the Member States. Its particular focus is on how the structural funds are intended to contribute to the common social inclusion and social protection objectives.[85] In addition, this chapter seeks to assess how the operational programmes address the country-specific social inclusion and social protection challenges identified in the 2007 Joint Report.

The European Social Fund (ESF) is the main financial instrument through which the European Union translates its strategic employment and social policy aims into action. Together with the European Regional Development Fund (ERDF) it will make a significant contribution to achieving the common social inclusion and social protection objectives during the 2007-2013 programming cycle. The Funds will complement national, regional and local funding activities. However, as the scope of the common objectives extends beyond that of the structural funds, ESF and ERDF support will concentrate on a limited number of specified fields.

In pursuing the common objectives, the main focus of the ESF is on the social inclusion of disadvantaged people with a view to their sustainable integration within employment. To this end, the ESF will promote employability measures, the social economy, access to Vocational Education and Training (VET) and lifelong learning (LLL), care and other relevant measures and services improving employment opportunities. The ESF will also support gender mainstreaming and specific actions to promote gender equality as well as anti-discrimination measures in the labour market.

In the field of pensions the ESF will contribute to ensuring their financial sustainability by promoting longer working lives and active ageing through flexible measures to keep older workers in employment longer. In addition, the ESF will contribute to the healthcare and long-term care objectives by developing human resources for the health care sector and by promoting health and safety at work.

Furthermore, the overarching common objective of good governance, transparency and stakeholder involvement will be supported by ESF funding in the Convergence regions. The ESF can promote the efficiency and effectiveness of social inclusion and social protection policies as well by strengthening the institutional capacity of convergence countries to design and evaluate these policies.

85 Though outside the scope of this chapter, it should be noted that also other EU financial instruments may contribute to implementing the common social objectives. So e.g. 2007 is also the start of the new programming period of the EU rural development policy. One of its three main objectives is to improve the diversification of economic activities and the quality of life in rural areas. This will be achieved by supporting the creation of jobs outside agriculture and financing basic services lacking in rural areas. Thereby lending a contribution to social inclusion in these areas, 94 rural development programmes will spend approximately 17% of the EU rural development budget, i.e. some €15 billion, over the period 2007/2013 on such measures.

The main focus of the ERDF is to promote public and private investments to reduce regional disparities. Support for regional development, economic change and enhanced competitiveness will create new and better jobs, which in turn will facilitate the social inclusion of disadvantaged people.

In addition, the ERDF will play a significant role in achieving the common objectives by investing in social infrastructure (education, health, childcare, housing and other social infrastructure) in the Convergence regions. This investment will increase access to social services and to health and long-term care services, thus contributing to the success of the social inclusion and social protection policy.

7.2. Structural Funds resources set aside for social inclusion and social protection policies

The ESF budget for 2007-2013 is €76.2 billion, which will be spent on a total of 117 operational programmes (OPs). The social inclusion priority[86] has been allocated almost €10 billion representing some 12.4% of the total funding available. The Member States have generally programmed social inclusion activities either as a specific priority axis or as part of a priority axis in the operational programmes. Uniquely, one of the Spanish OPs will be exclusively dedicated to social inclusion and anti-discrimination.

Apart from this direct allocation for social inclusion, the ESF operational programmes include other activities to support socially disadvantaged people. Those activities include increasing access to education and training for disadvantaged, the development of services to improve employment opportunities, the integration of migrants within the labour market, promoting longer working lives, and training for the staff of care institutions. Some programmes will support strengthening the governance of social inclusion and social protection policies and capacity building and activities jointly undertaken by social partners.

The ERDF budget for 2007-2013 is €267.8 billion, which will be spent on a total of 314 operational programmes. The ERDF will also make a significant investment of €16.8 million in the development of social infrastructure (education, health, childcare, housing and other social infrastructure) in the least developed areas[87]. Moreover, the ERDF has set aside nearly €0.2 billion for OPs to improve the social inclusion of the disadvantaged, over €1 billion for OPs to improve access to employment and sustainability, over €1 billion for OPs to improve human capital, nearly €0.4 billion for OPs to support reforms in the fields of employment and inclusion and nearly EUR 1 billion for OP's to increase the adaptability of workers, firms and entrepreneurs. This investment will contribute significantly towards attaining the common objectives of social inclusion and social protection, in particular by increasing the accessibility and quality of social services and health and long-term care services. It will also contribute to regional and local development and to increasing the quality of life. The ERDF and the ESF investment should complement each other to achieve an optimal added value. This underlines the necessity for Member States to ensure that the implementation of both the ESF and the ERDF programmes are coordinated throughout the 2007-2013 period, notably in terms of planning, timing and complementary activities.

86 Social Inclusion is one of seven ESF priorities in the 2007-2013 period.

87 The main beneficiaries of social infrastructure funding by the ERDF are the Convergence regions. The funding allocated for that purpose in their ERDF programmes varies considerably. The ERDF share for social infrastructure, as a proportion of the total SF available to a MS, ranges from 0.2% in the UK (0.6% in NL, 0.9% in LV) to 15% in EE (11.5% in LT, 10.9% in HU, 10% in SK, 8% in PT, 7% in MT). Other Convergence regions allocated from 2.2% (FR) to 4% (PL).

In noting the extent of funding provided by the ESF and the ERDF to social inclusion and social protection, it is important to bear in mind also that this funding does not represent the totality of spending by Member States in these areas. Rather, the Structural Funds will complement the broader range of Member States activities and funding as outlined in the National Strategic Reports on Social Inclusion and Social Protection. This is even more so the case in those Member States where the structural support represents a very small fraction of GDP. In such cases, the focus of activities under the Funds tends to be on niche measures which address specific challenges and that demonstrate added-value.

In the following sections of this chapter, examples are cited of the approaches adopted by the Member States in the different fields. This is done by way of illustration and is not to be taken to represent the totality of activities across all of the Member States and all of the 117 ESF and 314 ERDF operational programmes.

7.3. Promoting active inclusion

The concept of "**active inclusion**" is based on three main pillars: (i) a **link to the labour market** through job opportunities or vocational training; (ii) **income support** at a level that is sufficient for people to live in dignity; and (iii) **better access to services** that may help some individuals and their families in entering mainstream society, supporting their re-integration into employment. The promotion of active inclusion is one of the most common country-specific challenges identified in the 2007 Joint Report on Social Protection and Social Inclusion.

While the ESF is not designed to provide income supports, it can contribute significantly to the other two pillars of active inclusion. It can support measures and activities to ensure a more effective provision of services and to facilitate access to vocational education and training and lifelong learning opportunities. Access to healthcare and other social services, including childcare, can also be supported to help address the marginalisation of the most vulnerable groups in society. In particular, the Fund can support the development of pathways to labour market integration as well as supporting social economy measures.

In addressing **the development of pathways to labour market integration**, most ESF and many ERDF OPs target specific disadvantaged groups. As might be expected, these groups vary depending on the scale of funding available, the particular circumstances of Member States and the key challenges they face in developing their labour markets. Sweden, for instance, will focus on helping people who have difficulty getting a job, such as young people, immigrants or people on long-term sick leave. In the Netherlands, a particular focus will be on addressing the needs of young ex-detainees who face difficulties in the labour market after imprisonment. Schooling and on-the-job experience will aim to increase their chances of obtaining employment. In France, specific programmes will support the (re)integration of vulnerable groups such as the long-term unemployed, social benefits recipients, the low-skilled, disadvantaged youth (for example, in second chance schools) and other very disadvantaged people. In Hungary, a broad programme targets several disadvantaged groups, such as Roma people, the long-term unemployed, low-skilled, elderly workers, people with altered working capabilities, and women returnees, including measures to enhance entrepreneurship amongst these groups. In Slovakia, active labour market polices to increase the professional mobility of job seekers and to modernise public employment services will be tailored to the needs of job-seekers, the self-employed, employees at risk, and enterprises as well. Poland plans to support young people at risk of exclusion and prisoners

through measures to ensure early identification of their needs and develop their pathways to the labour market. In Latvia, activities will be implemented to increase motivation and competitiveness in the labour market, by supporting projects to improve integration opportunities. Social risk groups like the long-term unemployed, those with addiction problems, the disabled and the economically inactive will be targeted. In Estonia, the OP provides for work practice and services for disabled people to increase their participation in the labour market.

The development of access to better quality services is a significant feature in a number of the OPs in the Convergence regions in particular. These activities are often coupled measures to build capacity of various actors in the delivery of social services which are analysed in more detail in the governance section of this chapter. Slovakia, for instance, aims to promote increased access to better quality and more effective care services as well as to strengthen professional expertise and capacity in the area of social inclusion, with a focus on NGOs and marginalised groups. Similarly, the Czech Republic will support the overhaul of institutions supporting the quality and accessibility of social services including support for partnerships at local and regional levels. Bulgaria plans to extend the network of providers of social services in the community and to support the municipal strategies for social services. An important element of the Polish OP is to develop high standards of social services and their implementation in social assistance institutions. These activities, coupled with enhanced cooperation between social assistance institutions and Public Employment Services (PES) will improve opportunities in the labour market. Estonia and Lithuania plan to devote ESF funding to the development of human resources in parallel with the development of social infrastructure with support from the ERF.

In parallel with this approach, attention is also being devoted to developing childcare and life-long learning systems, in Malta and Latvia for instance. This focus on life-long learning and on addressing skills deficits, especially amongst vulnerable groups, by widening access to life-long learning systems, is a common feature of many of the **Regional Competitiveness and Employment OPs** – including DK, NL, FR, IE, UK and SE amongst others. Lifelong learning activities also target those in work, including workers in low-skilled jobs, older workers, and workers in vulnerable sectors. This approach will enable beneficiaries to remain in employment or to progress to better employment. In Denmark, for example, in addition to support for the systematic planning of training in SMEs, the participation of low-qualified workers in training and improvement in the quality of vocational education and training, there is also a focus on support for the recognition of real competencies (skills or competencies acquired in the course of working life and not necessarily documented by an examination certificate) as part of expanding the recruitment base for enterprises. The Netherlands OP attaches a specific priority to improving the employability of employees with low or no qualifications, which will encompass three types of training– training for employees without 'start' qualifications (e.g. early school leavers); training to improve the competences of employees with second-level professional qualifications; and cross-sector training aimed at improving **adaptability** and preventing unemployment in the medium term. To encourage the acquisition of the skills necessary to entry to the labour market, Estonia will develop youth services.

Several OPs will support **the social economy sector**. This sector represents an important source of entrepreneurship and jobs in areas where traditional 'investor driven' enterprise structures may not always be viable. In BG, PL, IT and LU, by way of example, support will be provided for social entrepreneurship and for agencies providing support to the sector in the form of advice services, training and financial and legal services. In Romania**,** support will be

provided to develop the tools and mechanisms needed to fully implement the social economy concept.

Most Member States specifically refer to measures to enhance **the employability of older workers**, through targeted interventions aimed at up-skilling and retraining. This will help to make better use of the potential within the labour force in Member States to sustain economic growth, tax revenues and social protection systems, including adequate pensions, in the face of expected reductions in the working age population. Belgium proposes extending labour market services to include awareness raising activities drawing the attention of employers to the opportunities resulting from flexible use of the older labour force. Slovakia will invest in the up- and re-skilling of workers at risk of dismissal with special regard to older workers and the low-skilled, while ES, IT and RO, plan to support similar training activities for older workers and those affected by restructuring. In Hungary, employers' will receive credits towards social security contributions where they take on the older unemployed as an incentive to promote active ageing. In Denmark, the focus will be put on supporting efforts by enterprises to develop an active staff policy adapted to older workers on initiatives to reduce sick-leave and on improving the co-operation between municipalities, education and training institutions and enterprises in order to retain older workers in activity longer.

7.4. Supporting equality between women and men and anti-discriminatory measures in relation to the labour market

The importance of promoting gender equality is reflected in a number of OPs. Several ESF programmes promote reconciliation of work, private and family life and access to childcare and care for dependant persons to aid the labour market participation of women (for example the UK OP). The Hungarian programme envisages the enforcement of equality between women and men in active labour market policies and foresees the encouragement of women's entrepreneurship. Malta makes reference to the development of special programmes, campaigns and studies/research to support women in re-entering the labour market and improving their career prospects. There is also evidence of ESF being used to combat stereotyping and to change attitudes, including via the training of men/women for professions in which they are underrepresented.

Many programmes include specific actions designed to remove barriers to the labour market for those facing discrimination. The development of Equal Opportunities in the labour market is particularly evident as a cross-cutting theme. In Slovakia, two social inclusion horizontal priorities "Equal Opportunities" and "Marginalised Roma Communities" are reflected in both of the ESF OPs (and also in the relevant ERDF OPs). Several programmes make reference to training on anti-discrimination for employees of the public sector and capacity building of key equality bodies (for example, the Hungarian OP). A high proportion of programme resources is dedicated to the integration of migrants into the labour market in the Netherlands, Belgium and Finland.

In some Member States, including the Netherlands and the United Kingdom, key anti-discrimination bodies, including NGOs, are involved in the management (strategy development, monitoring and evaluation) of the ESF programmes. Belgium envisages the development of an 'equality-diversity' label for firms respecting non discrimination rules. The Swedish programme makes reference to possibilities for projects aimed at combating discrimination in getting and advancing in a job. Italy promotes corporate social responsibility and foresees awareness-raising anti-discrimination initiatives.

7.5. Strengthening the governance of social inclusion policies

Good governance can accelerate the socio-economic development of the Member States and their regions. Likewise, efficient and effective social policies and public services can only be designed and delivered if the competence and capacity of national, regional and local actors is sufficient and their action is properly coordinated. Good governance, transparency and partnership is hence one of the overarching objectives for the social inclusion and social protection process and each of the three strands – social inclusion, pensions and health/long-term care – has specific governance-related objectives. The importance of strengthening governance, in particular in the **Convergence regions** and **the Cohesion Member States,** is also recognised by the 2007-2013 ESF and ERDF regulations while the regions under the **Regional Competitiveness and Employment** objective will pursue governance-related activities mainly by supporting partnerships to aid socially excluded people. Therefore, the Member States have an opportunity to address administrative capacity building in the social field when implementing of the ESF and ERDF operational programmes. Here, particular attention should be paid to the country-specific governance related challenges identified in the 2007 Joint Report and the forthcoming Joint Reports.

One of the areas where the ESF will contribute to promoting good governance is **the development of mechanisms for social inclusion policy design, monitoring and evaluation** at national, regional and local levels. Country-specific challenges were identified for some Member States in the 2007 Joint Report (for example, for CY, HU, LT and SK). Here, Hungary plans to address the challenge by developing activity standards and protocols as well as monitoring mechanisms encompassing all social services. Slovakia will introduce quality management systems in public administration and for NGOs in the area of employment and social policies. Bulgaria will improve the effectiveness of labour market institutions and of social and healthcare services while Poland will develop IT systems for social welfare and social integration institutions. Both Lithuania and Estonia envisage horizontal measures for strengthening capacity for policy formation, strategic planning and management, thus it is important that the administration in the social field at national, regional and local levels would benefit from those measures. In addition, the ESF will promote **the development and reform of social services**. The Czech Republic and Malta plans to support the reform of the system of social services. Poland will develop service standards in social welfare and the national system of thematic and specialist training.

Many Member States will use ESF and ERDF funding for **the capacity building of different actors** at national, regional and local levels to deliver social services and to implement social policies. The importance of partnerships and the role of NGOs and social partners in **the delivery of services and policies** are also recognised in the ESF programmes. For example, in Poland half of the socially excluded people receiving ESF support will benefit from the integrated services delivered in partnership by the social assistance institutions and the PES or NGOs. Likewise, Cyprus and Romania will support the participation of NGOs and local authorities in the implementation of measures in favour of vulnerable groups and will upgrade the administrative capacity of the social welfare services. Slovenia will focus on the development of the NGO sector through capacity building and participation in the implementation of the ESF programme (7% of ESF funding or €53 million has been allocated to this task). Estonia will develop a separate administrative programme for social partners. Co-operation between different institutions will be further encouraged - in the Netherlands between the centre for work and income, the unemployment agency and municipalities, and in Italy between education, vocational training, employment and social inclusion services. France will promote territorial partnerships and local initiatives for social inclusion as well as

innovative partnerships. Seven German ESF programmes will support awareness raising and joint actions carried out by social partners and NGOs. Spain will establish a social inclusion network involving a broad range of partners at national and regional level for the coordination of social inclusion policies and implementation of the structural funds programmes. Slovakia has developed an innovative mechanism for cooperation between the ERDF managing authorities and the PES which should assist project promoters in finding the necessary human resources.

7.6. Supporting the reform of social protection systems

Some Member States intend to **support healthcare and long-term care reforms**. For example, Slovenia will promote the modernisation of healthcare processes, the accessibility of e-healthcare services (40% of all healthcare user should use them by 2013) and the development of human resources. Bulgaria will aim to increase the number of children receiving community-based social services while Romania will promote the improvement of the quality and efficiency of public health service delivery on a decentralised basis. Moreover, Member States have the opportunity to use ESF funding **to improve the coordination between care systems** and public and private institutions and to develop quality standards. In this regard, Slovakia will promote networking among care services in regions and Poland will develop and promote certification and accreditation systems for health care entities. The promotion of **preventative health strategies** has been identified as a country specific challenge for EE, HU and SI. Here, Estonia will make a significant investment in improving the health environment at work by training working environment specialists (covering 90% of enterprises with more than 10 employees) and strengthening the labour inspectorates. Hungary will support healthy life styles campaigns and disease prevention programmes.

In addition, most Member States have plans for the **development of the staff of healthcare systems** to support the sustainability of those systems. Poland, for instance, will develop qualification standards for health care managers and train 1,500 managerial personnel and public resources administrators in this sector. Training will also be provided for medical staff focussing on deficit professions (e.g. 24,000 nurses) and specialists such as oncology, cardiology and occupational medicine. Hungary will establish a regionally based national health monitoring system to provide the basis for local, micro-regional and regional health interventions such as allocation of resources and services. Romania will train 8000 staff within medical administration, hospitals and other medical institutions (5% coverage). BG, CY and SK have also envisaged training for healthcare professionals in the ESF programmes while many other Member States have foreseen measures for the development of public sector employees which could equally encompass training for medical staff.

The ESF will also support governance related activities for **pension reform**. LT and MT have included such a possibility in their ESF programmes. It is important for the Member States where pension reform has been identified as a country-specific challenge (for example CZ, LT, PL, PT, RO, SI) to take up of the opportunity to use ESF funding for governance related activities. However, the main ESF contribution to the adequacy and sustainability of pensions will take the form of facilitating the adaptation of older worker and support for active ageing and longer working lives.

7.7. Working with other Member States and regions: transnational and interregional cooperation

Over 2007-2013, value can be added to national, regional and local ESF and ERDF activities by engaging all relevant stakeholders in transnational or interregional cooperation in any field of ESF and ERDF assistance. Social inclusion is one of the fields where specific transnational or interregional cooperation is envisaged by Member States in a number of operational programmes.

Trans-national co-operation in promoting pathways to the labour market for the most disadvantaged and cooperation to combat all forms of discrimination in the labour market are common themes in the operational programmes. In particular, the cooperation is envisaged for the integration of the disabled, young and elderly, the long-term unemployed, immigrants and other social groups facing difficulties in the labour market. Some Member States (EE, LV and SK) have a special focus on cooperation in the development of services for the disadvantaged to help them enter or remain in the labour market, while others (for example SI and SK) envisage cooperation to promote the reconciliation of work and family life. Member States with significant Roma communities, including ES, HU and SK envisage co-operation to ensure the social integration of Roma population. To this end, Spain has established a transnational network on Roma issues to help validate, share and mainstream good practice among Member States. In addition, several Member States (e.g. MT, RO and SI) envisage transnational cooperation in the development of innovative methods to combat all forms of discrimination in the labour market and to enhance social inclusion. For instance, France will promote innovative partnerships (which could be transnational or interregional) between enterprises and a consultancy services for those furthest from the labour market.

The main form of co-operation envisaged is the exchange of good practice and mutual learning. However, it is expected that Member States will take the opportunity to draw on the evaluations of the 2000-2006 EQUAL Programmes which identified the development of complementary approaches and coordinated or joint actions as amongst the more efficient forms of cooperation.

8. VOLUNTARY UPDATE REPORTS FROM MEMBER STATES – SUMMARY OF MAIN DEVELOPMENTS

The 2007 Joint Report included assessments of the social protection and social inclusion strategies of each of the Member States. 2007 as an intervening year in the reporting cycle has allowed OMC work and preparations for the 2008 Joint Report to focus instead on the analysis of a selected set of themes. However, Member States had the option to provide an update in the event of significant developments. Three Member States (FR, SE, SI,) provided full new strategic reports, while six submitted partial updates (AT, ES, FI, NL, RO, UK)[88].

8.1. Poverty and social inclusion

8.1.1. Changes in the overall approach

Social Inclusion and Social Protection policy remains high on the political agenda for most Member States and some have even reinforced their commitments by setting quantitative targets to reduce poverty. France has set a new objective to reduce poverty by one third within the next 5 years (2.1 million). The Netherlands has set a target of 200,000 extra people in employment by the end of the 4 year government term. In Finland the new government has made it clear that it regards the ageing population, changes in the labour market and globalisation as major challenges and is reforming its social protection systems accordingly. The Slovenian Government has made efforts to strengthen its approach to Employment by amending the Employment and Insurance Act. Member States also reiterated their efforts to continue promoting greater gender equality.

On the whole, Member States main approach on social inclusion and social protection policies involves a continuation of previous Government policy and a deepening of social inclusion and social protection policies. In particular, several Member States are increasingly emphasising strategies and measures to facilitate labour market participation, through work incentives, income and taxation reforms (i.e. minimum income and/or old age income) as well as subsidised employment (SE, FI and FR). Others are focusing on minimum income and wage schemes. In Austria, the new government has committed itself to gradually implementing a means-tested minimum income. Furthermore, a minimum wage has been introduced based on a framework agreed by social partners. In Slovenia the Act regulating adjustments of transfers to individuals and households is in force since 2007 introducing several changes: maintaining the incomes of the most vulnerable groups, a reform of the indexation system by introducing a single indexation concept as well as a single, single period of indexation, and greater transparency.

More targeted approaches to ensure that measures to get people into work do not push those unable to work into increased exclusion and poverty, have also been put forward. The Netherlands government points out that the social cohesion pillar will focus not only on labour market participation but also on strengthening all levels of participation in society especially in the youth area while strengthening governance structures in the field of active inclusion. In Sweden a new reform to tackle the high number of people on sick leave and disability pension has been presented, including improved rehabilitation, uniform medicine guidelines for sickness insurance and restrictions within the sickness insurance system. The

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

Austrian Government has plans to reinforce measures to enhance integration of people with disabilities. Nevertheless, despite these efforts, the absence of reduction in intergenerational transmission of poverty is a cause of worries for most Member States.

8.1.2. Child poverty

As illustrated above incentives to work have been proposed by several MS, which could strengthen the income situation of families and thereby reduce child poverty. Other strategies for alleviating child poverty and the social exclusion of children are linked to educational reform. Austria is focusing on strengthening German language learning for immigrants. In the Netherlands a key policy focus is 'early school leaving' and a Minister responsible for youth has been appointed. Sweden is reforming the upper secondary school system by introducing a broader choice for young people, in particular with more vocational training and a new apprenticeship programme. Some Member States are in the process of establishing monitoring systems to follow developments linked to child poverty systematically. In Slovenia the Child Observatory will be put in place and a set of indicators for monitoring the status of children have been created.

As clearly comes across from the analysis in section 1.2 of this document, the strengthened efforts reported to promote greater gender equality has a strong bearing on the priority to tackle and prevent child poverty. Finland underlines that the government will take steps to ensure that the gender perspective is mainstreamed across all legislative drafting, budget procedures and other major projects right from the outset. It also affirms that more resources will be allocated to government agencies and women's organisations engaged in promoting gender issues. Sweden sees that improved gender equality policy as fundamental to promoting the security and well-being of families, socially and financially. The goal of eliminating the gender pay gap has also been underlined (Finland and France).

8.1.3. Active inclusion

As referred to above, some Member States have placed more emphasis on Active Inclusion by increasing support for unemployed persons through initiatives such as benefit reform, income support, training and also through innovative polices targeting the most disadvantaged (the disabled, immigrants and women). Under Pillar One 'income support' Finland has made policy changes to support the unemployed in finding work in the private labour market including increasing the domestic help credit and extending the low-pay support scheme to young people. The Austrian Government is reforming childcare allowance and is introducing as of 2008 the possibility for parents to return sooner to the labour market while receiving a higher monthly amount of allowance. At the same time, the salary threshold for receiving child care will be raised. The French Government has introduced an active solidarity income intended to make work more attractive for parents by compensating for the cost of returning to work and the potential loss of rights that the new status brings. The Slovenian Government has amended the Social Services Act. Spain has passed a new law on "Enterprise of insertion" aimed at the social and labour market integration of socially excluded persons, based on the active inclusion approach.

In Austria under Pillar Two 'link to the labour market', there will be a new focus on promoting the qualifications of girls in 'atypical' professions in the period 2007-2010. This should help counteract the tendency of women to opt for occupations in the low-wage sector. France has committed to targeting those who are not in education or training. The Finnish Government is expanding apprenticeship training and workshop activities targeting young people.

Under Pillar three 'access to quality social services', the Austrian Government is planning to increase the supply of childcare and enhance quality assurance in this area. The NRP Implementation Report states that an additional €20 million a year will be available from national funds (if matched by corresponding regional budgets) for the expansion of childcare facilities over the next three years. The Slovenian Government is taking measures to improve the link to the labour market. The Programme of measures of the active employment policy for 2007-2013 and an accompanying implementation plan have been adopted.

In Austria measures to enhance the integration of the disabled under the motto 'Removing barriers in laws and minds' are planned for the period 2007-2010. These include nationwide cross-cutting action programmes for the implementation of the equal opportunities law. Furthermore, an action plan to reduce physical barriers in buildings owned by the federal government should be adopted by the end of 2007. Public transport providers are obliged to submit respective plans for public transport. Finally, the second report by the federal government on the situation of disabled people is planned to be published in 2008 (the first report was published in 2003 on the occasion of the European Year of People with disabilities). The government programme provides for such a report to be drafted and submitted to Parliament every two years thereafter. In response to the 2007 Joint Report, the new Dutch government has announced its intention to develop an action plan in cooperation with the municipalities for the integration of minorities. This "Deltaplan Integration" will analyse the benefits of integration and the differences between recipients needs in order to better target integration policies.

8.1.4. Governance

In addition to the positive progress in social inclusion and social protection in general, the governance aspect of these policies has also been considerably strengthened by Member States. This is evidenced by the up-dates, in the cases where they have been drafted in consultation with stakeholders. In Sweden the up-date of the national strategy report for social protection and social inclusion covering the period 2006-2008 was prepared following consultation with the Network Against Social Exclusion, the Association of Local and Regional Authorities and central government agencies. The new government is continuing the initiative of mobilising actors for the implementation of the strategy report, in particular through the "Commission for service user influence" (established in 2003).

In Austria the updated report was drafted in consultation with the regions and other national stakeholders. In The Netherlands the social cohesion pillar was agreed following a "100-days consultation period with the public" after the new government took office in February 2007. Members of Government and Parliament consulted a wide-cross section of citizens, companies, policy makers, local political representatives and NGOs throughout the country.

Institutional reform has also been adopted by many Member States to strengthen the governance of Social Inclusion and Social Protection policies. In Finland the new government has appointed a committee to prepare a plan to reform and simplify the social protection system. An extensive long-term project has been launched for the restructuring of municipalities and services. The Romanian Government has created a new structure called the "National Commission for Social Inclusion" to strengthen the monitoring process. A new law clarifying responsibilities between different levels of central and local government has been passed. The law provides for the creation of three new structures and a timetable for the implementation of institutions: The Social Inspectorate, the National Agency for Social Benefits and the Social Observatory will support the Minister concerned in the efforts to

define social polices responding to the needs of all groups in Romania. In the Netherlands a project will be launched to further investigate how the policy framework between government, municipalities and social partners can be further strengthened.

8.2. Pensions

8.2.1. Extending working lives

A number of countries (AT, ES, FI, FR, NL, SE, SI, UK) have reported significant progress in reforming their pension systems, or have changed their approach since the 2007 Joint Report, largely to ensure adequacy and sustainability in the light of demographic change. Various efforts have been made to encourage extended working lives to enable the long term sustainability of pension systems. Sweden is continuing with its extensive range of policies to encourage working longer by making it easier and more lucrative to remain in work and encouraging employers to employ older workers through tax incentives. The UK has passed legislation to gradually increase the State Pension age to 68 by 2046.

France is currently preparing its first your-year review as laid out in the 2003 pension reforms (the 2008 "Rendez-vous"). It continues its pension reform with new proposals for 'special regimes', which were exempt from previous reforms, to ensure greater equity. Austria also hopes to bring special pensions more into line with the general pension system in the provinces and municipalities to ensure equality. France has also increased taxation on early exits from occupational schemes to improve employment levels amongst older people which remain relatively low. Slovenia's expert task force is also leading on-going discussions on encouraging longer working lives through incentives and flexibility in retirement, and enabling greater private saving for retirement by deregulating voluntary take up of insurance. Recent amendments to the pension system in Austria (reduced deductions for early retirement over a 40 year transition period and extending to 2010 the option to retire early for those with long insurance records) seem unlikely to help increase employment rates of older workers, despite Austria having relatively low levels of employment among older workers – although the changes should temporarily help to mitigate the potential adverse effects to pension adequacy among early leavers. Spain noted that it has recently passed additional legislation to, among other things, promote the voluntary extension of working lives through pension incentives for those entering retirement after 65; and to reorganise early exit pathways related to partial retirement and disability pensions.

8.2.2. Coverage and adequacy of pensions

The UK has recently taken steps to reform the state pension to provide a strong foundation for private retirement provision. Measures introduced include linking the basic state pension's value to earnings rather than prices, thus assisting pensioners in retaining their income relative to those in work. The number of years required for a full Basic State Pension in the UK has also been reduced; along with measures which are expected to substantially improve outcomes for people with broken careers, such as women and carers. These reforms will ensure that recent achievements in reducing pensioner poverty are secure into the future. The UK also continues to develop private pension reform with its centre-piece being a low cost portable private savings scheme. It is being proposed that in the 'Personal Accounts' scheme employees will contribute a minimum of 4%, matched by a minimum 3% employer contribution and around 1 per cent in the form of tax relief on earnings.

Austria has recently increased the minimum pension to an amount close to the at-risk-of-poverty threshold, in line with the introduction of a means tested minimum income. Finland is

focussing primarily on integrating and simplifying private pension legislation. From 2008 there will be a general harmonisation and increase in national pensions as the system of municipal pensions is abolished. This will correspondingly increase other income security benefits tied to the national pension. As pension income increases there will also be an increase in the pension income allowance permitted before taxation. The Netherlands are preparing a proposition for additional contributions to the state pension for those with an income of €18,000 or more.

8.3. Health care

8.3.1. Coordination and adequacy of health care

Since the 2007 Joint Report, some significant changes have been reported (AT, FI, FR, NL, SE, SI) – particularly in the coordination and monitoring of the adequacy of health care and long-term care. Finland has focussed on the coordination of care to ensure that the different elements complement each other while setting standards for evaluation. Austria also continues to establish an integrated health care system by: harmonising benefits; bundling health care contributions and earmarked taxes across the states; and joint control and planning. France has adopted several measures oriented towards a better care coordination and intends to pursue structural measures to make more efficient use of resources through the continuation of the integrated primary care provision efforts, control of pharmaceutical spending and structural measures to foster greater responsibility amongst patients such as the development of co-payments and out-of-pocket payments. Sweden has been active in setting quality guidelines and priorities, and coordinating services. It has identified areas for improvement including: an improved database to follow up and compare waiting times and a national medical helpline. Sweden is improving adequacy of health care through support to local authorities by making it easier to sub-contract activities and to support care staff who wish to take over publicly-run activities and, for a limited period, by allocating further resources to improve accessibility.

Austria increased health insurance contributions by 0.15% from 2008 and will place a limit on prescription charges of 2% of income for those with chronic illnesses. There are also plans to lower prescription charges for generic drugs and to create health care centres catering specifically for outpatients to improve specialised health care in rural areas. Slovenia also plans a significant increase in the number and level of contributions to insurance schemes to secure the financial sustainability of healthcare provision and enhance accessibility to quality services (social assistance framework covering surcharges for vulnerable groups). Despite decreases reported in the observed deficits of health insurance funds in France, the government recognises that new structural reforms are still needed and will propose a series of legislative measures in the course of 2008 after a general revision of public policies in that area and a major debate on health funding.

8.3.2. Prevention

The Finnish health care legislation will be revised in 2008 and coverage of the municipal service vouchers will be extended to include social and health care services. The gender perspective will also play a part in social and health care services and in the efforts to reduce health inequalities. A health promotion programme, together with a National Alcohol Plan, stresses the importance of physical activity and culture for well-being to prevent social exclusion. Similarly the Netherlands is also exploring a more general approach to the

prevention of sickness through first line clinics, employers, schools, municipalities and the professional world.

8.3.3. Long-term care

France reports the enactment and amelioration of national strategies oriented towards better palliative care and Alzheimer disease management amongst other things. It is continuing its strategy to enhance chronic disease management and promote efficient patient follow-up within an integrated care-continuum. The aim is to enhance patient choice between care in the home and an institutional setting, ensuring uniform application throughout France while significantly improving care conditions and the accessibility of institutional and residential services. In order to achieve this, the French government intends to set up quality evaluation mechanisms for long-term care services in both settings and to improve the professional qualifications and training of carers as well as their working conditions. France intends to extend the benefits (cash and in-kind) available to disabled persons and examine the possibilities of establishing a fifth social security branch for dependent persons to be adapted to their financial circumstances irrespective of age (such financial provision could be complemented by an individual long-term savings scheme allowing dependants benefits both in cash and in-kind). Spain has begun to implement new legislation to extend long term care attention to all people assessed as "major dependants".

In Slovenia, legislation to introduce social insurance for long-term care is under discussion. It provides for long-term care provision in a home or residential setting, improving the quality of long-term care (promotion of patient choice) and placing it on a sound financial footing. A more personalised and integrated provision of social care in a home or residential setting is also being promoted. Austria has also introduced measures to enable 24 hour care at home. From 2008 Finland will decrease the age at which the elderly are assessed for care and a comprehensive national advice and service network will be developed along with provision for preventive house calls. Housing repair subsidies will be provided to support the elderly and disabled in living at home. The Netherlands is concerned that insurance for long term care lacks efficiency, quality and transparency, and the Social Economic Council will report on this matter by December 2007.