COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 24.2.2009
SEC(2009) 255 final

COMMISSION STAFF WORKING DOCUMENT

Joint Report on Social Protection and Social Inclusion 2008

Country Profiles

TABLE OF CONTENTS

Introduction

These 27 country profiles aim at providing a synoptic view of key trends, major efforts and challenges ahead in each of the Member States with respect to their policies in the fields of social inclusion, pensions and health and long-term care. They are based on the renewed, integrated National Strategies for social protection and social inclusion that Member States presented in September/October 2008. They complement the 2009 Joint Report on social protection and social inclusion.[1]

Each profile identifies those aspects of performance deserving to be highlighted in the context of the Open Method of Co-ordination or presenting greater risks and therefore calling for particular policy efforts in the area of social inclusion, pensions, healthcare and long term care. The concluding section of the country profiles lists for each country the key challenges that the Commission services have identified on the basis of the analysis. The preparation of the profiles have benefited from bilateral exchanges with the Member States.

Unless otherwise specified, all indicators used in the country profiles draw on the indicators which Member States have agreed to use in the context of the OMC on social protection and social inclusion, either from the overarching portfolio or from the detailed lists covering the three strands of the OMC: social inclusion, pensions and health care and long-term care. The annex to this document is a methodological note explaining the overarching indicators and providing details on the EU harmonised data sources used to calculate them. Where relevant and necessary, national sources are used to supplement the picture provided by the EU agreed indicators.

[1] The Commission proposal for Joint Report on Social Protection and Social Inclusion 2009 was adopted on 13 February 2009 (COM(2009) 58; After treatment in the Social Protection Committee with possible amendments, the Joint Report will be adopted by the EPSCO Council of 9 March 2009.

Belgium

1. SITUATION AND KEY TRENDS

Although the forecasts for 2008 and 2009 are, as for the rest of Europe, not encouraging (expected growth: -1.9% in 2009), Belgium's economic growth gathered momentum in 2006 (3%) and 2007 (2.8%) compared to 2005 (1.8%). Public debt continued to fall in 2007 (to 84.9% of GDP). However, there was an unexpected deterioration of the public balance in 2007 and 2008. The inflation rate, though decreasing recently, has been sharply on the rise since the end of 2007, jeopardising the purchasing power, particularly of low-income families. The employment rate is rising but remains below the EU-25 average (62% compared to 65.8% in 2007), even though the female employment rate again rose rather strongly. The male employment rate still did not reach the level achieved in 2000. Regional disparities remain substantial (employment rate of 66.1% in Flanders, 57% in Wallonia, 54.8% in Brussels)[2]. The same conclusion applies to older people's employment rate: the trend is encouraging (it rose once again in 2007: +2.4 pts, to 34.4%) but the rate improved more for women than for men and the level remains significantly below the EU average (EU-25: 44.9% in 2007). On the other hand, the disabled people's employment rate is 17 pts below the general employment rate; there is also a much lower employment rate for people born outside the EU (46.3% in 2007) and for non-EU citizens (38.1%) compared to the others (respectively 58.1% and 61.2%[3]). As for unemployment, despite persistent regional disparities (4.4% in Flanders, 10.5% in Wallonia and 17.2% in Brussels[4]) and poor figures for people born outside the EU and non-EU citizens, the unemployment rate fell to 7.5% in 2007 (-0.8 pts compared to 2006). Youth unemployment is following the same positive trend (1.7 pts less than in 2005), although the rate remains above the EU-25 level. Long-term unemployment (as a percentage of unemployment) is also decreasing (from 51.7% to 50.4% since 2005) and more quickly for women than for men. Life expectancy at birth was 76.6 years for men and 82.3 years for women in 2006. Healthy life expectancy at birth remained stable between 2005 and 2006 (61.7 years for men; from 61.9 to 62.8 years for women) as well as healthy life expectancy at 65. Total gross social protection expenditure has increased slightly: it accounted for 28.7% of GDP in 2006 (+0.4 pts compared to 2005). Pensions and health represent the bulk of social protection expenditure (36.7% and 25.7%, respectively in 2006), even though health spending is decreasing.

2. OVERALL STRATEGIC APPROACH

Priorities and challenges are globally unchanged, but better coordinated. There are three key 'social challenges': tackling the budgetary burden of pensions in the context of an ageing population while ensuring adequate old-age benefits; providing sustainable access to quality health and long-term care services; and reducing the persistent risk of poverty. Five priority **areas** (axes) shape the action framework: promoting a global employment strategy; reducing the burden of taxes and social security contributions on low-skilled jobs; promoting entrepreneurship; strengthening the social protection system and fighting poverty; improving

[2] Ministry of Economic Affairs statistics 2008.
[3] Ministry of Employment statistics 2008.
[4] Ministry of Employment statistics 2008.

the environment and sustainable development policy. These main thrusts are supplemented by specific action lines. These are similar to the previous three key objectives when it comes to inclusion. They focus on three domains (reducing the public debt, developing the reserve fund and strengthening the social security financing scheme) for pensions**.** With regards to health care these combine achieving financial balance with improving the access to care services (for vulnerable groups). The last action line aims provide more specialised services as well as to improve their coordination as regards the long-term care policy. Improving the employability of people who are furthest from the labour market remains a major challenge, taking into account the recommendations inviting Belgium to 'enhance the labour market participation and reduce the tax wedge on low-skilled workers'. A specific priority axis refers to the strategy for sustainable development. As regards governance, the 'editorial committee' for drafting of the report guarantees the consistency between the different strands of the strategy, thanks to the presence of representatives of the main departments involved in the SPSI policy. One project ('on the ground' ombudsmen who's role is to know better the experience of people facing poverty) and a 'social inclusion' axis are in the federal ESF programme. The problem of gender equality is tackled with regards to homelessness, childcare facilities (in the context of female employment) and retirement age. The issue of disabled people is raised essentially in connection with the purchasing power: raising the minimum income, reducing the patient's contribution of, supporting home-help, assistance facilities and activation.

3. SOCIAL INCLUSION

3.1. Key trends

A limited progress is contrasting with certain aggravations or lacks of improvement. The positive points are the increase of the at-risk-of-poverty threshold (at €10 316 for a single person and €21 665 for a household with 2 children in 2006), the stability of the at-risk-of-poverty rate (which remained at 15% - after social transfers - in 2007 as well as the permanence of the in-work at-risk-of-poverty **rate**, of the at-risk-of-poverty **rate** for children under 18, of the share of children aged 0-17 living in a jobless household (12% in 2007) and of the share of early school leavers (12,3 % in 2007, still a bit lower than the EU-25 average for the same year: 14.5% in 2007). The relative at-risk-of-poverty gap is not improving (18% in 2007) but remains better than the EU-25 average as well.

On the other hand, however, important problems still deserve to be pointed out. The regional differences remain substantial as regards the at-risk of poverty rate (11.4% in Flanders, 17% in Wallonia and an estimated 26% of people below the national poverty threshold in Brussels) or early school leaving (24.6% in Brussels in 2007, against 12.3% at national level and 12.8% in Wallonia[5]). The situation of women and particularly older women is in some extent also a matter of concern as regards the risk of poverty, the in-work risk of poverty (growing from 24% to 28% for single women in 2006), the higher number of homeless women and the low impact of social transfers. In the opposite way, the rate of early school leaving is worse for boys (13.9% in 2007) than for girls (10.7%).

Older people's situation, and especially older women's situation as already said, is not improving either, particularly as regards the risk of poverty, which is higher than the EU

[5] Enquête sur les forces de travail (EFT) - IWEPS

average and the neighbouring countries, and as regards the impact of social transfers, which is lower in their case.

A significant imbalance also remains between non-EU (29.6% in 2007) and EU nationals: the unemployment rate gap is still high (29.6% against 9.8% in 2007), though decreasing slightly, whereas the employment rate is rising to 38.1% for non-EU nationals, compared to 61.2% for EU nationals during the same year[6]. Persistent differences can also be observed when making a comparison based on the place of birth.

Some other categories continue to be particularly exposed to the risk of poverty, like single persons, jobless households without children, unemployed persons and tenants. For the latter, the risk of poverty is almost three times higher than for home owners (28% against 10%).

Social benefits (except pensions) reduced the poverty risk by 44.5% (from 27% to 15%) in 2006, a greater reduction than the EU average, but reduced it by only 14.8% (from 27% to 23%) for people aged 65 and more, and by as little as 10.7% (from 28% to 25%, against a reduction of 16% in EU-25) for women aged 65 and more. The net income of social assistance recipients as a percentage of the poverty threshold was 72.7% for a single person, 64.8% for a married couple with two children and 85% for a lone parent with two children, which signals a downward trend to a drop compared to 2004.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The progress achieved is limited. At national level, none of the 2008 targets linked to the three 2006-2008 main objectives was met (except with regards to the women's and, to a lesser extent, the old-aged workers' employment rate), even though there are still important contrasting results between the different regions. The non-EU nationals' unemployment rate, though falling, remains particularly high. There is no indicator available to measure the progress of employment among disabled people. Despite the large number of measures described, the report does not provide clear evidence of the actual progress made on poverty's ground: beside improvement made, particularly as regards the elderly people's social covering in the area of pensions and health care or, more generally, the easing of criteria for benefiting from reduced out-of-pocket payments for health care, it can hardly be said that either the most disadvantaged people's employment rate or housing conditions have specifically known a real improvement. This lack of progress can perhaps be partly explained by the political difficulties that Belgium is going through and the delicate coordination among the country's different authorities and institutions. But more basically, the question should be raised whether the actions undertaken fit with the targets, and whether the actions should be more appropriate or better resourced.

3.3. Key challenges and priorities

Like the strategy presented, the three former objectives have been renewed: decent and affordable housing for everyone; getting risk groups to be proactive; breaking the cycle of child poverty. They incorporate the two "Inclusion" challenges set for Belgium in the 2007 Joint Report and make it possible to meet most of the main political priorities set out in the 2006-2008 National Report. The modernisation of social welfare systems appears under the

[6] Statistics Ministry of Employment 2008.

"Activation" objective: the tax measure (employment premium and exemptions) is presented as an employment incentive. Furthermore, the need to improve access to high-quality services is covered by the three objectives, in particular through improved assistance for tenants, children attending school and jobseekers with the poorest job prospects. Special attention is paid to homeless women, and to the matter of childcare; there has in fact been in improvement as regards the female employment rate.

3.4. Policy measures

The report presents a wide range of measures, detailed by region, the impact and results of which are not always apparent. The planned measures are, as regards the 'housing' objective, in line with the measures taken over the last few years by the different authorities. They aim to improve the quality of the supply (by streamlining the procedures, setting priority rules or reducing the number of unhealthy dwellings) and to control the quantitative parameters (by increasing the stock of social housing, creating a tax on derelict buildings, monitoring prices more closely, adopting social measures regarding energy or developing housing subsidies). The purpose of some other measures is to improve guidance services or governance tools (better participation of tenants' representatives in consultation committees, development of accommodation centres). Progress is also made on account of special measures for homeless people, especially for homeless women, the number of whom is growing, for instance by enabling them to obtain a mailing address or by increasing the supply of 'transit accommodation'. The 'Activation' objective is covered by initiatives aimed at increasing the motivation to work (via tax incentives and by reforming the unemployment benefit system with no evidence of a beneficial effect on inclusion so far, however), but also improving the follow-up of unemployed people, developing recruitment incentives towards employers (by making companies more sensitive to discrimination, by the obligation to include a social clause in public procurements or by promoting social responsibility issues), improving the training supply (skills validation, literacy courses, guidance) or enlarging childcare facilities. There is also a political will to promote low-skilled jobs (e.g. via service vouchers, the long-term indexation of which was decided by the end of October 2008). Flanders has established a subsidy to encourage companies to hire old-aged workers and has adopted a range of measures to reduce the risk of school failure and of youth unemployment. It has also launched initiatives for monitoring the groups exposed to poverty risk. Different actions for rationalising or assessing currently existing procedures are worth mentioning as well. Companies devoted to social integration and promoting a 'training by working' approach are also supported. Regarding child poverty, the measures are classed under five main objectives: raising families' purchasing power (via social benefits, wages, taxation or employment); fighting over-indebtedness (by preventive and curative measures); supporting parents; developing alternative measures to children's placement in institutions (by giving more support to host families and to family mediation), improving pre-school facilities (by increasing reception capacities in schools and in childcare services) and, finally, focusing on children at risk in school (through tailored financing of educational establishments, better benefits system, setting a ceiling for school expenses, improving remediation mechanisms and providing additional training for specialised personnel).

3.5. Governance

Coordination of the drafting of the social inclusion chapter is the responsibility of the 'Social integration' administration which is represented on the report's editorial committee, so that consistency between the different strands of the SPSI strategy can be achieved. Two working groups ('Actions' and 'Indicators') are open to representatives of all relevant organisations,

institutions and poor people's associations. The follow-up tools used are to be improved via different channels: the 'Indicators' working group has added to the set of indicators available, even though an serious gap remains with regards to the statistics on immigrants; the introduction of a 'poverty barometer' should also refine the poverty indicators and studies carried out for measuring the impact of decisions taken in the sustainable development area will strengthen the visibility of the poverty aspect too. The Federal Government also wants the target groups to participate more fully and information campaigns are programmed in Flanders and Wallonia as well. However, effective use of feed-back from the target groups and grassroots organisations should be guaranteed. While the will to improve the quality of indicators must be welcomed, a special effort remains to be made, especially with regards to the capacity for making comparisons combining the different objectives and different dimensions of indicators e.g. childhood poverty and housing policy, nationality and education…).

4. PENSIONS

4.1. Key trends

The average age of exit from the labour market is steadily rising (from 59.4 years in 2004 to 61.6 years in 2007); this increase is similar for men and women. The dependence rate should be 26.1 in 2010 (25.9 in 2007), which would be better than the European average (25.9); it is expected to rise to 37.6 in 2030 and 43.9 in 2050. The replacement rate, lower than in France and the EU overall but close to the level in the Netherlands and Germany, remained virtually unchanged in 2007 in relation to 2006 (0.44, i.e. + 0.02 points).

4.2. Key challenges and priorities

Three key challenges were identified: as Belgian pensions are relatively low and the actual age of exit from the labour market, although steadily rising, is still low (a little higher than the EU average for men and a little lower for women), it is necessary to deal with the consequences of a lack of positive budget balance and of the increases in budgetary costs linked to ageing; secondly, statutory pension levels must be raised by adapting the replacement ratio and the calculation mechanisms; thirdly, the rate of cover for pensions from the second pillar must be increased while also increasing contributions. The challenge set out in the 2007 Joint Report to "guarantee the sustainability and adequacy of the pension systems while continuing to reduce the level of public debt and make the systems under the second pillar more accessible, particularly for women" has therefore been achieved only in part: although there was a further drop in Belgium's public debt in 2007 (84.9% of GDP, i.e. -3.3 points), it was not possible to achieve the aim of a positive budget balance in 2007 and 2008 in order to finance the "ageing fund", nor is this expected over the next few years. Furthermore, access to the second pillar has been fostered by a range of measures.

4.3. More people in work and working longer

A number of initiatives have been taken since 2006 to increase the employment rate among people over the age of 50. However, these have resulted in progress which, although tangible (+2.4 points in 2007), was only limited. The aim of these measures is as much to lengthen careers as to generally increase the number of people in employment. A "pension bonus" has for instance been introduced for workers who remain in employment after a certain age (60 or 62, depending on the category of worker) or who have completed a certain number of years in

employment (with variable impacts, depending on the categories concerned); likewise, a tax concession is now granted if workers reach the statutory retirement age before obtaining a pension under the second pillar. Young people are encouraged to enter the labour market more quickly through the allocation of pension entitlements subject to the acceptance of a part-time job or participation in a part-time course. In addition to this, a targeted policy of reducing taxes and social security contributions aims to increase the number of young and older workers. Lastly, the statutory retirement age and duration of working life giving entitlement to a full pension will eventually become identical for men and women.

4.4. Privately managed pension provision

Use of pension schemes under the second or third pillar currently seem to be infrequent: in 2000[7], the premiums represented 1.4% and 3% of GDP respectively (but with very rapid growth in total premiums and in the number of contributors for the third pillar), in comparison to 11% of GDP for pensions from the first pillar. The data needed to judge whether these advantages are evenly distributed throughout the population are not available. One of the challenges set out in the report is to promote second-pillar pensions by improving the coverage rate for employees affiliated to this type of scheme or by exemption – under certain conditions – from social security contributions on the premiums paid (an increase in the level of contributions is, however, also envisaged). Access to second-pillar pensions has in fact already been made easier for the self-employed through the creation of sectoral pension funds. A legal framework in this field adapted to contractual workers in the public sector will eventually also be established. In accordance with the government agreement of July 2007, third-pillar pension schemes should likewise be encouraged and better managed.

4.5. Minimum income provision for older people

The situation of older people is not improving. The risk of poverty among people over the age of 65 is rising (from 21% to 23% between 2005 and 2006); it remains higher than the European average and even higher than in neighbouring countries. The situation of women over the age of 60 is deteriorating and remains worse than that of men; after the age of 75, it is similar for the two sexes but deteriorates in both cases. The difference in the income of people over 65 in relation to the poverty threshold has increased (from 14 to 17% between 2005 and 2006), and their income as a percentage of the median income of people aged 18-64 has fallen (from 0.73 to 0.71). Lastly, the impact of social transfers has weakened (from 19.2 to 14.8%; from 15.3 to 10.7% for women).

The aim of the authorities, reinforced by the will to maintain purchasing power in the context of crisis, is still to guarantee "a sufficient pension income for everyone and pension entitlements which make it possible to maintain a reasonable standard of living after retirement, in a spirit of equality and solidarity within and between generations". Particular emphasis is laid on the need to guarantee universal access to a sufficient first-pillar pension. The improvement of pension benefits is pursued in various ways: minimum pensions and the income guarantee for elderly persons (*garantie de revenu aux personnes âgées*, GRAPA) were last increased in May and August 2008, although in many cases this did not result in these amounts rising above the poverty threshold), simplified eligibility conditions and more favourable calculation mechanisms, an extension of the guaranteed minimum pension benefit

[7] Latest available figures. See *Revue belge de sécurité sociale*, 2003-4, pp. 1077-1112; also: *Revue économique*, National Bank of Belgium, December 2007.

to part-time workers (which above all affects women) and a general upgrading of pensions (in addition to index-linked changes). The pension/work combination has also been facilitated. Pensions are upgraded regularly through their automatic link to the index and through other increases of either a sporadic or structural nature (e.g. the wellbeing bonus). The pensions bonus mechanism for those still in employment over the age of 60 constitutes a further means of boosting pensions. The report also refers to the other specific or improved benefits existing for older people (in terms of care, social assistance or social housing).

4.6. Information and transparency

Efforts continue to improve the "customer focus" of the services offered by the administrative authorities dealing with pensions, among other things owing to an expansion of their clientele to younger population groups. Strategic approaches are taken to clarify users' rights ("Charters"), draw on new information technologies (Website), accelerate the processing of files, improve the quality of information disseminated by traditional means (telephone, post) and propose new services provided on request or automatically (since 2007, a pension estimate has been sent to everyone who is 55 years old).

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Belgian healthcare system is based on a compulsory insurance scheme which forms an integral part of the welfare system. Cover is practically universal, at 99.6% after the extension of cover for self-employed workers on 1 January 2008. Total health expenditure amounted to 10.4% of GDP in 2006, almost 71% of which was public expenditure and 29% private expenditure (patient's share and private insurance). Around 44% of the population subscribed to private insurance in 2005.

Patients are free to choose their provider and have direct access to specialists. Providers are generally remunerated upon provision of the service according to rates set jointly by their representatives, the social partners and the mutual insurance companies. Mutual insurance companies reimburse patients *a posteriori* for medical expenses; however, for a hospital stay or the purchase of medicines, the patient pays only their share, and the mutual insurance company pays the balance directly ("*tiers-payant*", direct billing system).

For many risk groups, the patient's personal share is reduced by the BIM (*Bénéfice de l'Intervention Majorée*, higher rate of state contribution) and the MAF ("*Maximum à facturer*", maximum to be billed) mechanisms. The BIM sets a higher rate of reimbursement of medical services for certain social categories of unemployed people and for households whose annual income does not exceed a certain threshold. The MAF sets a maximum amount (which varies according to household income) of annual expenditure per family on healthcare.

The Federal State has exclusive competence over the compulsory healthcare insurance scheme, but shares responsibility with the regions for the provision of healthcare and public health.

The Belgian strategy is underpinned by three main aims: to expand accessibility (by stabilising and even reducing the patients' share, lowering the price of medicines, improving

provision where necessary, developing special provision for older people and maintaining the organisation of certain preventive measures); to guarantee the quality of care (mainly by establishing new governance tools, heightening the sense of responsibility of medical staff and promoting continuity of care); and to preserve the financial viability of the system (by setting standards, creating a fund, rationalising administrative procedures and encouraging a healthy lifestyle). 2007 and 2008 saw an expansion of the categories benefiting from the systems to reduce the patient's share and cap expenditure; a reduction in the cost of a number of medicines; the strengthening of strategies to achieve a higher return on investments and greater continuity of care; the creation of a fund for the future thanks to the application of budgetary growth standards since 2005; and lastly, following the development of supplementary insurance schemes, the adoption of measures relating to contributions and cover conditions.

5.1.2. Accessibility

Four directions have been taken: the maintenance of a broad, universal compulsory insurance scheme; the strengthening of financial protection mechanisms, particularly in the interest of certain groups; sufficient, appropriate and local healthcare; combating inequalities, particularly through preventive policy. It is imperative for the authorities that the financial sustainability of compulsory insurance be assured and that it guarantee universal access to healthcare. The extension of personal cover for the self-employed is in line with this logic, as is the longer list of insured healthcare: free preventive dental care is now offered to young people until the age of 15 (with plans to increase the age limit to 18). Secondly, although studies indicate rates of unmet needs which are lower than the European averages and decreasing (0.6% of the population declared having postponed care in 2006, in comparison to 1.8% in 2004), worries in relation to maintaining sufficient financial protection mechanisms persist, reinforced by the crisis (purchasing power support). The aim is to reduce the contribution paid by certain categories of patients (reinforced systems to reduce contributions - "BIM" – and to cap expenditure by social category and household - "MAF"; direct billing of doctors' consultations to the mutual insurance company for certain people in economic hardship) and also to provide a universal reduction in expenses (reduction in the cost of certain medicines; ban on certain surcharges invoiced in hospitals). Thirdly, there are regulatory instruments intended to help improve rationalisation and guarantee a geographically balanced availability of general practitioners, specialists and hospital infrastructure, even though the problem of waiting lists is still almost non-existent. Lastly, regarding the combating of health inequalities, tools already in use are being strengthened: greater support for medical health centres, the establishment of "*Relais santé*" in Wallonia, the creation of a network of assistance services, ongoing awareness campaigns, ongoing vaccination or screening operations, and the creation of a Walloon Observatory.

5.1.3. Quality

The measures taken revolve around four aims: to improve the overall efficiency of the system, monitor the quality of services, offer multidisciplinary care and respect the rights and dignity of the patient. Measures which are already in place are being continued rather than introducing new initiatives. However, there is a plan to publish a report for the first time in 2009 on the performance of the health system, and a decision has been made to create a permanent representative cross-section of patients. New awareness-raising campaigns (on the use of antibiotics) have been organised. Lifelong learning for care providers is always encouraged, as is the formalised exchange of information between hospitals ("panel of doctors"). Multidisciplinary care continues to be promoted ("care roadmaps" between

different establishments, the coordination of primary healthcare in Flanders, "health networks" in Brussels). A national plan to combat cancer for the period 2008-2010 has been launched. Lastly, various initiatives exist to guarantee respect for patients' rights when faced with cultural or linguistic barriers. Patient platforms work to improve the life quality of patients and their families, and groups of local residents in Brussels are taking part in health development projects.

5.1.4. Sustainability

According to the Study Committee on Ageing[8], total public health expenditure, which represented 7% of GDP in 2007, should rise to 8.9% of GDP in 2030 and 10.4% of GDP in 2050. Each year, a growth standard for public health expenditure sets the maximum authorised health insurance budget for compulsory care under a number of main headings (out-patient care, hospital care, medicines). This standard was met in 2006 and 2007, which in 2007 made it possible to create a "fund for the future of healthcare". Furthermore, the regulatory framework for supplementary health insurance, group insurance and individual insurance schemes (which are playing an increasing role) has been strengthened by protective measures to control the rise in contributions and guarantee the stability of cover conditions. System durability is also targeted through measures which can be evaluated in the longer term, such as administrative simplification measures or the promotion of a healthier lifestyle: for example, from the start of the 2007 school year, Flemish schools must develop a health policy and smoking has been prohibited in all work areas since January 2006.

5.2. Long-term care

5.2.1. Description of the system

Long-term care is part of the integrated healthcare system. Even though it is difficult to deal with this type of healthcare separately, a differentiated, specific long-term care policy is gradually being introduced. Particular reference can be made here to services which meet specific long-term healthcare needs and services to help patients who have lost their independence.

The provision varies from one community to another, with coordination between federal and community-based structures, and also between the general health services and the long-term health services, for example via the integrated home-care services. Full use is therefore made of the complementarity between the different healthcare providers and welfare services.

5.2.2. Accessibility

The accessibility of long-term care has been improved through better reimbursement conditions and a more diverse provision. Since 2008, a new budget has been created to improve the MAF mechanism to benefit the chronically ill; furthermore, care specific to long-term patients has been added: for instance, the reimbursement of travel expenses for cancer patients was increased as of 1 July 2007; lump-sums for certain types of care have also been increased. The range of available healthcare continues to develop, offering suitable alternatives to hospitalisation as a means of encouraging home care wherever possible: short stays in day centres, family drop-in centres, care circuits and platforms and dependency insurance in Flanders.

[8] 2008 Annual Report

5.2.3. Quality

The quality monitoring of institutions and the training of staff are organised in this field in the same way as for acute care. Follow-up, outcome standards and specific quality benchmarks also exist. A continuous assessment tool has been created: a feasibility study will run until 2009 and will be followed by implementation if the results of this study are positive. The opinions of patients' associations are also surveyed. Lastly, incentives for the long-term patient to stay in work or return to work also help to improve quality.

5.2.4. Long-term sustainability

The 2008 report by the Study Committee on Ageing forecasts that public expenditure on long-term care will increase from 0.9% to 2.1% of GDP between 2007 and 2050. Apart from the need to ensure budgetary scope for manœuvre, the challenge will therefore be to develop a long-term global vision of how to approach the issue of long-term care. Good governance and forecasting tools must be established. The Federal State is helping the Communities and regions to set up alternative forms of care, and also new healthcare functions and new synergies.

6. CHALLENGES AHEAD

It is important for Belgium to focus more closely on populations who are most at risk of exclusion: immigrant populations, the elderly (especially women), children in difficulty at school and single parents (once again, women in particular). Activation policies should include a more proactive approach in the fields of vocational training and lifelong learning.
A better evaluation of housing policy is also recommended in order to ascertain whether the measures adopted are actually helping to better meet the demand from economically disadvantaged populations. An analysis of the financial feasibility of the described measures would also be useful.
Given the poor situation in terms of government deficit in recent years and the economic downturn expected in 2009 and 2010, the budgetary conditions for ensuring the viability of the pensions system should be re-examined. There is a also a case to strengthen measures to encourage the employment of older people and to assess how each pension reform measure helps to fight poverty, in particular among the elderly.
While positive results have been achieved in relation to fostering the rationalisation and continuity of healthcare, a uniform standard of long-term care provided within each Community should also be ensured.

- Belgium is also asked to refine its strategy and monitoring tools, better adapt the measures taken to the objectives set, and improve evaluation tools. Coordination between the actions initiated at each level of authority should also be reinforced and regional disparities should be tackled. The measures to encourage victims of social exclusion and the associations representing them to voice their needs must have a real impact.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,7	125,9	**2000**	60,5	54,7	46,3	29,1	26,3	**2000**	6,9	5,6	8,5	16,7
2005	1,8	119,4	**2005**	61,1	68,3	53,8	27,5	31,8	**2005**	8,4	7,6	9,5	21,5
2008*f*	1,3	114,7	**2007**	62,0	68,7	55,3	27,5	34,4	**2007**	7,5	6,7	8,5	18,8

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	73,5	80,4	14,8	19,3	63,3	66,4	5,9	**1995**	8,2	78,5	n.a.		-
2000	74,6	81,0	15,6	19,7	65,7	69,1	4,8	**2000**	8,6	71,8	23,9	**2005**	0,8
2006	76,6	82,3	17,0	20,6	62.8b	62.8b	3,1	**2006**	10,4	71.4**	20.9d	**2006**	0,5

s: Eurostat estimate; b: break in series; d:change in methodology **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	27,4	43,1	23,6	13,0	8,8	2,7	8,8
2000	26,5	44,1	24,2	11,8	8,8	1,8	9,3
2006	30,1	47,0	25,7	11,9	7,1	2,0	6,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	25,8	25,4	10,4	6,2	0,9
2010	26,1	-0,3	0,0	0,2	0,0
2030	37,6	4,5	4,3	0,9	0,4
2050	43,9	6,3	5,1	1,4	0,9

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
	SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	15	17	13	23	18	18	21	15	3,9	**2005**	15
male	14	-	2	21	19	-	22	17	-	**2006**	14
femal	16	-	13	25	17	-	20	14	-	**2007**	14

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	12,9	13,8	11,5	16,2	**2000**	3,2	2,9	3,5	**2000**	13,6	15	12,3
2004	13,2	13,7	11,3	16,0	**2004**	4,1	3,7	4,7	**2004**	11,9 (b)	8,3 (b)	15,6 (b)
2007	12,0	12,3	10,6	13,9	**2007**	3,8	3,3	4,3	**2007**	12,3	13,9	10,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,74	0,76	0,73	***Aggregate replacement ratio***	0,44	0,46	0,45

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
3	5	-1	DB	5	DC	100	55	16,3	NA	4,25

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Bulgaria

1. SITUATION AND KEY TRENDS

GDP growth reached 6.3% in 2006 and 6.2% in 2007. It will contract following the global financial crisis. Inflation for 2007 was high at 7.6% and is expected to increase further in 2008. The employment rate (15-64) increased from 58.6% (2006) to 61.7% (2007) but remained among the 10 lowest in the EU27. Female and male employment rates increased from 54.6% and 62.8% (2006) to 57.6% and 66% (2007), respectively. Unemployment declined from 9% in 2006 to a record low of 6.9% in 2007 with female unemployment falling from 9.3% to 7.3% and male unemployment from 8.6% to 6.5%. It will pick up again in 2009, reflecting falling output. Long-term unemployment was 4.1% in 2007 (5% in 2006) but remains among the five highest rates in the EU. Against a background of strong economic performance, the at-risk-of-poverty rate after social transfers (total) stood at 14% in 2006, compared with 15% in 2004. Women were more at risk of poverty (16%) compared to men (12%). The poverty threshold in Bulgaria in 2006 (annual basis) was BGN 1999 (€1022). In 2006-2007, population growth continued to be negative, contributing to one of the most unfavourable demographic situations in the EU. In an expanding economy, the GDP share of total social protection expenditure declined from 16% (2005) to 15% (2006). In 2005-2006, old-age social benefits stood at 47.6% of total benefits, while sickness and health care benefits dropped from 29% to 26%. During the same period, employers' social contributions, as a share of total social protection receipts, dropped significantly from 42.4% (2005) to 38.3% (2006), which was offset by an increase from 18.3% (2005) to 19.7% (2006) in the social contributions paid by insured persons and by an increase from 36.1% (2005) to 39.5% (2006) in the share of Government-paid social protection contributions.

2. OVERALL STRATEGIC APPROACH

The report outlines a clear strategy, demonstrating the positive role played by the OMC in policy development and the mobilising effect of setting quantitative targets. It offers a balanced and critical assessment of the achievements. The new overall approach steers policy actions and resources towards well-defined target groups: Roma, people with disabilities, children, elderly, single parent families, inactive persons, people with low educational level and those furthest from the labour market. The long-term priorities in the area of social inclusion are: a) equal participation of groups at risk in the labour market; b) equal access to services to prevent social exclusion; c) social inclusion of the most vulnerable ethnic groups; d) poverty reduction among people outside working age. In the area of pensions, the priority is to raise the standard of living of pensioners. Improving the access, quality and efficiency of services as well as pursuing deinstitutionalisation of long term care (LTC) and support to families with dependent members are the main priorities of the health and LTC strands. ESF co-funded actions are given as an example of coordination between the social protection and inclusion strategy and the Structural Funds. However, the targets of the report are not linked to the implementation of the operational programme, which provides significant resources for social inclusion.

3. SOCIAL INCLUSION

3.1. Key trends

16% of women (17% in 2004) live on a disposable income below the at-risk-of-poverty threshold. For women aged 65+, the at-risk-of-poverty rate stood at 24% (2006) compared with 9% for men aged 65+ in the same year. Another group severely exposed to the risk of poverty are children aged 0-17 years, with a rate of 16%, much higher than the average for the total population. The report points out that without any social transfers the at-risk-of-poverty rate would have been 40.5%. Following the progress on the labour market, in-work poverty stood at 6% compared to 8% for the EU. The share of people in jobless households (total) slightly improved from 11.6% (2006) to 10.2% (2007), but was still above the EU averages, particularly for children. With 12.8% of children living in jobless households in 2007 (9.4% for the EU), Bulgaria belongs to the group of countries where child poverty is above the EU average and where children have a significantly higher risk of living in poverty than the overall population. In 2007, half of all children aged 0-17 years and living in jobless households were living in a typical 'couple with children' household. The percentage of early school-leavers (total) improved from 18% in 2006 to 16.6% in 2007, as against 14.8% in the EU (2007). Nevertheless, increased economic opportunities have not translated into a significant reduction in poverty and better school integration for all.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

In 2006, the Government put forward twelve quantified targets for 2008 which form a holistic approach:

Employment: targets were achieved, with employment exceeding the target by 1.1 percentage points, while unemployment was already down to 6.9% in 2007 as against the target of 9% for 2008. Social inclusion and education: the target was to halve the number of pupils in mandatory school age dropping out of school, from 20% in 2006, but the recorded performance in 2007 showed an increase. It is not, however, possible to fully assess the progress made in increasing the number of persons from vulnerable groups in vocational training, set to increase by 20%, despite the many initiatives undertaken in this field. Even if the report states that many other targets are met on the basis of administrative data, the lack of statistically validated national aggregated data does not allow progress to be objectively assessed in terms of: i) increasing by 15% the number of children with special educational needs in mainstream and professional schools; ii) increasing by 20% the number of persons receiving social and health services within the community; iii) increasing by 10% the number of Roma schoolchildren taken out of segregated schools; iv) decreasing by 10% the number of persons in specialised institutions.

Overarching objective: An increase of at least 15% in total household income seems to be on track, as the Government reports an increase of 10.6% in household income in 2007 as against 2001. For the second overarching objective set in 2006, the Government reports an increase of 9.9% in the real growth of income from pensions for the last two years, compared with the target of 5% per annum. The minimum wage in 2008 rose to BGN 220 (€112). In addition, over the period 2006-2008 the Government continued its policy of lowering social contribution (including pension contribution) rates and introduced a flat 10% income tax.

The effect of these measures on low-income households and poverty reduction is likely to be neutral. As these measures were introduced recently, their future impact assessment will indicate their contribution to poverty reduction. Children and women, as well as people above 65, remain highly exposed to poverty even in an overall economic environment generating more and better opportunities.

Regarding the 2007 challenge to improve the quality of care in institutions, progress has been made and new strategic documents adopted (the National Strategy for Children). However, fragmented competences[9] between the central authorities supervisory tasks and the local authorities management responsibilities over the institutions for people with disabilities, the poor interaction between the health care system, the social inclusion and protection arrangements and the education system and the proliferation of project-based activities with weak policy and institutional coordination need to be addressed in order to further boost progress in this area.

3.3. Key challenges and priorities

The new strategy has four policy objectives:

– Limiting the inter-generational transmission of poverty and social exclusion with a focus on child poverty (objective A);

– Active inclusion of those furthest from the labour market (objective B);

– Equal opportunities for the most vulnerable groups (objective C);

– Better governance of social inclusion policy (objective D).

The new objectives have a stronger focus on poverty reduction and on particular vulnerable groups and their formulation corresponds to the main challenges. Although the issue of quality improvements in the provision of institutional and community care, identified as a challenge in the 2007 Joint Report, is mainstreamed within policy objectives A and B, it would have been justified to make it a separate policy objective in light of the critical developments and weaknesses in 2007 concerning institutional care for children with disabilities. The report adds many new measures without, however, outlining the priorities, critically assessing their institutional feasibility and the challenges to deliver. The State budget and the ESF co-funded operational programme will be the main sources of financing, but there are no specific financial allocations per objective/group of measures to indicate their financial importance and relevance.

3.4. Policy measures

For each of the four policy objectives outlined above, policy measures are planned for 2008-2010:

Objective A:

[9] The Law on Social Assistance and its implementing rules subordinate the implementation of the quality assurance recommendations of the central supervisory bodies (Agency for Social Assistance and State Agency for Child Protection) for closing of institutions and of social services to a decision of the municipal council-owner of the specialised institution.

This objective will be pursued in conformity with the National Strategy for Children 2008-2018 and comprises 6 main strands: 1) creation of an appropriate family environment, including foster care; 2) access to quality pre-school preparation; 3) access to quality health services; 4) de-institutionalisation; 5) protection of children from abuse and violence; 6) improved institutional capacity for child protection.

Concrete measures have been taken and new are planned within the overall commitment of the Government to de-institutionalisation and to improvements in the quality of social services for disabled children in institutions and in the community. Although the legislation allows the placement of children with in-born disabilities in institution as early as 0 years of age, the Family Code was amended to facilitate their adoption.

Objective B:

This objective targets young people in vulnerable situations, persons of working age on social assistance, persons with low or outdated education and skills, illiterate persons and inactive or discouraged persons. Labour market inclusion measures are part of the national employment plan and include subsidies for the labour costs of employers, public employment programmes, educational and vocational programmes, and literacy courses.

The Government is aware that some social groups are excluded from the increased economic opportunities. However, the design of some targets (number of persons living on social assistance) takes no account of their potentially adverse impact on low-income households in term of poverty reduction. In a period of economic slowdown and increasing unemployment, increasing the conditionality of access to an already low level of minimum income support (below the poverty line) would run counter to the political objective of social inclusion.

Objective C:

Some of the measures are part of the National Action Plan for the 'Roma decade'. Additional attention will be given to the effective implementation of anti-discrimination law, the development of integrated services and the acceleration of desegregation in education and others. The National Strategy for Equal Opportunities for people with disabilities 2008-2015 will be implemented through monitoring of accessibility, encouragement of social entrepreneurship among disabled people, increased funding of social services for people with disabilities, better mainstreaming of disability issues in the media, creation of 'sheltered jobs', and other measures. The report also refers to the introduction of paternal leave and the preparation of a methodology to detect gender differences in pay and to other measures.

Objective D:

The main action is the development of a long-term strategy for social inclusion with a focus on poverty. This will address the long-term challenges, while the three-year NAP for social inclusion under the OMC will deal with the emerging short- and medium-term challenges. There are plans for a new high level consultative body on social inclusion, composed mainly of state officials. Civil society organisations will participate in a separate consultative body together with central, regional and local officials.

The report mark important steps forward in the area of social inclusion governance. The broad nature of the policy objectives and the references to existing but as yet unevaluated strategies highlight the need for improving the links between overall policy formulation and the design

of concrete implementation instruments. The use of quantitative analysis, particularly in areas such as Roma inclusion and policy for people with disabilities, could be very helpful in developing evidence-based policy making.

The Government set the following targets for 2010 (baseline: 2007) which are inter-linked across sectors and could be presented as follows:

At-risk of poverty: maximum 15%; decrease in at-risk-of-poverty rate among children: 15%; 10 percentage point decrease in at-risk-of-poverty rate among households with three children; 20% increase in average household income.

15% early school-leaving rate; 100% net enrolment in primary education and in pre-school education; doubling of the number of children with special educational needs in general and vocational schools; 30% increase in the number of Roma pupils taken out of segregated schools.

15% fewer children using social services in institutions; doubling the number of children at risk placed in foster families; 50% increase in social services offered within the community;

66.5% employment rate for the 15-64 age group, 60% for women, 27% for persons aged 15-24; 12% youth unemployment rate; 3.5% long-term unemployment; reduction of 2 percentage points in the share of persons with disabilities in overall unemployment; max. 10.5% of children living in jobless households; share of persons living in jobless households: 8%; 20% fewer persons living on social assistance; share of social expenditure in GDP: 17%.

3.5. Governance

The preparation of the current strategy marks a significant improvement in the consultation process. The Government launched an internet consultation on the draft strategy, giving the public the opportunity to react. The 2008-2010 strategy includes an analysis of the governance of social inclusion policy and outlines a plan for action, including the strengthening of the professional capacity of those involved in the design and implementation of social inclusion policies at central and local levels, the creation of a national consultative body on social inclusion, and improvement of the system for monitoring indicators. However, there is further scope for similar analysis concerning the other strands and for better policy coordination. Similarly, the strategy mentions the prevention of child abandonment and violence against children, but no concrete measures are outlined to improve the interaction between the hospital and social services to support the parents of children with disabilities. While it is encouraging that the Government has set quantified targets, there is a need for better coordination between the different national policy strategies. The strategy for life-long learning adopted in October 2008 set a target of 12% for early school-leaving in 2013, whereas the ESF aims to reduce this rate to 13% in the same year.

4. PENSIONS

The pension system comprises a mandatory public scheme (PAYG), a compulsory funded, defined-contribution scheme, where contributions are accumulated and capitalised in individual accounts, and a voluntary scheme. Pension contributions are calculated on the basis of 'insurable income', which is determined by the main economic activities carried out. While the minimum wage for 2008 was BGN 220 (€112), the minimum insurable income was BGN 240 (€122). The maximum insurable income ceiling was BGN 1400 (€716) in 2006/07

and BGN 2000 (€1022) in 2008. In some cases, employers pay social security contributions on the minimum insurable income and not on real wages.

In 2006, the overall social security contribution rate was reduced by 3% and, in 2007, by 6%, which led to a 6% reduction in the PAYG contribution rate followed by an additional reduction of 2% in 2007. As a result, at the end of 2007, the public pension contribution rate stood at 22% (32% in 2000). While in 2005 the ratio between employer/employee contributions was 70:30, it changed to 60:40 in 2008, reflecting the transfer of the insurance burden. The current retirement age is 63 years for men and 59.5 years for women, with the latter due to rise to 60 years in 2009.

4.1. Key trends

In 2007, some 2.23 million people (29% of the total population) came under the public pension scheme, 2.8 million people (37% of the total population) were insured in the mandatory funded scheme and 592 805 (7.7% of the total population) in the occupational schemes. The mandatory funded scheme comprises two types of pension funds: universal and professional. They will start paying out benefits in 2020 for the former and in 2011 for the latter. In 2008, the contribution rate for the funded scheme was raised from 4% to 5% (3% in 2006), shared between the employer (60%) and the employee (40%). Self-employed persons pay 100%.

The main public pension is called 'insurance and old-age pension'. At the end of 2007, the average monthly amount was BGN 177 (€91) and the minimum amount BGN 102.85 (€52.5). Approximately 30% of retirees receive pensions below BGN 120 while 54.5% receive BGN 160, thus indicating significant differences within the public pension scheme, attributable to differences between the lengths of periods of affiliation and past insurable income basis for paying contributions.

A particular feature of the public pension scheme is the inequality between different age cohorts: people aged 80 years+ (14% of the total) received, on average, individual pensions of BGN 139 (end 2007), people aged 70-79 years received 15% more, and people aged 60-69 years old 24% more. This age-related inequality is due to the methodology for setting pension levels, introduced after the entry into force of the social security arrangements in 2000, and to the fact that older pensioners were insured on a lower income basis compared to those who retired after 2000.

Public pension expenditure in 2007 increased by 11% compared to 2006. The GDP share of public pensions was 8.27% in 2007 (national data), and is projected to decline to 7.11% in 2027 but to increase again to 14.6% in 2050. Key trends for 2007-2008 also include the lowering of corporation tax from 15% to 10% and the introduction of a flat income tax rate of 10% as of 1 January 2008.

4.2. Key challenges and priorities

Long-term financial sustainability is a key challenge, as the public pension system is projected to be in deficit for the next 42 years. A law establishing a demographic reserve fund was consequently adopted in 2008. It will accumulate reserves over ten years from 90% of all privatisation revenue and 25% of any budgetary surplus. The fund can only be used to keep the public pension scheme in balance, and its future investment policy needs to be carefully chosen in view of the current financial crisis.

Pension adequacy is an ongoing challenge. Despite pension increases, the public continues to perceive pensions to be low. Public confidence in the pension system could be strengthened if pension adequacy is improved, which in turn will encourage people to refrain from grey non-contributory economic activities and to enrol in voluntary pension funds. To respond to this challenge, a reform was introduced in 2007 so that public pensions granted by the end of the previous year are indexed each following July to ensure an increase equal to 50% of the increase in the consumer price index and 50% of the growth in average insurable income (gross salary). For 2006, the aggregate total replacement rate was 60%, with a significant gender difference: 62% for men and 58% for women[10]. The projected theoretical replacement rate for the PAYG scheme will decline significantly to reflect the transfer of part of the public pension contribution to the funded scheme (second and third pillars), where the replacement rate will gradually increase. Over all an increase in net theoretical replacement rates is expected with 15 percentage points between 2006 and 2046. The long-term challenge for the mandatory pension pillars will be how to address the issue of old-age poverty and how to ensure decent living conditions for older people, whose share in the total population is growing. Old-age dependency ratio in 2010 will reach 25.3 and will increase to 36.3 in 2030 and to 43.6 in 2040[11].

Improving adequacy and financial sustainability calls for more social security revenues. Eliminating the maximum ceiling on insurable income could bring in resources from the higher income deciles. Limiting the abuse of paying contributions on the minimum wage level in the private sector could also improve social security revenues. As an example, in 2006 the real annual growth of the average wage was 2.11% while the growth of insurable income was only 0.34%. Therefore, the policy of reducing social contribution rates needs to be reassessed against the artificially low levels of minimum insurable income on which rates are based. Another key challenge is the inclusion within the social security scheme of some 350,000 persons not paying social security contributions.

4.3. More people in work and working longer

Employment rates for older workers (55-64) stood at 39.6% in 2006 and improved to 42.6% in 2007 (EU averages: 43.5% and 44.7%). The average retirement age in 2006 was 67.7 years. However, the average age for first-time pensioners in the same year (new pensioners) was as low as 54.9 years. This results from the transitional arrangements still in force under the 2000 social security code for early retirement. In order to encourage longer working lives, each additional year of working after reaching the minimum of 37 contributory years for men and 34 for women will count for 3% (previously 1%) in the pension formula. As of 2009, each additional year of working beyond retirement age will count as 5 contribution years. The increase in the long-term unemployment rate (65% in 2005 and 68% in 2007) for people aged 50+ is a particular challenge if pension adequacy is to be ensured for this group. Unemployed persons over 50 years of age are enrolled in subsidised training and employment programmes in order to increase their employability. The ESF will support a special programme for active labour market measures targeting an additional 18 000 unemployed persons over the age of 50.

[10] BG national Household budget survey (2006), income data 2006

[11] Eurostat (2008) Convergence scenario.

4.4. Privately managed pension provision

Private pension provision is based on voluntary contributions to private pension funds. Pension entitlements start at the same retirement ages as for the public pension scheme. Contribution rates are fixed in individual contracts. People are entitled to change funds against a fee and to receive a lump sum or a pension at a fixed age. Private pension funds are supervised by the National Financial Supervision Commission (NFSC). Only 42% of all privately insured persons are women and their acquired rights are less then those of men. According to the NFSC, the overall profitability of the private pension funds declined in 2008. A detailed analysis of their investment policy shows that between 2006 and 2007 they reduced their share of government bonds and banks deposits but acquired more risky assets such as commercial bonds, shares and equities.

4.5. Minimum income provision for older people

Minimum income support for older people exists in the form of the 'social pension for the elderly'. While the 'individual insurance and old-age pension' is set each year under the law governing the public social security budget, the 'social pension for the elderly' is decided by the Council of Ministers. As of 1 October 2007, it was BGN 76.23 (€39) per month or 42% of the monthly minimum wage for 2007 (BGN 180). At the end of 2007, 24.5% of all pensioners received various types of minimum pensions.

4.6. Information and transparency

All contributors to pension funds receive a yearly individual report on their acquired rights in a personal account showing the financial gains and the balance, and can ask for the annual financial report of their fund and for information about the fund's investment policy. They are also entitled to complain to the NFSC or to contact its call centre. Despite these legal requirements, there is a need to raise awareness about the importance of social security coverage, particularly among younger generations.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

The health care system is financed by mandatory contributions to the National Health Insurance Fund (NHIF), central government funding, voluntary health insurance with private health insurance funds, and co-payments from patients. General practitioners (GP) are mainly paid on a capitation basis under a collective framework contract with the NHIF. Secondary health care providers (public and private hospitals or collective practices) are paid partially by the NHIF for particular medical services (clinical pathways) and by the State budget for well-defined types of medical services.

5.1.1. Health status and description of the system

Life expectancy at birth for 2006 was 72.7 years (76.3 for women and 69.2 for men), showing a large gap with the EU benchmark and a marginal increase since 2004. Between 1986 and 2006, life expectancy at birth increased by only one year (1.2). Infant mortality was 9.2 in 2006 (11.6 in 2004), but remained the second highest in the EU. Leading mortality causes are cardio-vascular diseases (65.8%), cancer (15.9%) and respiratory diseases (4%). According to national data, disability-free life expectancy was 52.5 years for men and 66.8 for women in

2002. The report underlines a general negative trend affecting the health of pupils. Although aggregated statistically validated national data are not provided in the report, the Government emphasises the poor health status (shorter life expectancy at birth and communicable diseases) of the Roma population. According to the report, there are 260 000 persons recognised as disabled, of whom only 13% are in paid employment. People with disabilities face infrastructure barriers in accessing medical facilities, as well as limited capacity to provide expertise on disability issues.

5.1.2. Accessibility

The Government has developed a National Health Strategy seeking to ensure the financial sustainability and efficient and effective delivery of accessible good-quality health care services for the period 2008-2013. Health insurance covers mainly primary and hospital health care services. Some 5128 primary health physicians have a contract with the National Health Insurance Fund. Significant geographical disparities exist: 17.8% of primary health practices in less developed regions are unoccupied. 328 hospitals deliver hospital health care, of which 145 are general, 137 are specialised and 46 are dispensaries. 77% of these facilities are public (state and municipal property). Patients' access to specialised medical services is subject to prior authorisation from their GP on the basis of a limited number of 'tickets' allocated by the NHIF, an arrangement limiting the access to specialised services. In 2007, the number of hospital beds increased by 1608, of which 68% were in private hospitals. In 2007, the ratio of beds per 10 000 persons was 59.5. However, the ratio for long-term treatment and care stood at 8.16/10 000 in the same year. The report underlines the persistent problems of access to emergency care.

5.1.3. Quality

The quality of health care services varies across the country and needs substantial improvements in non urban areas. In addition to the existing system for the accreditation of medical facilities independently of the Ministry of Health, a system for medical audits and monitoring will be established by an executive agency tasked with developing uniform criteria for assessing the efficiency and effectiveness of health care services.

5.1.4. Sustainability

Total health expenditure as a share of GDP was 7.7% in 2005. Total public health expenditure stood at 4.2% of GDP in 2007. Per capita health expenditure in 2006 was €132 (national data). Recently, the health insurance contribution was increased from 6% to 8%. Co-payments for health care services (official and unofficial) were between 20-40% of public health expenditure in 2006 and play an increasing role in a health care system suffering from under-financing. In this context, a significant proportion of paid health contributions is retained as a reserve outside the financing of the health system for which they were collected. The share of NHIF health care financing in total health expenditure rose to 66% in 2007, indicating a gradual increase in insurance-based health care financing. The central budget finances the regional health surveillance authorities, 12 psychiatric hospitals, 32 institutions for the long-term care of children, 28 centres for emergency health services, 63 haemodialysis centres and 4 regional blood transfusion centres. It also finances vaccination, expensive pharmaceuticals, prevention and health promotion activities at national level, medical care for uninsured pregnant women as well as capital investment and purchase of equipment in publicly owned hospitals.

The number of people with no health insurance is estimated at 1 million. The health care system continues to be under-financed given the needs for capital investment and renewal of medical technologies. At the same time the health care system continues to be unreformed with excessive hospital capacity. The lack of effective monitoring and spending control mechanisms highlights the need to progress with the implementation of an effective IT system both in the outpatient and inpatient care in order to enhance transparency and accountability of health care spending. Improved medical and continuous vocational training of general practitioners will contribute towards reducing undue referrals of patients to secondary health care services. In terms of human resources, the ratio of physicians per 10 000 people was 36.5/10 000 (medicine) and 8.4/10 000 (dental medicine) in 2007. Anaesthetics, emergency care, paediatrics, nephrology, gynaecology, radiology and psychiatry are experiencing a shortage of physicians. Only 1.7% of primary health care physicians hold a degree in 'general medicine'. The drop in the number of nurses is a major concern, and the ratio of physicians to nurses went down to 1/1.2 in 2007, a record low for the EU.

According to the report, improving financial sustainability should include better collection of contributions, a higher health contribution rate, increased public health expenditure, a methodology for setting costs per medical intervention, better negotiations between the NHIF and primary physicians (national framework contract), a new compulsory complementary health insurance, and tax rebates encouraging the take-up of voluntary complementary health insurance. Although these proposed measures should improve the overall sustainability and accessibility of health care services, there are no specific mechanisms to limit income inequalities in access to health insurance outside the package of services provided by the NHIF.

In the context of falling profitability in the insurance industry, the NHIF should remain a solid central pillar of the health system while the introduction of mandatory complementary health insurance should be reassessed.

5.2. Long-term care

5.2.1. Description of the system

Formal long-term care (LTC) is offered mainly in specialised institutions owned by line ministries (in the case of services for children 0-3 years old) or by municipalities (in the case of care for the elderly or adults with disabilities) and in community based social services (day care centres, protected housing, centres of social rehabilitation). These facilities are financed through earmarked grants from the state budget to the municipalities and fees for services. Other types of institutions include facilities for physiotherapy and recovery from chronic illness. Few LTC facilities are run privately. The services provided by 'social' or 'personal' assistants are part of formal care provision. Informal care is provided within families to meet the needs of the elderly and people with disabilities. There are no studies or estimations of the magnitude of informal care.

5.2.2. Accessibility

Over the period 2006-2007, 30 new protected homes were established. By the end of 2008, 12 new day facilities will add to the existing 21 facilities for elderly people. The European Social Fund is a major contributor to the expansion of 'social' and 'personal' assistant services. The de-institutionalisation agenda, which has been developed nationally after successful pilot initiatives, includes an increasing supply of community-based services (day centres, protected

homes, and centres for social rehabilitation) as well as a 9% decrease in the number of adults in institutions. These services also improve overall accessibility, an important objective of the LTC strategy.

5.2.3. Quality

Central supervisory institutions perform quality assessments and issue recommendations to the LTC providers. However, local authorities have full legal and financial powers over the facilities they own. They are also employers of the staff working in the facilities. The recommendations of the supervisory bodies concerning the quality of care, including proposal for closing of specialised institutions or of social services, need a decision of the municipal councils to be implemented. In the previous Joint Report, Bulgaria faced a particular challenge in achieving an overall improvement in community-based services and the quality of institutional care. In 2007-2008, the quality of institutional care for children with disabilities was reviewed by the Government in the light of serious weaknesses in the quality control and surveillance of institutions for abandoned children. An action plan was designed, some facilities for disabled children were closed and others are to be restructured[12]. A common methodology for calculating the minimum staff requirements for LTC institutions was prepared along with training master plans. The Government also launched a third national monitoring exercise to examine specialised institutions for people with disabilities, which resulted in 29 institutional plans for development.

The quality of LTC facilities could be significantly improved by better surveillance, enhanced staff skills and better division of competences between the central supervisory bodies and the municipalities. There is a strong need for better governance and funding of the decentralisation of social services. Improved interaction between the health and long-term care systems, particularly with a view to preventing institutionalisation, could advance the overall de-institutionalisation policy.

5.2.4. Long-term sustainability

Long-term care expenditures stood at 0.17% of GDP in 2005, a figure among the 5 lowest in the EU. Measures were developed for introducing common standards for the financing of social services, which has led to increased provision of the most commonly used social services such as day care centres for elderly people, LTC homes for the elderly, centres for social integration, protected homes, and personal and social assistants. However, there are no indications that private investment in this sector is growing. The state budget remains the main source of financing for the tasks delegated to municipalities, which they co-fund. There are also modest fees paid by users on a means-tested basis. Private social services are paid for by users on a contract basis. Although regional strategies exist for the provision of social services, small municipalities are dependent on central budget financing to fund social services. Many of the social services (personal and social assistants) are provided by unskilled persons and are used to pay a salary to a family member. The low economic added value and social recognition of these services are factors restricting their development as a genuine economic sector.

[12] http://www.mlsp.government.bg/en/index.htm.

6. CHALLENGES AHEAD

- To monitor the effects on low-income households of the conditionality of access to minimum income in terms of social inclusion and school integration. To this end, to undertake studies of vulnerable communities in order to monitor and critically evaluate whether policies correspond to real needs and to adjust the ESF programmes accordingly.

- To continue undertaking measures to increase social security revenue in order to improve the adequacy of pensions and the sustainability of the pension system by eliminating the abuse of paying contributions on the minimum wage as well as to include high wages in the insurance base and by facilitating longer working lives.

- To improve long-term forecasts for all social security branches, including health insurance, in order to set consistent contribution rates and avoid divergent rate changes in individual branches, thus improving the predictability of the overall social security burden and the consistency among policy measures in different policy strands (health, education, social inclusion, pensions and LTC).

- To assess the impact of introducing mandatory complementary health insurance in the context of unstable financial and insurance markets and improve access for all income groups to health care services through reforms seeking better efficiency in the delivery and coordination of primary and secondary health care services.

- To review and strengthen the coordination between health care and LTC systems and the relevant legislation in order to reinforce the follow-up of quality monitoring and to make the recommendations of the supervisory bodies fully executed by the providers of the LTC facilities. To this end, to make better use of the ESF to fund appropriate continuous training of staff working in long-term care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5,4	27,8	**2000**	50,4	54,7	46,3	19,7	20,8	**2000**	16,4	16,7	16,2	33,7
2005	6,2	34,5	**2005**	55,8	60,0	51,7	n.a.	34,7	**2005**	10,1	10,3	9,8	22,3
2008*f*	6,4	38,5	**2007**	61,7	66,0	57,6	n.a.	42,6	**2007**	6,9	6,5	7,3	15,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	67,1	74,6	12,5	15,2	n.a.	n.a.	14,8	**1995**	n.a.	n.a.	n.a.		-
2000	68,4	75,1	12,8	15,4	n.a.	n.a.	13,3	**2000**	6,2	58,7	40,9	**2005**	n.a.
2006	69,2	76,3	13,2	16,3	n.a.	n.a.	9,7	**2006****	7,7	60,6	38	**2006**	n.a.

s: Eurostat estimate; p: provisional

**THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	25,0	n.a.	n.a.	n.a.	n.a.
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2010**	25,3	n.a.	n.a.	n.a.	n.a.
2006	15	52,9	26	2,2	7,4	2,5	9,1	**2030**	36,3	n.a.	n.a.	n.a.	n.a.
								2050	55,4	n.a.	n.a.	n.a.	n.a.

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	14	16	12	18	18	22	18	14	**3,9**	**2005**	14
male	12		12	9	18		19	8	-	**2006**	n.a.
femal	16		12	24	17		18	16	-	**2007**	n.a.

	People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	19,0	17,3	16,8	17,8	**2000**	9,4	9,6	9,2	**2000**	n.a.	n.a.	n.a.
2004	15,6	13,7	13,2	14,2	**2004**	7,2	7,3	7	**2004**	21,4	20,7	22,1
2007	12,8	10,2	10,1	10,3	**2007**	4,1	3,7	4,5	**2007**	16,6	16,9	16,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	n.a.	n.a.	n.a.	***Aggregate replacement ratio***	n.a.	n.a.	n.a.

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
15	15	15	DB/DC	/	-	n.a.	/	n.a.	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Czech Republic

1. SITUATION AND KEY TRENDS

Economic growth reached 6% in 2007 (with GDP per capita at 80.2% of the EU average) but is projected to slow down to about 4.2% in 2008 and 1.7% in 2009. The open Czech economy is affected by the deteriorating situation of its main trading partners, and thus a fall in external demand has already had a negative effect on the export-oriented industrial sector. The unemployment rate is projected to rise. In 2007, the total employment rate of 66.1% was above the EU average, as was for older workers at 46% (55-64 cohort). The female employment rate (57.3%) has been increasing more slowly than the EU average (58.3%) and for the first time fell behind. The employment rate among the 15-24 age group increased to 28.5%. The unemployment rate (total 5.3%; men 4.2%; women 6.7%) has decreased substantially. Youth unemployment has fallen even more to 10.7% (2005: 19.2%), and for the first time is considerably lower than the EU average (15.3%). Long-term unemployment (2.8%) also dropped below the EU average, except for women (3.6%). On the other hand, activity rates have decreased (69.9% in 2007) with a significant difference between men (78.1%) and women (61.5%).

The at-risk-of-poverty rate is one of the lowest in the EU (2007: 10%)[13], but the threshold is one of the lowest as well. A higher poverty rate for children (16%) remains a problem, together with gender differences increasing with age. The fertility rate has been slightly increasing (2006: 1.33) but is still one of the world's lowest. The Czech Republic is projected to face rapid ageing: the old-age dependency ratio was 20.6% in 2008 but could reach 54.8% by 2050. Life expectancy at birth was 76.8 years (2006: men 73.5, women 79.9), below the EU average but increasing. Healthy life expectancy (2006: men 57.8, women 59.8) was below the EU average as well. Social protection expenditure was 18.7% of GDP in 2006, lower than the EU average, but projected growth based on 2004 figures is 7.1% by 2050. Of these, expenditure on pensions was 43.1% and on sickness and health care 34.4%.

2. OVERALL STRATEGIC APPROACH

The point of departure of the Report is that the social protection system is able to guarantee a low level of poverty and prevent social exclusion, but population ageing will negatively influence public finances and long-term sustainability, so there is a need for reform of pensions and health care. Social inclusion should be supported by the activation of people at risk of social exclusion by improving their social skills and employability, and by preventing and tackling inter-generational social exclusion. The first approved stage of the pension reform includes an increase in the retirement age and period of insurance and further attention will be paid to the private insurance. The main health and long-term care priorities focus on better health status of the population, sustainability, quality, integration of health and social services, modernisation of health insurance, and more investment in the long-term care sector. The main challenges are almost identical to those for 2006-2008, though with less attention paid to adequacy of social protection, access to health care and health inequalities.

[13] Source: EU-SILC (2007); income year 2006.

The sustainable development perspective is not evident, but the link to the Lisbon strategy is present. There was quite strong economic growth and falling unemployment, to some extent supported by social policies. Flexicurity is receiving more attention but mostly in the form of work incentives (restricting social benefits). In contrast, growth and jobs policies did not significantly contribute to social cohesion, as the main focus has been on stabilising public budgets. Child poverty has remained an important issue and the most disadvantaged groups have not profited much from economic growth. Gender equality and mainstreaming are neglected in the report as a whole. Therefore, a balanced, comprehensive approach to active inclusion, including adequate incomes, and efforts to ensure synergies between actions across the three pillars would be welcome. The Structural Funds along with the state budget will play a significant role in financing the majority of the report's objectives. The mainstreaming of social inclusion is still unsatisfactory, coordination is rather formal and public awareness is low. Pension reform is being discussed at the political level and with social partners, and cooperation on health care reform could be improved.

3. SOCIAL INCLUSION

3.1. Key trends

The Czech Republic has one of the lowest at-risk-of-poverty rates (10%) in the EU, but the threshold is one of the lowest as well, amounting to only €3251 (EU-25: €8368) per one-person household per year and €6828 (EU-25: €17573) for two adults with two dependants. The group below the threshold of 40% of median income is very small (2%), and there is a very low proportion of poor older people (65+ age group: 5%) due to the regular adjustment of pensions. Women (10%) are more at risk of poverty than men (9%), and the difference increases with age (65+ age group: women 8%, men 2%). Child poverty is quite high (16%), even if below the EU average. In addition, the at-risk-of-poverty rate of groups most at risk of poverty is higher than the EU average: the unemployed 48% (EU 42%), single-parent families with at least one child 37% (EU-25 34%) and households with three or more children 29% (EU-25 24%).

The number of people in jobless households (8% for children aged 0-17 and 6.5% in the 18-59 age group) is lower than the EU average. The rate of in-work poverty (3% for full-time workers and 4% for part-time workers among the18+ group) is also significantly lower than for the EU-25 (7% for full-time workers and 12% for part-time workers). The unemployment trap and the inactivity trap were 84% for an one-earner + 2 children family (at 50% of the average wage level), the low-wage traps were 53% and 50% (for 33-67% and 67-100% of the average wage level). The employment rate gap between persons born inside and outside the country was even negative -2.3% (2007). The role of social transfers (excluding pensions) is significant: without transfers, 20% of the population as a whole would fall under the poverty line, including 31% of children and 19% of people aged 18-64. The net income of social assistance recipients was 60% of the at-risk-of-poverty threshold for single persons, 80% for lone parents with 2 children and 80% for couples with 2 children. There is a lack of child care provision (only 2% of children below the age of 3 are cared for under formal arrangements as against the Barcelona target of 33%) and a large employment gap between women with and without children (60% as against 76%).

The situation regarding educational achievement is positive: low educational attainment is well below the EU average for all age groups, for example for the 25-64 age group it was 9.8% in 2005 (EU-25: 30.5%). Youth educational attainment (20-24 age group) is the highest

in the EU, with 91.8% having completed at least upper secondary education in 2007 (men 91.3%, women 92.4%). The number of early school-leavers is very low (5.5% in 2006).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Assessing progress is complicated by the lack of data and quantified targets, few indicators and the omission of goals used in the 2006-2008 Report. The strategy is long-term and oriented to developing social services as a tool for social inclusion. Therefore, there has been only partial progress and the previously identified challenges are still valid. Overall, priority was given to decreasing social expenditure and promoting active inclusion. Thus - although the concept of active inclusion still mainly focus on active labour market policies - the system of social benefits was reformed to ensure more directness and motivation for the unemployed to enter the labour market (in January 2007, the subsistence minimum, the criterion for claiming social benefits, was complemented by a new, lower living minimum for those unwilling to cooperate with the labour offices). Moreover, automatic adjustment of the subsistence minimum in line with inflation was abolished in January 2008.[14] There was a significant tax reform in 2008: a flat-tax on personal income was introduced and the lower VAT band was increased. As a result, inflation has risen and a negative impact on income distribution is possible.

The Social Services Act (2007) introduced a specific care allowance to give persons in need of care a free choice to purchase services. However, the system is very costly, one problem being the possibility to spend the care allowance outside the social services system, and there is still no evidence of any improvement in quality and accessibility. The amendment of the Schooling Act now also guarantees access to basic education for all children of foreigners. Regarding the challenge concerning the most disadvantaged groups in the 2007 Joint Report, the Agency for Social Inclusion in Socially Excluded Roma Localities has been created and social field work has been ongoing, but its impact on the living conditions of the Roma is still only marginal. Almost no progress has been achieved in the social economy. Regarding the challenge of implementing social inclusion at regional/local levels, not much has been achieved, apart from more frequent use of community planning of social services (186 municipalities are involved, the target was 200). The objective of decreasing poverty in single-parent families with children was partly achieved as the at-risk-of-poverty rate decreased from 41% to 37%. The ESF has already contributed substantially to social inclusion, especially by supporting employment and social services.

3.3. Key challenges and priorities

The priority objectives of the current report are similar to those for 2006-2008 and respond to the challenges identified by the 2007 Joint Report; they target the most disadvantaged groups, families and governance. The priorities take into account that the poverty rate is low and concentrated among some population groups and that social protection systems face a financial sustainability challenge. Mainstreaming social inclusion, especially at regional/local levels, continues to be considered important. In principle, the strategy will follow already established pathways and its focus on developing social services and decreasing social

[14] On the other hand, since January 2007 housing expenditure has been taken out of the subsistence minimum and the normative expenditures used for the calculation of housing benefit have been twice adjusted for inflation

welfare dependency has even been strengthened, thus putting aside the issue of adequacy of social benefits and active employment policies, which are considered only in relation to the NRP 2005. This is unfortunate because unemployment is the main reason for poverty. More attention could be paid to broader aspects of child poverty. Reliance on the ESF is substantial, but the full potential of the Structural Funds is not exploited and there is little connection with the ERDF investment programmes, although they aim to finance infrastructure for education, social, health services, development in socially excluded localities, etc. The priorities do not take into account gender equality issues, particularly the gender differences in poverty.

3.4. Policy measures

.The first priority aims to increase the integration and labour market participation of socially excluded persons through the social services; coordination with other policies is limited. The focus is on the most disadvantaged groups, such as the long-term unemployed, people with disabilities, older people, people from different socio-cultural backgrounds, children and youth, third country nationals, victims of crime and domestic violence, the homeless, ex-prisoners. Attention is paid to increasing employability, promoting equal opportunities in education and preventing criminality. Social field work will be carried out to reduce social exclusion. The activities of the Agency for Social Inclusion in Socially Excluded Roma Localities are only in the initial stages, but the pilot programme for local development strategies should be implemented in 2008-2011. Towns with significant social problems have prepared crime prevention concepts for 2008-2011. Special ‘mediators' have been employed to facilitate communication between the police, minorities and socially excluded localities. Special strategies have been designed for third country nationals and older workers but they still need to be properly implemented.

Compared to the 2006-2008 Report, the second priority is now limited only to families with special needs. Given that child poverty is a broader problem, this narrowed focus does not seem to be sufficiently justified. Social services play a key role and the main goals are active inclusion through a reformed social benefits system, social and legislative child protection and support for young people leaving institutions or foster care. At present, the Czech Republic is among the countries with the highest number of children in institutions, so support for other forms of care is highly advisable. Other relevant issues, such as social benefits adequacy, housing, education or active labour market policies, are not mentioned. Only few measures have been proposed for reconciling family and working lives and tackling unemployment among women after parental leave, despite the fact that it is the EU highest (2007: CR: 43.2%, EU: 12.6%) and increasing, and supporting childcare facilities.

The third priority aims to support policy making, communication and partnership at all levels of public administration, and focuses on the development of social services. Priority is given to community planning of social services with the aim of including all ‘delegated’ municipalities by 2010 and ensuring training for all relevant actors. The continued support for the transformation and modernisation of institutional social services is welcome. There is a new and potentially very useful measure for the social economy with arrangements prepared for 2009. Adequate attention is paid to housing, particularly for people at risk of social exclusion, through financial contributions. About 8-10 pilot projects will be selected and comprehensive social inclusion activities will be carried out for the Roma communities. This priority is almost entirely co-financed by the Structural Funds, which offers an opportunity to develop innovative approaches, but also poses a threat to sustainability.

These general priorities are not developed into specific measures; the indicators used for the 2006-2008 Report were not evaluated and are no longer used. Only few targets are set in the 2008-2010 Report, which could be at least partly achieved because of positive trends: to decrease the number of at-risk-of-poverty households, especially those with more members (though predicted slow down of economy could affect current development); to involve all 'delegated' municipalities in community planning of social services.

3.5. Governance

The NAP/incl. was prepared by the Ministry of Labour and Social Affairs in cooperation with the Committee on Social Inclusion. The process seems to be rather technical, and even if the Committee provides a forum for cooperation among various actors, it does not have any real competence for coordination and initiative for strategic planning and impact assessment. Several NGOs are members of the Committee, but the broader involvement of civil society and people experiencing poverty is still a challenge. No political or public discussion has taken place on the report. Ownership of the strategy is low and social inclusion mainstreaming is underdeveloped. Gender mainstreaming is missing and gender equality bodies were not involved in the preparation. No budget allocations, timetable or clear and quantified targets have been provided and the role of relevant actors in implementation could be better specified. Monitoring and evaluation should be more developed. There is no proper assessment of the progress achieved, with only few common EU indicators used and no national indicators. The use of indicators from the Structural Funds programming documents is welcome, but the indicators should also take into account the difference between the processes.

4. PENSIONS

4.1. Key trends

The Czech pension system consists of the universal public mandatory PAYG pillar, a voluntary supplementary pillar, i.e. private pension insurance with a state contribution, and life insurance. The pension contribution rate is 28% of gross income and is split between employee (6.5%) and employer (21.5%). Pensions consist of a basic amount (flat rate, at present approx. 9.4% of average gross monthly pay) and a percentage based on the insurance period and gross earnings. The minimum insurance period is 25 years. The basic pension scheme will be under significant financial pressure, so the reforms so far introduced, such as prolonging working life and restricting early retirement, are aiming to improve its sustainability. The retirement age is being raised gradually, in 2008 to 61 years and 10 months for men and varying between 56 years, 4 months, and 60 years, 4 months, for women (depending on the number of children raised). To support longer working lives, benefits are being reduced for early retirement and increased when pensions are deferred. Private pensions schemes still do not have significant weight, even if the number of participants has been steadily increasing. To support this type of insurance, tax incentives were introduced as of January 2000. The relative income of older people (0.81% for 65+, men 0.83%, women 0.80%) is lower than the EU-25 average (0.84%) and has slightly decreased (0.83% in 2004).

4.2. Key challenges and priorities

The main challenge is to ensure the long-term financial sustainability of the pension system, since population ageing is one of the fastest in the EU. The old-age dependency ratio was

projected to rise from 19.7% to 54.8% of GDP between 2004 and 2050 and public pension expenditure from 8.5% to 14% of GDP. However, according to national projections future level of expenditure could be reduced to about 10.2% of GDP in 2050 as a result of the first stage of the pension reform. At present, the system ensures relative adequacy. At 5%, the at-risk-of-poverty rate for older people is very low. In 2007 the aggregate replacement ratio was slightly over the EU-25 average, 51% in total (men 51%, women 56%). According to projections of the theoretical replacement rates, the net retirement income as a ratio of work income at the point of retirement is expected to drop by twenty-one percentage points between 2006 and 2046 for a worker retiring at age 65. Compensation for this negative trend should be sought in longer working lives and broader use of private pensions.

The challenge of securing sustainability (including adequacy and increasing the employment of older people), identified in the 2007 Joint Report, has been partly addressed. Pension reform is being formulated and so far three steps have been proposed. The first step to come into force in January 2010 comprises parametrical changes to the PAYG system with the aim of gradually increasing the pensionable age to 65 years for men and for women without children or with just one child and to 62-64 years for other women. The period of insurance needed to acquire a pension entitlement will be gradually lengthened to 35 years. The second and third steps of the reform, which will concern private pensions, are to be discussed in 2008-2009. The vision is to introduce an option to transfer a small part of the contribution under the statutory PAYG scheme into the private system.

All the proposals in the 2005 Pension Report are being pursued and should be implemented within the reform. Pensions are indexed once a year on the basis of prices (100%) and real wages (at least 1/3). A new measure now allows for adjustment of pensions on an ad hoc basis when inflation exceeds 5% (previously 10%).

4.3. More people in work and working longer

The employment rates of older workers have increased (2007: 46%, men 59.6%, women 33.5%) as a result of economic growth and pension policy measures, mainly the increase in retirement age. Further support is needed to increase the employment of older women, which is lower than the EU average (36%). Since many of them provide long-term care to their relatives, more in-depth analysis is necessary for an integrated approach. Incentives to work longer are still insufficient for workers on low wages. Not much attention is paid to increasing the human potential of older workers; their participation in training and upgrading is very low but the ESF could help. The labour market is still not favourable to flexible forms of employment, such as part-time work, which has a negative impact particularly on women. The lack of care facilities for children aged 0-3 prevents or postpones the return of women to work after parental leave and contributes to their lower employment.

While rising the effective labour market exit age (60.7 in 2007) is lower than the EU average (61.2). Early retirement is still widespread; it can be claimed up to three years before the normal pension age after at least 25 years of contributions. The number of people claiming early retirement sharply decreased in 2002-2003 but started to increase again in 2004, reaching 31 811 in 2007 (compared to 69875 entering standard retirement). However, the first phase of the pension reform provides for further reduction in early retirement benefits.

4.4. Privately managed pension provision

The system of privately managed pensions was established in 1994 as a voluntary, supplementary system with state subsidies. At present, it has 4 million members. Coverage in the age group 15-64 is 46.5%. However, average contribution per head is still very small and stagnating (at 2% of average wages since 1999). The state contribution is an average CZK100 per month while 23% of participants also receive an employer contribution of around CZK500 per month. Moreover, since its creation it has been used mostly as a savings mechanism, with 71% of payments taking the form of a lump sum. At present, there are 10 funds with assets of around CZK 167 billion, but the system is still underdeveloped and its contribution to pensioners' income is negligible.

4.5. Minimum income provision for older people

Pensions decrease poverty by 18%, while the at-risk-of-poverty rate for older people at 5% (men 2%, women 8%) is low and significantly lower than the EU average of 19%, but with significant gender differences increasing with age (75+: 7%, men 2%, women 10%). Striking gender differences emerge when measured at 70% of median income (men 9%, women 23%). The reason for lower female pensions is lower income during working life; the gender pay gap was still relatively high at 18% in 2006 (EU-27: 15%). The subsistence minimum is used as a safety net in the case of low pensions. They are adjusted each January for inflation and wage growth (at least 1/3 of real growth in wages). In addition, old-age pensioners are allowed to receive income from gainful activity. Yet various factors, such as high inflation, in particular increasing energy and housing prices, represent a threat to the continued ability of the pension system to ensure a decent standard of living for pensioners. One risk group in terms of the adequacy of pensions are the self-employed, who minimise their social security contributions.

4.6. Information and transparency

The public insurance body in the Czech Republic is the Czech Social Security Administration, which is also responsible for providing regular information to scheme members. The Association of Pension Funds in the Czech Republic provides information about private supplementary pension insurance and individual pension funds publish information on their web pages. The social partners are taking part in discussions on the reform.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Practically all the population is covered by compulsory universal health insurance financed through an earmarked payroll tax on employees, employers and the self-employed and by state budget contributions. Private insurance is negligible. Primary health care (about 95% is private) is organised by municipalities and delivered in municipal health centres, polyclinics, and the private premises of general practitioners (GP), dentists and gynaecologists. A GP referral gives access to specialists, polyclinics and hospitals. 75% of specialist outpatient facilities are private, whereas hospitals are mostly public. Life expectancy at birth increased to 76.8 years in 2006 (men 73.5, women 79.9), but together with the indicator for healthy life years (men 57.8, women 59.8 in 2006) is still lower than the EU average.

The main objectives of the report are in line with those set out in the 2006-2008 Report, but less attention is paid to health inequalities, availability, and maintaining coverage of the system. There are some disadvantaged groups with a lower health status, especially people from deprived localities (mostly Roma) and the homeless. More policy measures should be designed to address population ageing and cooperation between health and long-term care. So far, a new option to provide out-patient care in social service facilities and social services in health care facilities has been introduced. The Government has recently announced a health reform but without assuring the comprehensiveness of the strategy and with shortcomings in its preparation in terms of communication and cooperation with stakeholders. It is not clear to what extent some of the measures under discussions, such as the privatisation of faculty hospitals and transformation of public health insurance funds into joint-stock companies, would ensure accessibility, quality and sustainability.

5.1.2. Accessibility

In principle, health care services are broad and freely accessible to the entire population except for certain groups of third country nationals. General access to care is considered good: self reported unmet need for medical care is one of the EU lowest at 0.7% in 2006 (EU: 3.1), only a little higher in the lowest income group (1.4%) and similarly for dental care (CZ 0.9%, EU 5%). No significant regional inequalities or waiting lists exist. The Structural Funds will be used to improve the health infrastructure. Reduction in capacity of acute hospital beds, which was one of the EU's highest, took place because of inadequate staffing and low medical treatment. The establishment of one-day health care services is a positive development. A more general system of co-payments is not in place but is being discussed; so far, there are co-payments for a few services (prostheses, dental care, and medicines). Statutory fees introduced in January 2008 for GP visits, emergency treatment, hospitalisation and the prescription of medicines have led to a decrease in the use of care. Newborn children have recently been exempted from payments. There is an annual financial ceiling (but not all kinds of fees are included) and recipients of social benefits 'in material need' do not pay fees. Even if the fees do not seem to have negative effect on accessibility, it is necessary to monitor and evaluate their impact on low-income groups, the chronically ill and older persons.

5.1.3. Quality

The independent accreditation agency, the United Association Commission, has been carrying out external evaluations of the quality of health care in hospitals since 1998. Otherwise, there is no national system of quality and safety evaluation. The proposed Act on Health Care Services and Conditions for their Provision aims to establish a system for evaluating quality and safety as a voluntary process. Furthermore, no effective mechanism for dealing with patient's complaints is in place and patients are not sufficiently informed about their rights. Therefore, the steps described in the Report are welcome. As an initial step, the Information Portal for Safety and Quality in Health Care was launched in June 2008. To increase patient safety, health care providers will be obliged to establish internal regulations concerning the handling of medications and medical documentation. The National Programme for Improving Quality in Health Care should become an information source. The National Network of Health Promoting Hospitals is under preparation to promote international cooperation. The Expert Forum for the Creation of Health Care Standards has been established for treatment standards. On the other hand, it is not evident that health technology assessment is being used effectively.

5.1.4. Sustainability

Total health care expenditure (6.8% of GDP, PPP1490 per capita in 2006) is below the EU average and has been slightly decreasing since 2005 in GDP terms (7.5% in 2004) but growing in absolute terms per capita. The share of public expenditure was 88% (2006), one of the highest in the EU. Public expenses are projected to increase by 2% of GDP by 2050 (EU-25: 1.6%) due to population ageing. The 2007 Joint Report challenge of improving efficiency and reducing waste has been partly addressed. Statutory fees helped to reduce overuse of care and led to decrease in the number of visits to specialists, hospitalisation and its length, the number of prescriptions and expenditure on medications. However, at present the new regional governments intend to pay statutory fees in the regional facilities on behalf of the patients from the regions' budgets.. No measures were presented to attract and retain staff. Lifelong learning will be supported by the ESF in particular; specific legislation has been prepared for the further education of medical professionals, which will also regulate specialist training. Disease prevention and the promotion of healthy lifestyles are still an issue; it is necessary to address risk factors such as smoking, fitness levels, eating habits and obesity (14.8% of the population in 2005 according to OECD data), and specific diseases.[15] A positive aspect is that the report mentions preventive screening for selected cancer types paid for by public insurance and the creation of special Network of Comprehensive Oncology Centres, and several activities on healthy lifestyles.

5.2. Long-term care

5.2.1. Description of the system

Long-term care is provided within the health care system (mainly public health insurance) and as part of social services (the state budget). Expenditure was quite low (0.3% of GDP in 2005, EU-25: 0.9%) and is projected to grow by 0.4% by 2050 (EU-25: 0.6%). The bodies responsible are the regional authorities and municipalities but several NGOs have an important role especially in out-patient care. The 2007 Joint Report challenge of enhancing coordination between health and social care and different stakeholders and to improve access to long-term care has been addressed partly by the Social Services Act (2007), which introduced the concept of the social-health care bed.

5.2.2. Accessibility

Access to long-term care is not regarded as problematic by the population.[16] The regional authorities are obliged to carry out strategic planning of social services. The number of beds in health care is adequate, but there is a shortage of beds in social care. Due to population ageing, the increasing demand for geriatric services and hospices will have to be addressed. Attention is being paid to support for home care provided by public agencies, health care facilities, private doctors and NGOs. Home care has developed considerably and now covers, with few exceptions, the entire territory.[17]

---

15 Coverage of mammography screening for women aged 50-69 was only 18.6% in 2006; and only 38.8% of women aged 20-69 were screened for cervical cancer in 2002 (EU-15: 60-70%)

16 According to Special EUROBAROMETER 283, 2007, 80% of people consider they will be provided with the appropriate help and long-term care if needed (EU-27: 71%)

17 In 2007, social field work was provided in 121 573 cases and there were 71 642 people in institutional care

5.2.3. Quality

The objective of the previous report to introduce quality standards has been met. All service providers have to be authorised and fulfil specific registration conditions, including demonstration of quality standards. Monitoring is performed by the social services inspection. Moreover, criteria have been established for the competencies of social workers, whose continuing education is at present financed by the ESF. Care outside institutions is a priority; the Government has adopted a strategy for transforming institutional care into other types of care, and a further system of planning for social services should help to support home and community care. However, it has so far been little used. The care allowance introduced by the Social Services Act has given clients a tool to freely choose services according to their needs and thus contribute to the development of better quality services.

5.2.4. Long-term sustainability

Social services are financed from various sources (state, founder's budgets, clients' payments, revenue, gifts) and the ESF plays an important role in strategic planning, training, and some services. The care allowance has become an important financial tool, for both professional services and family caregivers. However, it requires more funding than anticipated and is easily used outside the social service system, so less money than expected is paid to providers. Out-patient services in particular are often in a worse financial situation and there has been no corresponding decrease in institutional care and rise in family care. The proposed legislative change is intended to restrict the allowance only to the actual purchase of social service. More support for informal carers is needed. Much still needs to be done to support the coordination of health and social care and implement the ageing strategy.

6. CHALLENGES AHEAD

- To take further steps to improve the situation of vulnerable groups (e.g. the Roma), particularly those living in disadvantaged regions and localities, including by enhancing the implementation of social inclusion policies at regional and local level, with further emphasis on integrated and balanced active inclusion policies.

- To support the reconciliation of work and family life and increase the employment of women, including by supporting childcare facilities, with a view to improving the financial sustainability of the pension system.

- To take further pension reform steps and encourage the creation and take-up of jobs for older workers and increase their employability so as to help balance financial sustainability and pension adequacy.

- To improve health care efficiency through more rational use of resources (notably through a stronger focus on primary health care while reducing the high dependency on specialist and hospital in-patient care) and by adjusting staff numbers; to allocate more public funding to effective and targeted health promotion and disease prevention.

- To ensure that reforms (e.g. privatisation of funds) are properly thought through on the basis of past experience and the experience of other countries.

- To enhance coordination between health and social care and between different stakeholders and to improve access to long-term care services, including by ensuring a sufficient quantity and quality of staff.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,6	68,5	**2000**	65,0	73,2	56,9	36,4	36,3	**2000**	8,7	7,3	10,3	17,8
2005	6,3	75,9	**2005**	64,8	73,3	56,3	27,5	44,5	**2005**	7,9	6,5	9,8	19,2
2008*f*	4,2	80,6	**2007**	66,1	74,8	57,3	28,5	46,0	**2007**	5,3	4,2	6,7	10,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	69,7	76,8	12,7	16,2	n.a.	n.a.	7,7	**1995**	7	90,9	9,1		
2000	71,7	78,5	13,8	17,3	n.a.	n.a.	4,1	**2000**	6,5	90,3	9.7b	**2005**	1,2
2006	73,5	79,9	14,8	18,3	57,8	59,8	3,1	**2006**	6,8	88	11,5	**2006**	0,7

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old age dependency ratio eurostat	Expenditure (% of GDP) Level in 2004 and changes since2004			
										Total social expend.	Public pensions	Health care	Long-term care
1995	17,4	39,8	37,2	2,3	11,9	1,3	7,5	**2005**	20,6	19,3	8,5	6,4	0,3
2000	19,5	43,4	33,6	3,5	8,4	3,4	7,7	**2010**	21,8	-0,5	-0,3	0,4	0,0
2006	18,7	43,1	34,4	3,2	7,6	3,1	8,6	**2030**	35,7	1,7	1,1	1,4	0,2
								2050	54,8	7,1	5,6	2,0	0,4

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	10	16	8	5	18	19	19	7	3,5	**2005**	
male	9	-	8	2	19	-	21	14	-	**2006**	2878
femal	10	-	9	8	17	-	19	7	-	**2007**	3251

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	8,0	7,9	6,2	9,5	**2000**	4,2	3,5	5,2	**2000**	n.a.	n.a.	
2004	9,0	8,0	6,4	9,6	**2004**	4,2	3,4	5,3	**2004**	6,1	5,8	6,5
2007	8,0	6,5	4,9	8,1	**2007**	2,8	2,1	3,6	**2007**	n.a.	n.a.	

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0.81	0.83	0.8	***Aggregate replacement ratio***	0.51	0.51	0.56

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
-21	-15,6	-15,6	DB	/		100	/	28	/	

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Denmark

1. SITUATION AND KEY TRENDS

The slow-down in economic activity in 2008 has been rapid and pronounced, most likely leading to a contraction of GDP in 2008 and 2009. Denmark already meets all the EU employment targets. The employment rate (77.1% in 2007) is historically high and the unemployment rate (3.8% in 2007) at its lowest level since the early 1970s. Although starting to diminish, employment remained at a high level in 2008, but is expected to fall over the coming year. Similarly, the unemployment rate of around 3.5% in 2008 should be lower than in 2007, but is expected to increase in 2009. Long-term unemployment (0.6% in 2007) and youth unemployment (7.9% in 2007) are among the lowest in the EU. Gender differences are fairly small. Demographic effects have started to affect labour supply negatively.

The social protection system continues to provide universal basic protection against economic risks from unemployment, illness or dependency for all citizens. Total public social protection expenditure (29.1% of GDP in 2006) is persistently among the highest in the EU and projected to grow more than the EU average. Denmark has a compressed wage structure and the at-risk-of-poverty rate (12% in 2007) remains below the EU average. People with a foreign background and the unemployed are overrepresented in the lower income brackets. While growth in male (76.1 in 2006) and female life expectancy (80.7 in 2006) has been moderate, healthy life expectancy is among the highest in the EU (67.7 for men, 67.1 for women in 2006) and shows a positive trend. Infant mortality (3.8 in 2006) and perinatal mortality (3.3 in 2005) show a decreasing trend.

People with a foreign background constitute about 9.4% of the working age population, with 7.5% from non-EU25 countries. Migration patterns are changing, with a strong increase in labour migration and declining levels of humanitarian migration and family reunification. The employment rate gap between nationals and people with a foreign background is still significant (16.0 for Denmark in 2007, compared to the EU average of 2.6), although their employment situation has improved recently. The performance of children with a foreign background in the education system (upper secondary attainment rates, early school-leaving, reading literacy) remains significantly below that of native students.

2. OVERALL STRATEGIC APPROACH

Denmark's overall strategic approach builds on principles of universality, accessibility, gender equality, adequacy and sustainability. Systems are primarily financed from general taxes and important parts do not depend on labour market attachment. All citizens have access to health services, all citizens have the right to old-age pension and all citizens that meet the legal conditions are entitled to a comprehensive range of social services and provision. Key overall challenges remain to 1) increase the labour market participation of disadvantaged groups, 2) ensure equal access to a high-quality, efficient health care system and 3) support budgetary conditions for maintaining the universal pension system. Denmark has addressed all three overarching objectives of the Open Method of Coordination.

While no direct link is made with the Danish National Reform Programme, social inclusion policies are presented as reinforcing labour market initiatives. The National Strategy Report is

the product of a process involving a wide range of stakeholders, including social partners, civil society, evaluators, regional authorities and relevant ministries. All initiatives of a legislative nature involve the Parliament. The ESF is contributing through the Objective 2 programme 'More and better jobs', but the funding is negligible in comparison to total expenditure on social inclusion in Denmark.

3. SOCIAL INCLUSION

3.1. Key trends

Denmark continues to have one of the lowest levels of income inequality in the EU. In 2007, 12% of the Danish population lived on an income of less than 60% of the median income. The proportion is significantly below the EU average for all population groups. There are no significant differences in the share of men and women, but people with a foreign background and the unemployed are over-represented in the lower income groups. The share of people living in jobless households continued to decrease in 2006 to 6.9% for adults and 5% for children. The employment rate of people with a foreign background and disabled persons remains significantly below the national average.

The upper secondary completion rate stood at 70.8% in 2007, which is below the EU average and considerably short of the EU and national targets of 85% by 2010 and 95% by 2015. The share of early school-leavers is below the EU average. The performance of children with a foreign background is below that of native students.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The Danish 2006-2008 National Strategy Report established nine priority areas for social inclusion and social protection (cross-cutting and basic activities, breaking the vicious circle of deprivation, teaching and education, employment, housing, integration, combating human trafficking, substance misuse, qualified everyday life) and the 2008 report includes information on the progress of policy plans in relation to these areas. Implementation seems most advanced in breaking the vicious cycle of deprivation and integration.

In the 2007 Joint Report, two challenges were identified for Denmark in the area of social inclusion:

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

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

The 2008 NSR stresses that employment is crucial for social cohesion and inclusion and the financial sustainability of the welfare system. The two-year campaign 'A New Chance for Everyone' has a particular focus on social assistance and starting-allowance recipients (one third of the target group consists of people with a foreign background). Three years ago, one in six young people with a foreign background were dependent on social assistance or starting allowance. Today, the figure is one in eleven.

Older workers have been targeted through a temporary wage subsidy scheme in the private sector and by offering older people who lose their right to unemployment benefit a job in their

local authority. A number of initiatives have been taken under the government's strategy 'Disability and work — an employment strategy for disabled persons'. Recent examples include a trial scheme with social mentors for persons with a temporary mental disorder. Another ongoing trial involves a 'flexi-job certificate', which states which safeguard requirements may apply to employment and provides information on assistance schemes.

The Welfare Agreement (2006) has been complemented by a new 'Job plan' (2008), which includes additional initiatives to enhance activation and work incentives to wean people off public benefits. The main measures aim to strengthen employment among people with a foreign background, older workers and persons with a reduced working capacity and to promote the recruitment of qualified foreign labour. The policy is a good example of how social inclusion and a strategy for growth and jobs can mutually reinforce each other. Nevertheless, attention should be paid to potential side-effects, as the 'Job plan' primarily focuses on increasing labour market participation through financial incentives for the unemployed.

Initiatives are also being taken under the 'Quality Reform' (launched in 2007) with the main aim of improving and securing the level of welfare for the population. The focal points are the future challenges that an ageing population will present, improvement of the quality, effectiveness and efficiency of the Danish health care system (including a cancer treatment plan), and initiatives to keep and recruit workers in the care professions. Although the plan has been criticised by various actors, it is a focused effort to deal with some of the challenges identified in the Joint Report.

3.3. Key challenges and priorities

The Danish NSR presents three key policy objectives for 2008-2010 in relation to poverty and social exclusion: 1) supporting disadvantaged children and youth, 2) supporting socially disadvantaged groups, and 3) social inclusion of people with a foreign background. The three objectives build on the focal areas of the 2006-2008 NAP, which indicates a high level of consistency. The focus on older workers and the disabled in the 2007 Joint Report has, however, not been carried forward in these objectives. Nevertheless, the selected priorities are highly relevant, although the focus is broad and the objectives and expected outcomes could be specified further.

3.4. Policy measures

Supporting disadvantaged children and youth

The measures target disadvantaged children, young people and parents. Action areas are: early and cohesive intervention, academic proficiency and early learning, youth education, special social problems, networks, parental responsibility, and documentation and impact. The actions respond to three of the seven key policy priorities adopted by the EU (tackling disadvantages in education and training, eliminating child poverty, increasing labour market participation).There are clear arrangements for the effective delivery of the policies. A weakness is the lack of a gender dimension, as gender is of great importance in for example youth education. There is also no specific reference to the number of children living in poverty or how other welfare reforms influence the situation for children and young people in low-income families.

Supporting socially disadvantaged groups

The measures target disadvantaged adults, including drug and alcohol abusers, the mentally ill and the homeless. Housing, health and employment are the main areas, and actions respond to four of the seven EU key priorities (ensuring decent accommodation, improving access to quality services, overcoming discrimination, increasing labour market participation). There is a good balance between prevention and alleviation in the actions. Gender aspects are also reflected.

Social inclusion of people with a foreign background

The measures target refugees and people with a foreign background and mainly focus on the barriers of language, cultural values and traditions that may limit labour market integration and access to resources and services. Actions respond to three of the EU key priorities (increasing labour market participation, tackling disadvantages in education and training, and overcoming discrimination). However, structural barriers are not explicitly mentioned, and it would be important to ensure a comprehensive approach that takes into account all mechanisms that could come into at play when the advanced Danish system of employment and social policies fails to deliver similar results for both people with a foreign background and the native population. There is also no specific reference to the risk of poverty and bad health among people with a foreign background or the living conditions of asylum-seekers, which have attracted recent attention. Nevertheless, the employment area is well developed and the delivery of policies is in place. Gender aspects are also well reflected, particularly in relation to education and employment.

3.5. Governance

The National Strategy Report is the product of a process involving a wide range of stakeholders, including interest groups representing disadvantaged people (e.g. the homeless, unemployed, drug users). A website has been launched to invite debate and comments from the public. A large-scale conference was held in spring 2008 to discuss the challenges of the Danish welfare system and priorities.

General indicators to monitor progress towards the achievement of each priority policy objective have not been identified in the report. Monitoring and evaluation arrangements exist, but relate more to the individual actions and programmes being implemented. There is also independent research on specific initiatives (e.g. the strategy to combat homelessness and initiatives for vulnerable children).

4. PENSIONS

4.1. Key trends

The ratio of persons aged 65 and above to 15-64 year olds is projected to increase from 23.6% (2008) to 37.8% in 2030 and 41.3% in 2050 (significantly below the EU27 average of 50.4% in 2050). Denmark has a well-balanced, multi-pillar pension system. The statutory public old-age pension has two elements. The first is a universal, non-contributory, residence-based scheme financed from general taxation on a pay-as-you-go basis. Benefits are taxable and consist of a flat-rate part and an income-tested part. The second is a funded defined-contribution scheme (ATP) financed from mandatory contributions from all employed persons and organised in a separate fund under tri-partite management. Pensionable age for both men and women is currently 65 years, while the average exit age was 60.6 in 2007.

Statutory pensions are supplemented by occupational pension schemes based on collective agreements and individual pension savings. Occupational pension schemes have expanded substantially and today cover around 90% of employees, who typically pay contributions of between 12% and 17% on gross wages. Most are fully funded defined-contribution schemes. The compulsory personal pension savings contribution (SP) has been suspended for 2009. A financial stability package for pensions with initiatives to ensure market stability and prevent forced sale of mortgage bonds owned by pension funds has been implemented.

The income of people aged 65+ relative to the 0-64 age group stands at 70% (2007), which is lower than in most other Member States, while the risk of poverty for the elderly population remains at a moderate level (18%), but higher than for the total population (12%). Under a broader definition of income, including imputed rent, the risk of poverty in Denmark for elderly people is almost the same as for the rest of the population.

Public pension expenditure is projected to increase from 9.5% to 12.5% of GDP between 2004 and 2050. As occupational pension schemes mature, they will contribute significantly to the income of future pensioners. At present, gross theoretical pension replacement rates are relatively low compared to almost all other Member States, but is expected to increase substantially, reflecting the maturing of occupational and voluntary pensions. The replacement rate should be seen in relation to the supplementary benefits (housing benefits, heating benefits, health allowances, reduced tax on owner-occupied housing) and services targeting pensioners (health and long-term care, including free home help). The aggregate replacement rate is 39% (2007).

4.2. Key challenges and priorities

The Danish pension system is intended to ensure i) a basic retirement income, ii) a reasonable replacement rate, and iii) solidarity between generations, by maintaining and expanding the three-pillar pension system and preserving a fair balance between the pillars.

In terms of adequacy, the Danish system is considered able to secure present and future pensioners a reasonable standard of living. Nevertheless, the growing importance of savings-based pension schemes requires more focus on persons at risk of having insufficient pension savings.

As concerns financial sustainability, public debt was further reduced to 26% of GDP in 2007. Gross debt developments are strongly affected by the response to the financial crisis, increasing the gross debt ratio in 2008. The government budget surplus (4.5% of GDP in 2007) could exceed 3% of GDP in 2008, but the downturn could push it close to balance over the following two years. The macro-fiscal framework, the ‘Denmark 2015 plan’, relies on counteracting the negative demographic impact and raising structural employment by 20 000 by 2015.

Regarding the modernisation of the pension system, Denmark stresses the increased need for information on pensions as an important challenge.

4.3. More people in work and working longer

The employment rate of older workers, while among the highest in the EU, drops drastically for the 60-64 age group, reflecting the influence of the voluntary early retirement benefit. The average exit age (60.6) from the labour force decreased slightly in 2007, but remains close to

the EU average. Increasing the labour supply continues to be among the key challenges and priorities of the government, as it is considered essential to secure the financing of the welfare society over the longer term. Measures have addressed retirement age thresholds and activation and work incentives for older workers and people with a foreign background in particular.

The welfare reform (2006) introduced changes in retirement age thresholds, to become effective from 2019 onwards (the early retirement age will increase from 60 to 62 from 2019 to 2022, and from 65 to 67 for old-age pensions from 2024 to 2027, while from 2025 it will be indexed to life expectancy). However, the timing of this reform will mean that the most of the large age cohorts (baby-boomers) will have retired before it takes effect. Thus, it will not contribute to the labour supply over the shorter and medium term. In February 2008, as a part of the new 'Job Plan', further incentives were introduced for old-age and disability pensioners to maintain or resume labour market participation. The Job Plan also includes tax incentives for people who remain in employment until 65. Further reform measures are in the pipeline and advance policy advice has been provided by the Labour Market Commission, which will submit its full report by mid-2009. The Tax Commission is examining reform options and will submit its report in early 2009.

The strategy for ensuring the adequacy and financial sustainability of the pension system seems appropriate in the long run. A budget policy leading to quick debt reduction has already been sustained for several years. A continued budget surplus will help address ageing-related growth in public expenditure. Sustainability also relies on increasing structural employment, which will require further measures, especially to maintain older workers in employment and improve the labour market integration of people with a foreign background and other disadvantaged groups. The maturation of occupational pensions should contribute to the future adequacy of pensions. Nevertheless, the future contribution of private pensions would benefit from periodic reviewing, also taking into account aspects such as the impact of irregular attachment to the labour market and the gender pay gap on future pensioners.

4.4. Privately managed pension provision

The growing importance of savings-based pension schemes requires more focus on persons at risk of having insufficient pension savings. Temporary absence from the labour market (due to illness, unemployment, maternity, child-caring) will lead to reduced pension savings and thus to a smaller supplementary pension (although the old-age and ATP pensions are not influenced by absence from the labour market and thus mitigate the effect). The calculation of both public and occupational pensions is based on a gender-neutral principle. Women have a high employment rate and the prevalence of occupational pensions is as high for women as for men. However, women work part-time more often than men and the high and persistent gender pay gap (17%) in Denmark will have an effect on the income of female pensioners. Initiatives are ongoing to address the gender segregation of the labour market and raise awareness of the gender pay gap.

4.5. Minimum income provision for older people

The non-contributory, residence-based old-age pension constitutes the minimum level of income provision for older people in Denmark. The flat-rate part is tested against work income above a significant level. The income-related part is tested against certain types of capital and pension income. A supplementary benefit is paid to those who have no other income than the full old-age pension. A personal allowance may be granted to old-age

pensioners to cover reasonable necessary expenses following a specific assessment of their needs. This allowance may for example be granted to old-age pensioners who receive a reduced pension due to a residence period of less than 40 years. Social assistance may be granted to older persons who do not meet the requirement for a full or reduced old-age pension. Pension income is underpinned by a range of needs- and income-tested benefits targeting pensioners (e.g. housing and heating benefits, health allowances). The effective purchasing power of pensioners is also raised by age-related tax rebates (e.g. on owner-occupied housing) and discounts on drugs, transport, admissions and radio/TV. Health and long-term care services provided in the home are free. The old-age pension keeps the risk of poverty for older people at a moderate level, but current theoretical replacement rates are low.

4.6. Information and transparency

The complexity of the pension system and the growing importance of savings-based schemes are putting greater demands on the knowledge of individuals and decisions about their pensions. In addition to the obligation on pension schemes to disclose annual information and a common database, *PensionsInfo*, a public pension portal is being developed where citizens will get both general information on pensions and information on their own pension savings. The portal will also provide calculation functions allowing citizens to calculate the pension-related consequences of different choices (change of time of retirement, increased pension savings, savings needed to obtain a given pension, etc.). New rules have been introduced concerning the supervision of life insurance companies and multi-employer pension funds.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Denmark's tax-based, decentralised health care system provides universal coverage for all citizens. Following the administrative reform in Denmark in January 2007, the primary sector is financed by the regions and local authorities. Medical assistance and hospital treatment are free of charge for patients, and between 25-60% of the costs of specialist health services (dentists, psychologists, chiropractors and physiotherapists) are also covered. Local authorities are responsible for home nursing (offered free of charge on doctor's orders), and as of January 2007 also for some rehabilitation and health promotion and prevention. The secondary sector, consisting of hospitals, including psychiatric treatment, is operated by the five new regions. As mentioned, hospital treatment is free, but non-emergency treatment requires referral from a doctor.

While growth in male (76.1 years in 2006) and female life expectancy (80.7 years in 2006) has been moderate, healthy life expectancy is among the highest in the EU (67.7 years for men, 67.1 years for women in 2006) and shows a positive trend. Over the next decade, Denmark aims to achieve an increase of 3 years in life expectancy. Self-perceived general health is among the highest in the EU, also in the lowest income groups. Nonetheless, cancers result in premature deaths more often than in many other countries. Smoking has decreased significantly. In contrast, obesity is rising and excessive alcohol consumption, notably among young people, remains problematic.

5.1.2. Accessibility

As mentioned, the Danish health care system is universal and tax-financed, giving everybody access to health care free of charge. Self-reported unmet needs for medical care and dental care are among the lowest in the EU, also in the lowest income groups. Waiting times were reduced by 6 weeks (20%) from 2002 to 2006. Currently, the health care sector is facing a considerable short-term challenge in reducing the waiting-time backlog following the large-scale strike in the public sector in spring 2008.

The 2007 Joint Report identified 'safeguarding the current high level of protection, while satisfying increasing demands for health and welfare services in view of the ageing population' as a challenge for Denmark. Among the policy measures mentioned, patients' rights to free choice have been further improved. From October 2007 (though effective only from 1 July 2009 due to the public sector strike), all patients that have been waiting for at least one month for public hospital treatment can opt for a private hospital instead. Furthermore, as from spring 2009, all patients will have a free choice of general practitioner regardless of geographical distance. Considerable extra resources have also been channelled to the hospitals in order to shorten waiting times and reinforce efforts to treat heart and cancer patients.

Denmark is also increasingly focusing on social inequalities in health, acknowledging that disadvantaged groups generally have poorer health and fewer healthy years to live than the rest of the population. To achieve an increase of 3 years in life expectancy over the next decade, a Prevention Commission has been set up to examine and report (early 2009) on how to cost-effectively prevent lifestyle diseases and increase health, with a special focus on disadvantaged groups. It may be noted that as from August 2007 it is prohibited by law to smoke in workplaces, public indoor places and institutions, taxis, restaurants and cafés.

The issue of patients' rights to choose treatment across borders has not been addressed in the NSR.

5.1.3. Quality

The 2007 Joint Report identified 'taking the necessary steps to further improve the quality, effectiveness and efficiency of the Danish health care system, including measures to improve the organisation and performance of cancer treatments' as a challenge for Denmark.

In spring 2008, the first version of the Danish quality model for hospitals was approved. The model comprises 104 standards for good quality (accreditation standards). However, they will not be implemented until autumn 2009 due to the public sector dispute mentioned above.

There is a continued focus on earlier diagnosis and access to quality treatment, in particular for cancer. Pathways for individual types of cancer are being introduced gradually and will cover all cancer types by the end of 2008. Investment projects will be launched to ensure a modern and rational hospital structure to improve the quality of treatment and the efficient use of equipment. The website providing information on treatment quality and waiting times at different hospitals will be extended to include more treatment offers.

The quality of health care for the mentally ill has attracted some media attention, but this is not specifically mentioned in the NSR.

5.1.4. Sustainability

Danish public spending on health care is among the highest in the EU, both as a percentage of GDP (9.4% in 2005) and per capita (US$ PPP 3169 in 2005). Public expenditure on health care is projected to increase by 1% of GDP by 2050.

The 2007 Joint Report identified 'taking more actions to recruit people to work in the care professions and improve the working conditions' as a challenge for Denmark. The ageing population represents a double challenge for health and long-term care, as fewer people will have to care for more patients. Recent estimates indicate that the health care sector may have a staff shortfall of 20% by 2020. Following the public-sector wage negotiations in the spring, a Pay Commission (due to report in 2010) has been established to analyse, among other aspects, wage differentials, working conditions and a possible response to public sector recruitment problems.

The initiatives under the 'Quality Reform' and 'Quality Fund' are being implemented with the aim of maintaining or increasing welfare service standards and improving administrative efficiency. Denmark has initiated a 'debureaucratisation' effort to ensure that staff in the healthcare sector spend most of their working time on core activities, i.e. treating patients. The Prevention Commission can also be seen as an attempt to reduce the expected increase in the need for future health care services.

Every five years, starting in 2008/2009, conditions in the hospital sector will be compared with conditions in neighbouring countries in order to continually strive for excellence. Information on productivity and quality is regularly published to contribute to knowledge-sharing between hospitals. The 'debureaucratisation' initiative also involves developing further reliable and timely health statistics in areas such as waiting times, free choice, etc.

5.2. Long-term care

5.2.1. Description of the system

The basic principle of free and equal access for all citizens also applies to long-term care. Coverage is among the broadest in the EU. The local authorities are responsible for providing the various forms of long-term care services. The local authority grants assistance following individual assessment of the recipient's functional abilities and needs. Assistance mainly takes the form of home help or a cash subsidy to pay for assistants.

5.2.2. Accessibility

Danish long-term care aims to ease and improve the quality of everyday life and enhance the possibilities for individuals to manage on their own. Target groups comprise older people and (physically or mentally) disabled people. User involvement in the planning of assistance is considered a key principle. Permanent personal care and practical help is free. Fees may be charged for meal schemes, for example. Residents in social housing for the elderly or care homes pay a modest monthly rent and may have access to housing benefits or rebates depending on their financial situation.

Reducing waiting times and providing places in social housing or care homes constitutes a challenge. From January 2009, a care-home guarantee will ensure that older people with special needs for a social housing or care home place receive an offer within two months of

being put on the waiting list. The Prevention Commission is working on proposals that may help postpone the need for public assistance.

5.2.3. Quality

The ongoing quality reform of the public sector should help improve the conditions for people in need of care and people employed in the care sector through measures to ensure e.g.:

– Attractive jobs within a better framework for the recruitment and retention of staff (particularly important as many nurses and other staff will retire in the coming years and recruitment poses challenges due to demographic factors and the relatively low attractiveness of these professions);

– A reduction in the number of different assistants visiting an individual and one permanent contact person for the recipient of home-help services;

– Modernised buildings, facilities and technology (one initiative addresses labour-saving technology in the social and health field, including old-age care);

Accreditation: an accreditation model will be tested in care homes/assisted-living accommodation areas to systematically support staff quality development.

5.2.4. Long-term sustainability

In the longer term, the challenge is to ensure the financial sustainability of the care sector without affecting the quality of care or limiting the groups in real need of assistance. Sufficient labour will be needed to tackle the important welfare tasks. It will also be crucial to continue developing resource-saving working methods and further knowledge and knowledge-sharing on the most efficient methods. Actions are ongoing to improve quality and efficiency and to release resources, including reducing administration expenses, streamlining procurement, reducing absence due to sickness, using new technology and improving work organisation.

Public expenditure on long-term care is projected to increase to 2.2% of GDP by 2050 (from 1.1% of GDP in 2004), while the EU25 average is projected to be 1.5% by 2050.

6. CHALLENGES AHEAD

- To continue increasing the social and labour market participation of people with a foreign background and other disadvantaged groups through a comprehensive approach covering both personal and structural barriers to social inclusion.

- To continue efforts to retain older workers longer in employment in view of the ageing population and the need to ensure the fiscal sustainability of the welfare system, including initiatives to counteract the negative impact of voluntary early retirement benefit.

- To intensify multi-faceted efforts addressing disadvantaged children and youth, in particular with a view to reaching the targets for secondary education attainment.

- To further improve the quality and efficiency of the Danish health care system, including measures to recruit and retain staff and to strengthen prevention initiatives to achieve a 3-year increase in life expectancy.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,5	131,6	**2000**	76,3	80,8	71,6	66,0	55,7	**2000**	4,3	3,9	4,8	6,2
2005	2,4	123,6	**2005**	75,9	79,8	71,9	62,3	59,5	**2005**	4,8	4,4	5,3	8,6
2008*f*	-0,6	116,3	**2007**	77,1	81,0	73,2	65,3	58,6	**2007**	3,8	3,5	4,2	7,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	72,7	77,9	14,1	17,6	61,6	60,7	5,1	**1995**	8,1	82,5	16,3		-
2000	74,5	79,2	15,2	18,3	62,9	61,9	5,3	**2000**	8,3	82,4	16,0	**2005**	0,3
2006	76,1	80,7	16,2	19,2	67.7b	67.1b	3,8	**2006**	9,5	84.1d	14.3d	**2006**	0,2

s: Eurostat estimate; p: provisional; b: break in series; d:change in methodology

**THE: Total Health Expenditures*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	31,9	37,7	17,8	14,8	12,4	6,8	10,6
2000	28,9	38,1	20,2	10,5	13,1	6,1	12,0
2006	29,1	37,9	21,6	7,2	13,1	5,3	14,9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
2004	23,6	26,8	9,5	n.a.	n.a.
2010	25,0	0,2	0,6	n.a.	n.a.
2030	37,8	4,0	2,9	n.a.	n.a.
2050	41,3	4,8	3,0	n.a.	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate*				***Poverty risk gap****				***Income inequalities****	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	12	10	11	18	17	21	24	9	3,7	**2005**	12
male	11	-	11	16	19	-	24	7	-	**2006**	11
female	12	-	11	19	16	-	22	9	-	**2007**	11

**without imputed rent*

	People living in jobless households					***Long Term unemployment rate***			***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64			% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female	Total	Male	Female
2002	5,6	7,6	7,2	8,0	**2000**	0,9	0,8	1	**2000** 11,6	13,4	9,9
2004	6,0	8,5	8,3	8,8	**2004**	1,2	1,1	1,3	**2004** 8,5	10,4	6,7
2006	5,0	6,9	6,4	7,3	**2007**	0,6	0,5	0,7	**2007** 12,4b	15,7b	8,9b

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,7	0,73	0,7	***Aggregate replacement ratio***	0,39	0,38	0,43

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
7	20	-10	DB	30	DC	100	78	0,9	8,8	12,7

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Germany

1. SITUATION AND KEY TRENDS

After weak growth in 2005 (0.8%), GDP increased more quickly in 2006 and 2007, amounting to 2.9% and 2.5% respectively, and influenced the labour market positively: unemployment came down from 10.7% (2005) to 8.4% in 2007 (men: 8.5%; women: 8.3%). In 2007, the number of unemployed came down to a level last seen in 1994 (3.8 million). In November 2008 the unemployment rate declined to 7.1% (EU27: 7.2%).

With an employment rate of 69.4% in 2007, Germany almost achieved the Lisbon target while already meeting the target for female employment (64%) and older workers (51.5%) — the latter amounting to only 37.6% in 2000.

Vulnerable groups benefited from the progress; the number of people living in jobless households — which peaked in 2004 (11.1%) — came down to 9.6% in 2007.

In terms of unemployment, regional disparities continue to play a certain role (both between and within the *Länder*)[18]: in 2005, the employment rate in Eastern Germany (66%) was 3.6 percentage points lower than in Western Germany.[19]

However, partly as a result of the global financial crisis, growth has started to slow down in 2008 (1.3%) and the Commission and the German government expect it to become negative in 2009 (-2.3%, -2.25% respectively). The Commission forecasts for 2009 an unemployment rate of 7.7% and of 8.1% for 2010.

Inflation is expected to have increased from 2.3% in 2007 to 2.8% in 2008 due to higher wage growth and lagged effects from higher energy and food prices. This development might put some strain on households' disposable income. However, the Commission expects inflation to drop to 0.8% in 2009 and to 1.4% in 2010.

In 2007[20], the at-risk-of-poverty rate amounted to 15% (men: 14%; women: 16%)[21]. This is slightly below the European average (EU25: 16%). National data suggest that it had been rising steadily since 2000 but that this trend was broken in 2007.

Life expectancy is relatively high. The demographic old-age dependency ratio amounted, in 2008, to 30.3 and is expected to increase to 46.2 by 2030 and to 56.4 by 2050. Healthy life years have also been increasing (rising from 60 years in 1995 to 65 in 2003).

In 2006, expenditure on social protection amounted to 28.7% of GDP, which is above the EU27 average (25.8%). 12.2 % of GDP was spent on pensions, 8% on sickness/health care,

---

18 According to national data, in December 2008 unemployment rates varied between 4% in Southern Germany (Bavaria) and 13.5% in the North-East (Mecklenburg-Vorpommern).

19 National data, microcensus 2005.

20 The 2007 German SILC data are to be considered as provisional. The validity of any comparison with previously published data is limited.

21 Source: EU-SILC (2007); income year 2006.

1.7% on disability and 0.8% on housing and social inclusion benefits. The amount spent on families and children (3.1% of GDP) is significantly higher than the EU27 average (2.1%).

2. OVERALL STRATEGIC APPROACH

The 2008 – 2010 NSR aims for a socially inclusive society offering opportunities for every citizen to participate in economic and societal life. It follows up and builds on the 2006 – 2008 NSR, with the relevant challenges, the underlying approach to tackling them and the key priorities remaining largely unchanged.

Recent reforms, covering both employment and minimum resources policies, aim to activate people, striking a balance between the rights and obligations of benefit recipients. In parallel, Germany has pursued a policy of modernising its social protection system with a view to ensuring financial sustainability and curbing the increase on non-wage labour costs. The focus has shifted from reforming the pension sector towards health and long-term care. In addition, family policy has moved up the political agenda. New measures to boost child care facilities, a new benefit to facilitate reconciliation between work and family life and a new allowance for low-income families with children with a low income have been implemented. More generally, in response to Germany's poor performance in the first PISA study, a debate is ongoing on how to improve child care, education and training systems in order to fight the transmission of poverty, increase social mobility and enhance the social inclusion of persons with a migration background.

Support for persons with a migration background[22] has been mainstreamed within the strategy. Various measures have been taken in the field of employment policy and in the area of education and training, such as vocational training or language courses.

Germany is responding to the effects of the financial crisis with a number of measures[23]: the resources available to the public employment service are being increased (1000 additional placement officers are being hired) to ensure that those who become unemployed will be offered intensive coaching; the duration for receiving short-time working allowance (*Kurzarbeitergeld*) is being extended from 6 to 18 months.

The strategies under the Lisbon process and the social OMC have been designed in a consistent way. Progress on the labour market is crucial for the integration of people within economic life and society and to finance social protection systems. In general, a high share of the unemployed are at risk of poverty (51% in 2007) but their absolute number has fallen considerably (in the years 2006 and 2007 by more than a million).

The NSR sets few, yet ambitious targets. These call for boosting child care facilities, the employment rate among older workers and training for young people, creating employment

---

[22] According to the definition used by the German government, a "person with migration background" meets at least one of the following criteria: 1. the person was not born in the Federal Republic of Germany and has immigrated into Germany after 1949; 2. the person does not have the German citizenship or has been naturalized; 3. the person has at least one parent that meets the first or second criterion

[23] Furthermore, a second financial stimulus package is under preparation; it includes one-off bonus of 100 euro for every child in 2009; additional 2 bn euro (for 2009 and 2010) for further training and skills' upgrading for short-time and low-skilled workers; as of July 2009 the recipients of the second stage of unemployment benefit will receive a higher children allowance for children between 6 and 13.

for disabled people, cutting the ratio of school drop-outs, and raising the contribution rate in the statutory pension scheme as well as its replacement level before taxes.

The government involved the regions (*Länder*), the social partners and key stake-holders in the preparation of the NSR.

During the period 2007–2013, the ESF allocation for Germany amounts to €9.4bn. In comparison to the period 1999–2006, the policy focus has shifted to education and training. Increasing attention is being devoted to young people, migrants and people furthest from the labour market. Germany will spend 35% of its allocation on 'Improved Human capital' and 31% on 'Enhanced Access to Employment and Social Inclusion of Disadvantaged Persons'.

Equality between women and men is addressed within the overall approach, with the focus on the gender pay gap and the reconciliation of work and family life. Within the overall approach, disabled people are mainly taken into account in employment policy, where they represent an important target group. Other issues that are highly relevant from a social inclusion standpoint, such as housing or transport, are not regarded as urgent challenges.

3. SOCIAL INCLUSION

3.1. Key trends

While vulnerable groups have benefited from recent progress in the labour market, they still face important problems: long-term unemployment fell from 5.4% in 2004 to 4.7% in 2007 but is higher than the EU27 average (3.1%). Unemployment constitutes an important challenge among low-skilled workers (amounting to 17%, a figure exceeded in only four other member States) and among non-nationals (16.2% — EU27 average: 12.1%). In 2007, the employment rate of people born in another EU country (68.2%) was almost as high as that for people born in the country (70.9%), but was considerably lower for persons born outside the EU27 (49.6%). Youth unemployment — which was 15.5% in 2005 — fell to 11.9%, below the EU27 average (15.4%).

In 2007, the risk of poverty (15%) was one percentage point below the European average. Women faced a higher risk (16%) than men (14%), as well as older people (17%); again, the risk for women in this age group was higher (20%) than for men (14%). For children aged 0 – 17 the at-poverty-risk was one percentage point lower than the general rate. However, according to national data[24] for 2005, the poverty risk for people with a migration background is much higher (28.2%) than for others (11.6%).

A major determinant is economic status. While the overall share of people living in jobless households decreased from 11% in 2005 to 9.5% in 2007, 51% of unemployed households, 39% of jobless households without dependent children and 60% of jobless households with dependent children are at risk of poverty. The in-work-poverty-risk is 7% (one percentage point below the European average). Data on unemployment and low wage traps suggest that disincentives to work are still considerable, in particular for lone parents.

[24] Annex to "7. Bericht der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration über die Lage der Ausländerinnen und Ausländer in Deutschland", December 2007. The data are based on the "Mikrozensus 2005"; the data are not comparable to SILC data.

Another important factor is household composition: households consisting of one person display a higher poverty risk (men: 25%; women: 29%) as well as single-parent households with at least one dependent child (34%). For a household consisting of two adults and one child, the poverty risk drops from 60% (when both adults are inactive) to 13% when one person is in fulltime employment and to 6% when both are in employment.

One cause for concern is that, according to national data, the at-poverty-risk has been steadily increasing between 2000 and 2006. However, the trend came to an end in 2007. While these figures show that the recent progress in terms of growth and jobs has had a significant impact on poverty, the question is of how poverty will develop in a context of negative growth.

The impact of social transfers in fighting poverty is sizeable. These transfers reduce the poverty-risk from 25% to 15%. For children, they halve the risk from 30% to 14%. The net income of social assistance recipients amounts on average to 90% of the poverty threshold in the case of a single household, to 120% in the case of a lone parent with 2 children and to 110% in the case of a couple with 2 children.

Unemployment among persons that do not have German citizenship decreased by 12.8% from December 2006 to December 2007.

The early school-leaving rate is slightly under the EU average, but still far from the 2010 target of 10%. It declined from 14.9% in 2000 to 12.7% in 2007. The rate of low reading achievers also decreased from 22.6% in 2000 to 20% in 2006.[25] The inclusion of immigrants and their children remains a challenge.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Germany has achieved good progress in terms of ensuring that the labour market reforms support the long-term unemployed and people furthest from the labour market. It has furthermore adopted a large number of measures to support specific target groups, such as younger people or older workers. However, the situation of low-skilled workers remains unsatisfactory.

Germany has started to address the challenge of breaking the inter-generational transmission of poverty as well as ensuring the active social inclusion of persons with a migration background. Children and young people are a clear priority for Germany, with strategies being developed to overcome issues such as child poverty, early school-leaving and youth unemployment. However, agreeing a consistent policy among the various actors remains a challenge. The social inclusion of young persons with a migration background needs to be improved. Furthermore, the strong relationship between educational achievement and social background has to be addressed.

3.3. Key challenges and priorities

The key challenges and priorities are largely those identified in the 2006–2008 NSR. A cornerstone of the overall strategy is labour market reform, which aims to reduce unemployment and increase employment.

---

[25] German National Strategy Report, p. 50; source: OECD (Pisa-study)

Besides vulnerable groups such as the long-term unemployed, the 2008–2010 NSR focuses on (1) people facing multiple obstacles to (re)entering the labour market and improving their education and training opportunities; (2) the integration of migrants within economic and social life; (3) the fight against poverty among families and children, in particular the transmission of poverty, through improved access to education and (4) the disabled.

3.4. Policy measures

Germany has set up or strengthened existing measures to provide targeted support to vulnerable groups. Many are linked to the labour market, such as a number of new wage subsidies: '*JobPerspektive'*, for people facing multiple problems on the labour market; '*Kommunal-Kombi'*, to support the long-term unemployed; measures for young people (*Qualifizierungszuschuss* and *Eingliederungszuschuss*). One programme has been set up to help prepare for vocational training (*Einstiegsqualifizierung*). The government has also launched an initiative aiming to create 100 000 additional places for apprenticeships by 2010 ('*Jugend — Ausbildung und Arbeit'*), which is supported by a new subsidy for employers (*Ausbildungsbonus*). '*Perspektive 50plus'*, which aims to support older workers among the long-term unemployed, is being continued.

To facilitate the integration of disabled people within the labour market, the government has launched the programme '*job — Jobs ohne Barrieren*' (co-financed by the ESF). Furthermore, the programme 'Job4000' will run until 2013 with the aim of creating 4 000 new jobs for people with severe disabilities.

In January 2007 the government introduced a new parental benefit (*Elterngeld*), following the child allowance (*Kinderzuschlag*) in 2005, for low-wage earners. A new law was adopted in September 2008. Child care facilities will be increased by 2013 to cater for 35% of all children below 3.[26] In October 2008, the government approved a bill to increase child tax allowance from 1 January 2009 (*Kinderfreibetrag*).

These measures also form part of a wider strategy to improve education: in January 2008 the government adopted an initiative to improve skills, qualifications and education (*Qualifizierungsinitative*). It comprises a number of measures ranging from supporting life-long learning to vocational re-training, such as the IZBB programme (*Zukunft Bildung und Betreuung*), which is investing €4bn in all-day-schools over the period 2003–2009 to give targeted support to pupils facing particular difficulties. Another programme launched in 2008 helps young people to acquire a formal vocational qualification ('*Perspektive Berufsabschluss'*).

The NSR highlights the importance of the "national plan for integration", also from inclusion perspective. The plan contains 400 measures to support persons with a migration background. One key element is to promote proficiency in German.

3.5. Governance

The NSR was drafted in cooperation with the regions (*Länder*), the social partners and key stake-holders. In 2001, the 'Permanent Council of Advisors for Social Integration' was set up to assist in drawing up the National Action Plans. Furthermore, the government has continued the dialogue with relevant stakeholders through a series of seminars ('Forteil').

[26] The actual coverage varies between the regions; in average, the coverage was 22.7% in 2007.

4. PENSIONS

4.1. Key trends

The German pension system continues to rely to a large extent on its statutory pension scheme. It is a general pay-as-you-go, earnings-related scheme that covers about 80% of employed persons. Major reforms have been implemented since 1992 which (1) revise the pension adjustment formula (in particular the 'sustainability factor', which is geared to changes in the ratio between contribution payers and pension recipients), (2) increase gradually the retirement age, with actuarial reductions in the case of retirement before that age and (3) introduce mechanisms to take into account child care. Some of these reforms, in particular the modification of the pension formula, will lead to lower pension levels in the social pension insurance scheme.

To offset this reduction, a new state-subsidised, fully funded voluntary direct-contribution scheme ('Riester-Rente') was set up in 2002. This is a privately managed capital-funded scheme. The contributions are strongly state-supported. The scheme is supported by bonuses (independent of wages) and by the fact that contributions are tax deductible. As bonuses are independent of wages, the support for low-income groups is rather strong. In addition, a special child bonus makes the Riester-Rente particularly attractive to those who have children.

In 2006 it was decided to increase the pensionable age from the current 65 to 67 in 2029. The increase will be phased in gradually, starting in 2012, the first generation to be affected being those born in 1947. Early exit paths are being closed with a fairly short transition period.

In 2008, the government decided to suspend a certain part of the pension adjustment formula - the so called 'Riester-Treppe' - for 2008 and 2009. When indexing statutory pensions, the Riester-Treppe takes into account employees' increasing expenditure for their supplementary old-age provision. Thus, its suspension allows for a higher increase in pension benefits. Under the formula, the pension adjustment would have amounted to 0.46% in 2008. The actual increase was 1.1%. However, the suspension in 2008 and 2009 will be made up from 2012. This implies that pension adjustments in 2012 and 2013 will be lower.

At present, the level of pension expenditure is high but decreasing: according to ESSPROS data, pension expenditure was 13.4% of GDP in 2003 but 12.2% in 2006 (EU27 average: 11.9%). The reason is that the share of expenditure on early retirement, invalidity and survivors' pensions decreased. In January 2007, the contribution rate for the statutory pension scheme was increased from 19.5% to 19.9%.

The high level of overall expenditure corresponds to the good income position of older people: in 2007, the relative median income of people aged above 65 in relation to the age group 0 – 64 amounted to 86% (89% for men and 84% for women) – compared with the EU25 average of 84% (87% for men/82% for women). It is also reflected in the figure for the poverty risk for men (14%) which is one percentage point below the average for all age groups and 2 percentage points below the European average for the poverty risk among older men. The poverty rate for older women in Germany (20%) is higher than for older men but 2 percentage points lower than the European average. The aggregate replacement rate was 45% in 2007, for men 47% and for women 48% (EU25 average: 49%).

4.2. Key challenges and priorities

The challenge posed by demographic developments persists: the population aged between 20 and 64 is expected to decrease by 9.6 million by 2050. The number of people older than 64 is expected to increase by 7.6 million, while their life expectancy also continues to increase. As a result, the old-age dependency ratio — 27.8 in 2005 — is expected to increase to 56.4 by 2050. The pension dependency ratio was 74 in 2004, but is projected to increase to 98 by 2030 and to 117 in 2050.

The various pension reforms represent a balanced policy response in terms of sustainability and adequacy: the projected increase of 1.7 percentage points of GDP by 2050 is a fairly limited increase when compared with other European countries (public pension expenditure is projected to increase to 13.1% of GDP by 2050, as against 11.4% in 2004) — albeit at a high level. The theoretical replacement rate for the statutory scheme is projected to decrease by 9 percentage points, but this reduction is expected to be offset by the new voluntary scheme. Taking into account the effect of taxation in the future, the theoretical replacement rate in 2046 is forecast to be one percentage point higher than in 2006.

Germany has addressed the challenges identified in the 2007 Joint Report. Good progress has been made with a view to achieving longer working lives, participation in supplementary pensions has been further strengthened and its take-up has accelerated in recent years.

However, there is a risk that the high unemployment rates and high share of long-term unemployed among present cohorts of contributors will lead to low entitlements for a significant part of future pensioners and to a higher rates of old-age poverty.

The “Riester-pension” is likely to offset the decreasing replacement levels to some extent. The coverage of the "Riester-pension" and of the occupational schemes has been increasing continuously and, therefore, the German government is confident that both will ultimately play their role to ensure adequacy. However, the new scheme remains voluntary and therefore the further development should be monitored.

Concerns about maintaining the purchasing power of benefits may generate arguments for increasing pensions more quickly than the adjustment formula would allow. If such concerns continue to be met through ad hoc interventions in the way the formula operates, the credibility of the formula and its role in ensuring financial sustainability may be undermined.

In conclusion, the German pension system is a financially stable system that provides a high replacement ratio. It is rather successful in fighting old-age poverty, in particular in Eastern Germany. Periodic review mechanisms are in place for close monitoring of adequacy and financial sustainability as well as the reliable operation of schemes.

4.3. More people in work and working longer

The general employment rate was 69.4 in 2007 and is likely to have reached the Lisbon target in 2008. The employment rate for older workers has been increasing steadily for a couple of years: while it amounted to 37.7% in 1998, it rose to 45.4% in 2005 and 51.5% in 2007, thus reaching the Lisbon target. The government now aims to attain an employment rate of 55% in 2010. The effective labour market exit age in 2007 was 62 years (EU27: 61.2 years), compared with 60.6 years in 2000. Paths to early retirement are in the process of being closed.

The decision to increase the pensionable age contributes to ensuring financial sustainability and sends an important signal to workers and employers. Older workers will have to stay longer on the labour market to earn full pension entitlements. The government has taken measures to improve the situation and prospects of older workers (aged 55 – 64) on the labour market but the issue warrants continued attention. For people with low income and shorter careers the incentives to work longer will also depend on the future role of minimum income provision (*Grundsicherung*, cf. 4.5 below).

4.4. Privately managed pension provision

Occupational pensions of the book reserve type have been prevalent in the private sector for years. Recently developments and public discussion have centred on the new voluntary scheme introduced in 2002. The number of contracts for a "Riester-Rente" rose from 6.2 million in 2006, to 11 million in March 2008. So far little is known about the benefit levels of supplementary (occupational and private) pensions. However, projections suggest that the pension level – when taking into account social contributions but not taxation – will remain stable in the long run. Whether disposable income from this supplementary scheme will be able to compensate for the decline in benefit levels in the PAYG scheme remains to be seen.

4.5. Minimum income provision for older people

The German pension system does not provide a minimum pension (i.e. a benefit financed by pension insurance). In 2003 a tax-financed and means-tested allowance (‘*Grundsicherung im Alter’*) was introduced as a form of social assistance benefit for older persons with insufficient pension entitlements; it is currently drawn by only 2% of the population above 65.

However, future pension generations will find it more difficult to build up pension entitlements above the level of social assistance. For those with below-average earnings during working life, an even larger number of contributory years will be required to receive a pension above the social assistance level. In view of the labour market situation in the recent past (long spells of unemployment) and the higher age of retirement, the at-risk-of-poverty rate may well increase in the future and the *Grundsicherung* may therefore gain a bigger role.

4.6. Information and transparency

Germany has set up a comprehensive monitoring and reporting system that can be expected to achieve the necessary transparency (e.g.: annual report presented by the government on the financial prospects for the next 15 years; assessment of this report by the experts of the ‘Social Council’; a second report on old-age security to be published during every government term). When the reports show that the contribution rate needed for the desired replacement rate approaches certain thresholds, the government is obliged to submit a bill with counter-measures to parliament.

Information is also provided to individuals: every insured person above 27 years receives information every year on the projected amount of their future pension. Furthermore, a new initiative was launched in 2007: advisors working for the statutory insurance scheme inform citizens about old-age provision in adult education sessions (*Volkshochschulen*).

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The health care system is characterised by federalism and delegation to self-administered non-governmental bodies, which are the main actors in the system of social insurance: the health funds (HF) and their association on the purchaser side, and the physicians' and dentists' associations on the provider side. Hospitals are, on the other hand, represented by private-law organisations. The Ministry of Health proposes health legislation, supervises the non-governmental bodies and performs various functions in the field of licensing and supervision.

The health care system underwent major reforms in 2004 and 2007. The second reform entered into force on 1 April 2007 and has largely been implemented. It aims to: (1) ensure that every citizen has access to the system; (2) improve quality; (3) increase efficiency through higher transparency and more intensive competition; (4) extend the ability of insured persons to choose between different tariffs; (5) cut red tape, and (6) introduce a new financing mix.

The reform comprises a broad range of measures, including:

– Increasing competition within the statutory scheme by allowing contracts to be concluded between health funds and service providers and by introducing the possibility for insured person to choose between tariffs;

– Introducing a single contribution rate and a new health care fund (*Gesundheitsfonds*), which starts operating in January 2009, with an annually increasing contribution from the general budget to the new fund until 2016;

– Changing the overall structure of the system by introducing the possibility to merge health funds and allow them to become insolvent;

– Overhauling the remuneration system for doctors;

– Obliging private health insurance schemes to offer a 'basic tariff' (from January 2009 onwards) and making old-age reserves partly portable.

While the German health care system performs well in terms of access and quality, the level of expenditure is very high. The recent reform sets out to address, among other things, the efficiency of the system and its long-term sustainability; it aims to equalise differences in the distribution of financial burdens by introducing a uniform contribution rate. However, it is uncertain whether these aims will be met. In particular, it needs to be monitored whether the new fund will contribute to increasing efficiency, containing costs and avoiding risk selection.

5.1.2. Accessibility

89.6% of the population belong to the statutory health insurance scheme (SHI) and 10.2% have private health insurance (PHI). In the first quarter of 2007, 0.3% of legal residents were not insured. The 2007 reform introduced a legal responsibility to have an insurance policy, starting from 1 April 2007 for people formerly insured in social health insurance and from 1 January 2009 for people who were formerly privately insured. All those who have lost their

private insurance can apply to be affiliated, on the basis of the basic tariff, to any private insurance scheme.

In comparison to other countries, the level of co-payments is low (and generally limited to 2% of annual household income and to 1% for chronically ill persons).

Although the ratio of practising physicians per 1000 inhabitants is relatively high (3.5 vs. an OECD average of 3.1), problems have been reported concerning the geographical distribution of physicians, especially general practitioners in the new *Länder* and some rural areas. The 2008–2010 NSR addresses the issue by referring to a number of measures taken, without indicating the progress made. It needs to be monitored whether these measures are effective and sufficient.

5.1.3. Quality

The quality of health care has a high priority in Germany. Care providers, for instance, are legally obliged to implement quality management systems. Moreover, physicians are obliged to pursue continuing medical education. The Institute for Quality and Efficiency (IQWiG), which was established in 2004, performs health technology assessments for drugs and procedures. In addition, many hospitals acquire quality certificates on a voluntary basis to prove that they meet specific quality standards.

The Joint Federal Committee (*Gemeinsamer Bundesausschuss*) decided in May 2007 to extend quality management in hospitals. The 2007 reform has strengthened quality control mechanisms by giving the Joint Committee a more robust mandate.

The electronic health insurance card — seen as another tool to ensure quality — has entered its pilot phase (it is currently being tested in seven *Länder*). However, the NSR does not state when the card will be in use in the entire country.

5.1.4. Sustainability

Spending on health care in Germany is rather high: according to OECD Health Data 2008, Germany spent 10.6% of its 2006 GDP on health, following a steadily increasing trend (in 1990 it amounted to 8.3% of GDP). This was the fourth highest rate among OECD members and the second highest within the EU. Total health expenditure per capita is $3371 on a purchasing power parity basis. This was only the 10th highest rate among OECD members.

The bulk of total health care expenditure comes from the public sector (almost 76.9% in 2006), but the trend is decreasing: in 1992 it amounted to 81.5%. Public expenditure on health care amounted to 6% of GDP in 2004 (EU25: 6.4%) and is projected to reach 6.9% in 2030 and 7.2% in 2050, which would still be below the EU25 average (7.9%). The increase of 1.2 percentage points will also be below average (EU25: 1.6).

The recent reform introduced considerable changes to the financing system. Beginning in 2009, a uniform contribution rate will enter into force. Contributions will be centrally pooled in the new national health fund (*Gesundheitsfonds*), which will allocate resources to each health fund based on a risk-adjusted capitation formula. The new capitation formula will, in addition to gender and age, take into account morbidity from up to 80 chronic and/or serious illnesses.

Like other countries, Germany might face a long-term risk in terms of human resources in the health-care sector. By 2012 more than 40 000 doctors[27] will retire. However, the number of practicing physicians in Germany is well above the OECD average and growing each year. Furthermore, the attractiveness of the profession among students is still very high.

5.2. Long-term care

5.2.1. Description of the system

Social long-term care insurance was introduced in 1995. It is mandatory, covering the risk of needing permanent help, care and support, and comprises public and private schemes. The benefits in both schemes are the same. The level of grants is based on the degree of need for care, which is assessed by the Medical Board of the health insurance funds — irrespective of age, income or wealth. The insurance has been designed in such a way that it covers a large part of the costs linked to long-term care, but not all.

The system underwent a reform on 1 July 2008 to improve and extend, among other things, the benefits offered while increasing the contribution rate by 0.25 percentage points to 1.95%.

5.2.2. Accessibility

The entire population is covered by either the statutory scheme or a private scheme. The individual regions (*Länder*) can decide to establish long-term care centres (*Pflegestützpunkte*)[28]. The task of these centres is to improve the networking and interaction between local services (including services for the elderly and social welfare agencies etc) under one common roof, and especially to inform patients and their relatives in health and care matters. They must be independent and offer comprehensive counselling. They should be local and easily accessible.

As pointed out in the 2007 Joint Report, there is a debate in Germany on how to ensure access in the future, including specific contributions that long-term care insurance can or should make towards the total cost of care, notably in cases of intensive care needs.

5.2.3. Quality

Although the quality of care has steadily improved in recent years, findings of quality control reports still show that improvements are necessary in many respects. The government acknowledges the need to further strengthen and diversify measures in this field.

Different measures have been taken to strengthen quality: an important innovation under the Long-term Care Development Act is the expansion of quality assurance. The approved care institutions are obliged to take measures to maintain their quality and implement a quality management regime. The development and implementation of National Care Standards has become obligatory by law. In addition, outpatient and inpatient care facilities will be audited every year without prior notice. The quality performance of care facilities and the results of the external auditing carried out by the Medical Board of Health Insurance funds will be accessible to the public from 2009 onwards. In addition, the professional regulations have been changed to improve training in the care professions.

---

[27] Estimate by the Kassenärztliche Bundesvereinigung.

[28] Cf § 92 c of the Long-term Care Development Act (*Pflege-Weiterentwicklungsgesetz*).

5.2.4. Long-term sustainability

Long-term care insurance is financed through social security contributions. Their rate was increased on 1 July 2008 from 1.7% to 1.95%. According to the NSR, this is sufficient to finance the system, in view of the demographic development, until 2015. The NSR leaves the question open as to how the government intends to address long-term sustainability. However, it refers to an estimate by official advisors to the government (*Sachverständigenrat*) according to which the contribution rate will amount to 2.5% in 2050. The recent reform has not addressed concerns regarding the long-term financial sustainability of the system, for example, through the introduction of supplementary funded elements as referred to in the 2006 – 2008 NSR.[29] The task remains to present a concept to ensure the long-term sustainability of the long-term care system.

6. CHALLENGES AHEAD

- To ensure effective support for the long-term unemployed and people furthest from the labour market, in particular the low-skilled, low-wage earners and persons with a migration background, in an increasingly difficult economic context.

- To break the inter-generational transmission of poverty by increasing educational opportunities at all levels for disadvantaged groups.

- To ensure the adequacy and the long-term sustainability of pensions, notably by continuing to promote the participation in supplementary pension provision while reviewing whether progress made is sufficient and allowing the pension adjustment formula to play its role.

- To monitor the effect of the recent health care reform with a view to financial sustainability and, if necessary, to take further measures to keep expenditure growth under control and strengthen efficiency in the health sector.

- To monitor the effectiveness of the measures taken to address the geographical distribution of physicians and, if necessary, to take further measures to address the issue.

- To further improve the quality of care delivered in the long-term care sector while developing a concept to ensure the long-term sustainability of the system.

[29] National Strategy Report 2006 – 2008, chapter 4.3.4.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,2	118,5	**2000**	65,6	72,9	58,1	46,1	37,6	**2000**	7,2	6,0	8,7	8,5
2005	0,8	116,9	**2005*p***	66,0	71,3	60,6	42,2	45,4	**2005*p***	10,7	11,3	10,1	15,5
2008*f*	1,3	112,4	**2007**	69,4	74,7	64,0	45,3	51,5	**2007**	8,4	8,5	8,3	11,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2006)		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	73,3	79,7	14,7	18,5	60,0	64,3	5,3	**1995**	10,1	81,6	9,7		-
2000	75,1	81,2	15,7	19,4	63,2	64,6	4,4	**2000**	10,3	79,7	11,2	**2005**	n.a.
2006	77,2	82,4	17,2	20,5	65,0	64,7	3,8	**2006**	10,6	76,9	13,2	**2006**	n.a.

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

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care**
1995	28,3	42,7	30,9	8,8	8,2	1,9	7,4	**2004**	30,3	23,7	11,4	6,0	1,0
2000	29,3	43,3	29,5	7,9	11,3	1,7	6,5	**2010**	31,2	-1,2	-0,9	0,3	0,0
2006	28,7	44,3	29,1	6,3	11,1	3,0	6,2	**2030**	46,2	-1,0	0,9	0,9	0,4
								2050	56,4	2,7	1,7	1,2	1,0

**: including administrative costs; **: under the assumption that benefits are adjusted in l*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate**					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	15p	14p	15p	17p	24p	21p	26p	19p	5p	**2005**	12b
male	14p	-	14p	14p	25p	-	28p	19p	-	**2006**	15
femal	16p	-	16p	20p	23p	-	24p	19p	-	**2007**	14p

	People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	8.9	9.7	8.9	10.5	**2000**	3.7	3	4.6	**2000**	14.9	14.6	15.2
2004	10.9	11.1	10.8	11.4	**2004**	5.4	4.8	6.1	**2004**	12.1	12.2	11.9
2007	9.6	9.5	9.1	9.9	**2007**	4.7	4.8	4.7	**2007**	12.7	13.4	11.9

**: excluding students; **: Provisional data. Comparability with previous years are limited.; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0.86p	0.89	0.84		0.45p	0.47p	0.48p

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
1	2	-9	DB	11	DC	NA	70	19.5	NA	4

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Estonia

1. SITUATION AND KEY TRENDS

In 2007, GDP growth in Estonia remained high, reaching 6.3% (2006: 10.4%, EU: 2.9%). GDP per capita rose to 68% of the EU average. At the same time, inflation was almost twice as high as the EU average (EE: 6.7%, EU: 2.3%). However, recent developments show signs of recession. According to European Commission interim forecast of January 2009 the GDB growth is predicted to be -2.4% and inflation 10.6% in 2008.

The employment rate rose to 69.4% (EU: 65.4%) in 2007 and improvements were recorded both for young people (34.5%) and older workers (60%). The employment rate for both women (65.9%) and men (73.2%) was above the EU average with the exception of youth employment. The unemployment rate was 4.7% in 2007 (5.4% for men and 3.9% for women), which is lower than the EU average of 7.1% (6.6% for men and 7.8% for women). In the light of recent economic developments, the unemployment rate is expected to grow to 7% and the employment rate to fall by 2.5 percentage points by 2009, according to the Bank of Estonia's autumn forecast. Youth unemployment dropped to 10% and long-term unemployment decreased to 2.3% in 2007.

The ethnic minorities constitute almost 31% of the Estonian population, half of them holding Estonian citizenship. The unemployment rate for non-Estonians was approximately twice as high as for Estonians in 2007, and the difference for long-term unemployment was even higher. This fact has a strong correlation with regional disparities, unemployment being higher in the north-east of Estonia, where the percentage of non-Estonians is the highest. The main economic sectors in this region are basic and textile industries, which have suffered worst from difficult economic and financial circumstances.

The gender pay gap was very high at 25% in 2005, compared with the EU average of 15%. Women traditionally dominate in fields of activity and professions that are not very highly valued in society (for instance in education as kindergarten or primary teachers or in the welfare services as social workers).

Against a background of strong economic performance and improvement in the labour market, the at-risk-of-poverty rate increased to 19% in 2007, increasing 1 percentage point from 2006. In 2007, the at-risk-of-poverty rate was 18% for children and 33% for the elderly (compared with 20% in 2005).

The Estonian population is one of the fastest declining populations in Europe despite the rise in birth rates (1.64 in 2007). In 2006, life expectancy at birth was 67.4 years for men (13.2 years remaining life expectancy at 65) and 78.6 for women (18.3 years remaining life expectancy at 65). Healthy life years at birth were 49.4 for men and 53.7 for women. Despite positive trends in recent years, the indicators are still among the lowest in the EU. The old-age dependency ratio increased to 25.1% in 2007 and is projected to be 34.42% by 2030. Infant mortality is still high and increased to 5% in 2007.

In 2006, gross social protection expenditure decreased to 12.4% of GDP and is expected to fall by 0.6 percentage points over the period 2004-2010 and by 2.7 percentage points from

2004 to 2050, although the projections do not include long-term care[30]. Social protection expenditure is one of the lowest the EU (EU25: 27%[31]).

2. OVERALL STRATEGIC APPROACH

Estonia's overall overarching objective is rapid, sustainable and socially and regionally balanced economic development. The key areas for enhancing social protection and social inclusion are competitive education, participation in work life and good health. The social protection system should be designed to provide adequate support to cover social risks. The integrated approach to delivering benefits and services for people in need ensures the accessibility and quality of the help needed. The NSR consolidates the objectives and planned actions from strategic documents in different fields.

The main strategic areas in 2008-2010 are as follows: increasing employment; preventing long-term unemployment and inactivity; supporting families with children to avoid or eliminate poverty and social exclusion; supporting the active participation of the disabled and older persons; increasing the efficiency of social protection and providing incentives and services to support working, independent coping and participation in social life; creating equal opportunities for acquiring quality education in accordance with abilities; improving health indicators and extending quality lifetime; improving the quality and availability of medical and nursing care.

The goals of the NSR for social protection and social inclusion are in line with the Lisbon and Sustainable Development Strategies. Both strategies support improving the skills of the labour force, increasing the flexibility of the labour market and improving the quality of working life. NSR activities are financed under the State Budget Strategy for 2009-2012 and the National Strategic Reference Framework for the use of the Structural Funds for 2007-2013. For many social inclusion measures, use is made of programmes co-financed by the ESF (increase in qualified labour force, development of career systems etc).

For the preparation of the report, a steering committee was set up with representatives of ministries, major non-profit associations and European umbrella organisations. The report has been approved by the government.

3. SOCIAL INCLUSION

3.1. Key trends

In 2007, the at-risk-of-poverty rate was 19% (17% for men and 22% for women), and has increased one percentage point compared to 2006. The rate was 18% for children and 33% for the elderly, with 21% of men and 39% of women aged 65 or more. Thus the rate for elderly is much higher than for the rest of the population. The most vulnerable are single parents, the unemployed and those above 65 years of age living in one-person households, especially women. In 2007, the relative median at-risk-of-poverty gap was at 20%, lower that the EU

[30] Source: 'The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050)' Report prepared by the Economic Policy Committee and the European Commission.

[31] Provisional value.

average. Social transfers (excluding pensions) decreased poverty by 6 percentage points. For children and the elderly, social transfers reduced the at-risk-of-poverty rate by 10 and 3 percentage points, respectively. The share of children living in jobless households increased slightly in 2007 to 7.2% (6.9% in 2006) while the proportion of adults (18-59 years old) decreased to 6.0%, by 0.6 percentage points from 2006. The in-work poverty rate was the same as the EU25 average, 8% in 2006 (6% for men and 9% for women) and remained the same in 2007. The number of early school-leavers increased to 14.3% in 2007 while youth educational attainment (80.9%) was higher than the EU average (78.1%).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

For *the prevention and alleviation of long-term unemployment and exclusion from the labour market,* the new Employment Services and Benefits Act (which entered into force in January 2006) emphasised the importance of an individual and needs-based approach in employment services to ensure a more effective labour market policy. Attention was given to improving administrative capacity and promoting the services of the Labour Market Board among the inactive in order to increase employment rates. Active employment measures were made more attractive by providing access to heath insurance and increasing the daily unemployment allowance rate to €2.1. Long-term unemployment decreased from 5% in 2004 to 2.3% in 2007 and activity rates increased by 2.7 percentage points during the same period. As a new initiative, state funding has been introduced for in-service training of the workforce in accordance with the principles of lifelong learning, as an important element of in-work support. The level of lifelong learning has increased slightly to 7% but is still below the EU average of 9.5%. The purpose of the new Employment Contracts Act is to make the labour market more flexible while maintaining the security of employees, as only 8.2% are employed part-time. The registration of all so-called 'near-accidents' should improve occupational heath and accident prevention.

For *the prevention and alleviation of poverty and the social exclusion of families with children,* the duration of parental benefit was extended to 575 days, while several amendments to the 'State Family Benefits Act' introduced or increased various benefits for families with children and for foster care. The at-risk-of-poverty rate for children decreased by 1 percentage points between 2005 and 2006. The conditions for the payment of disability allowances were changed in accordance with the severity of a disability by the new Social Benefits for Disabled Persons Act, while for compensation for additional work-related costs was introduced to increase the employment rate of the disabled.

3.3. Key challenges and priorities

In view of the social situation in Estonia, the four policy objectives chosen to address poverty and social exclusion carry forward and extend the priorities selected in the 2006-2008 NSR and the challenges identified in 2007 Joint Report on SPSI by devoting attention to children, the disabled and the elderly.

The approach is sufficiently multi-dimensional, with quite a good balance between existing and new policy measures and also between prevention and alleviation. In contrast, the gender dimension has not been adequately taken into account — the gender pay gap (which is one of the highest in the EU) and the high share of single women among the elderly. Insufficient attention is given to the ethnic aspect of social inclusion and regional differences.

3.4. Policy measures

For the period 2008-2010 four priorities have been set:

Prevention of long-term unemployment and inactivity and bringing the unemployed and inactive people into employment. The focus is on the situation in the labour market: extending the target group of active employment services to include the inactive population; development of the career services system; facilitating labour market entry for persons released from custodial institutions; training of the unemployed to become home and community care workers; the purchase of nursing care services; support for active employment measures and their testing; and increasing awareness of flexible forms of work. While adequate income support (increase in unemployment allowance, access to health insurance) was emphasised in the previous period, the 2008-2010 NSR focuses on a combination of active employment measures with access to services. Nevertheless, no special attention is given to ethnic minorities. (Regardless of the measures, the unemployment rate is projected to increase).

Targets for 2010: Employment rate — 70% (2007: 69.4%); unemployment rate — 5.5% (2007: 4.7%); long-term unemployment rate — 2% (2007: 2.3%); activity rate — 73.8% (2007: 72.9%); employment rate of older people — 63.5% (2007: 60%); employment rate of women — 68.3% (2007: 65.9%).

Prevention and alleviation of poverty and social exclusion in families with children. As the family and child benefit system is now established, the main measures focus on the development of services to support families raising children and help bring parents to the labour market through: the advancement of parental education; support for parents and provision of welfare services based on need; providing equal opportunities for obtaining quality education; support for the participation of parents in the labour market; and carrying out surveys and analyses concerning children.

Targets for 2010: Share of children aged 0-15 living below the absolute poverty line — 6.2% (2007: 9.4%); share of children aged 0-15 living below the relative poverty line — 16.8% (2007: 18%); share of households with children on subsistence benefit — 30.1% (2007: 32%); number of children without parental care and in need of assistance (registered for the first time, per 10 000) — 54 children aged 0-17 per year (2007: 60); average number of children per child protection official — 1350 (2007: 1630); young people who are not learning, have acquired only basic education or have a lower education level — 10% (2007: 14.6%); share of 15-year-old children with low reading skills — 20% reduction (2007: 13.7%); employment gap of parents with small children — 35% (2006: 38.5%).

Supporting the active participation of the disabled in social and working life. Active inclusion of the disabled is an important challenge for Estonia. The main measures to improve self-realisation and independence of the disabled include: development of services to support the rehabilitation and independent coping of disabled persons; providing income support and employment opportunities for disabled persons; promoting the education of disabled persons; and conducting surveys and analyses on disabled persons. On the other hand, the social economy, social enterprises or sheltered employment as a source of work for disabled people are not mentioned.

Targets for 2010: Employment rate of persons (age group 15-64) with restricted capacity for work due to long-term illness — 38.5% (2006: 32.6%); disabled persons on 24-hour welfare services as a percentage of all adults with disabilities — 6.2% (2007: 6.4%)

Prevention of the social exclusion of the elderly and supporting active and dignified aging. Estonia has a relatively high share of elderly people and also a high employment rate of older people (55-64 years of age), but at the same time a high relative poverty rate among older people, particularly women. The main measures planned in the NSR for the prevention of social exclusion include: increasing employment opportunities for older people; developing a network of care institutions for the elderly; raising the qualifications of staff in the care institutions for the elderly; and developing a sustainable financing system for the old-age care system. However, the measures do not take adequate account of the gender dimension and ethnic aspects. Despite these measures, the poverty rate of persons over 65 is projected to increase.

Targets for 2010: Employment rate of older people — 63.5% (2007: 60%), health-related restrictions on daily activities among persons aged 65 or above — 33% (2007: 35.1% of the population over 65 years did not report any restrictions on their daily activities due to health reasons); persons over 65 on 24-hour care services as a percentage of the total population of the same age — 1.8% (2007: 1.72%); percentage of elderly people living under the absolute poverty line — 3.7% (2007: 3.8%); at-risk-of-poverty rate for persons over 65 — 35% (2007: 33%); households with retired members on subsistence benefits as a percentage of all households with retired members — 1.7% (2007: 2%).

3.5. Governance

For the preparation of the report, a steering committee was set up with representatives of ministries, major non-profit associations and European umbrella organisations. There is no evidence of debate in the media or political discussions. Arrangements to ensure the mobilisation and involvement of all relevant actors are in place, though insufficient attention is given to the involvement of people experiencing poverty.

Thematic roundtables and workshops of representatives of the government, local governments and NGOs will ensure monitoring of the implementation of the new measures. Third-sector organisations will be invited to participate. All ministries will be responsible for monitoring and evaluation of their respective action plans with the Ministry of Social Affairs, which is responsible for the implementation of the report as a whole. In addition, every sector will be responsible for the involvement of stakeholders. The arrangements to monitor and evaluate the overall implementation of the inclusion part are in place and commonly agreed EU indicators, supplemented by national indicators, have been identified for monitoring progress.

4. PENSIONS

4.1. Key trends

Since the previous reporting period no major changes in the Estonian pension system have been introduced. During 1999-2002 a pension reform took place, resulting in a statutory PAYG defined-benefit pension scheme, a statutory mandatory funded defined-contribution scheme and voluntary private pensions. The state PAYG system is financed from 20% (or 16% for members of the mandatory funded pillar) of the social tax, paid by employers, and is moving from a flat-rate pension scheme to a more earnings-related scheme. The statutory

defined-contribution system is financed from 4% of the social tax (paid by employers) and 2% of gross wages (paid by employees), and is mandatory for persons born in 1983 or later. Those born before 1983 and in the labour market can join the second pillar on a voluntary basis. The multi-pillar pension system is based on the requirement that income at pensionable age should be drawn from several different sources with different legal, organisational and funding principles. However, a closer relationship between pension, work and remuneration poses a risk that people with lower incomes or short professional careers may not have sufficient resources to ensure a decent subsistence at pensionable age. The large wage gap between different groups (e.g. men and women) will ultimately translate into an income gap in retirement as well.

The pension reform provides for an increase in the statutory retirement age and its gradual equalisation for men and women (to 63 years) by 2016. Currently, the retirement age is 60 for women and 63 for men. There is a possibility for retirement 3 years earlier if the person has a work record of at least 15 years, indicating a rather short average contributory period given the demographic situation.

The average old-age pension was raised twice over the period 2000-2007 to €200 a month, but is still rather low.

4.2. Key challenges and priorities

State pension insurance, which is partly financed by the central government, has been in deficit over the previous years (except for 2007) and will remain so for the period 2008-2011. The Government has put additional resources into the pension insurance reserves. Although the reserves are fairly substantial, the financial sustainability of the Estonian pension insurance system is weak, in view of the 2008 requirements. Likewise, the positive effect of the mandatory funded pillar on the pension insurance balance will not be seen for decades. In the meantime, the additional need for funds may amount to tens of billions in EEK.

Pension expenditure in Estonia was 6.0% of GDP in 2006 (EU25: 12.0%[32]). Public pension expenditure is projected to decrease from 6.7% in 2004 to 4.2% in 2050, as a result of the diversion of part of social security pension contributions into privately funded schemes. Total pension expenditure is projected to decrease from 6.7% of GDP in 2004 to 6.6% in 2050.

Under the new regulations, pension increases will be more in line with the increase in social tax, as 20% of the value of the index is based on the annual increase in the consumer price index and 80% on the annual increase in that part of social tax related to pension insurance, instead of 50% previously. This change should increase pension adequacy without jeopardising the sustainability of the system. The solidarity element in the state pension was increased by increasing the proportion of the basic pension amount. Given the current gravity of the economic situation in Estonia, the change could lead to a further deficit in the PAYG system.

In 2007 the aggregate replacement ratio was 47% (40% for men and 57% for women). According to projections of the theoretical replacement rates, an increase in net retirement income as a ratio of work income at the point of retirement is expected by 11 percentage

[32] Provisional value.

points between 2006 and 2046 for a worker retiring at age 65. This is due mostly to the calculated rates of return on the statutory funded scheme, covering younger workers.

4.3. More people in work and working longer

Generally, the financial incentives for working after retirement age are good in Estonia, as pension can be drawn in combination with salary. As a result, Estonia's indicators for the employment of older people are higher than the EU average. The employment rate was 41.4% for 60–64 year-olds (EU: 28.1%) and 58.5% for 55–64 year-olds in 2006 (EU: 43.6%). The effective retirement age was 62.6 years (EU: 61.2), whereas life expectancy at birth was 67.4 years for men and 78.6 years for women.

At the same time, about half of pensioners retire before statutory retirement age by taking up early retirement pension, special pensions and pensions under favourable conditions, indicating a need to look further at early exit pathways for older workers.

Preventing the social exclusion of the elderly and supporting active and dignified ageing is one of the priorities in the social inclusion part of the report, with measures for increasing employment among older people and promoting flexible forms of work.

4.4. Privately managed pension provision

The compulsory funded defined-contribution scheme was introduced in 2002 by diverting a proportion of contributions from the statutory PAYG scheme into private funds. The scheme is mandatory for those born from 1983, with the possibility for the others to opt in. Following recent modifications, the investment limits for real estate and real estate funds have been increased from 10% to 40% and for venture capital funds from 30% to 50%.

The first benefits will be paid as from 2009. The recently adopted legislation covers the regulation of annuity contracts, programmed withdrawals, lump sum payments from pension funds and stricter regulation of administration fees. The law also provides for an increase in the equity investment limit for so-called 'progressive' (higher risk) pension funds from 50 to 75%, which increases the risk at a time of crisis on the financial markets.

Voluntary private pension schemes were introduced in 1998. Participation in such schemes can take two different forms: pension insurance policies offered by licensed private insurance companies or units of pension funds managed by private asset managers. However, participation is low despite tax incentives (voluntary contributions are deductible from taxable income) covering around 8% of labour force.

4.5. Minimum income provision for older people

The relative standard of living for older people decreased to 69% (72% for men and 68% for women) in 2006 compared to 73% in 2003 for the general population. The relative income share for those aged 65 and older was 69%, lower than the EU average (EU25: 85%) in 2005. The risk of poverty for people aged 65 and older increased from 20% in 2005 to 33% in 2007 (36% before social transfers), women having the highest risk. Over the period 2000 to 2007, the share of persons over 65 with an income below the relative poverty line doubled, with a particularly high increase during 2004-2006. The minimum pension (which is below the poverty level) covers the minimum food basket, but has persistently been below the national minimum cost of living as well as the relative poverty line.

4.6. Information and transparency

The transparency of the system is good, especially given the high levels of internet usage among the public and the availability of most information and transactions via electronic channels. The report contains no specific information on the role of social partners and other stakeholders regarding pensions and how they are involved in the decision-making process.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Estonian Health Insurance Fund (EHIF) purchases and reimburses care for about 96% of the population, based on residence and group membership (e.g. the unemployed, children, pensioners, full-time carers). Provision is decentralised and mostly public. Residents register with primary health care (PHC) doctors, who play a gate-keeping role for specialist and hospital care. Specialist care is provided in health centres, hospital out-patient departments and specialists' own practices. In-patient care is provided in regional, central and local hospitals (mostly municipal or state). The system is financed through an earmarked payroll tax on employees and the self-employed and through taxation.

In 2006, life expectancy at birth was 67.4 years for men and 78.6 for women, among the lowest in the EU despite the positive trends of recent years. The gap between men and women is 11 years, which has remained approximately the same since 1996. In 2006, healthy life years came to 49.4 years for men and 53.7 for women. There is a significant difference between healthy life years and life expectancy at birth. This implies that many elderly persons are restricted in their daily activities for the last two decades of their life. There are also socio-economic health inequalities: women with a higher education live 13 years longer than men with a basic education.

The health behaviour of young people has deteriorated remarkably from the mid-1990s. The share of young people and adults who smoke, consume alcohol, use illicit drugs and are overweight is growing, and the level of injury continues to be high among young people. There is a high death rate from traffic accidents, cardiovascular diseases and cancer, while the incidence of newly reported HIV and TB infections is also high. These are deemed preventable to a large extent.

The government has approved the Public Health Development Plan for 2009-2020 with the strategic objective of continuously improving the health status of the population. Among the priorities are increasing the population growth rate, raising average life expectancy (at birth for men to 75 and for women to 84 by 2020) and healthy life expectancy (at birth for men to 60 and for women to 65 by 2020), while reducing socio-economic health inequalities

5.1.2. Accessibility

According to national data, 96% of the population were covered by public health insurance in 2007. Insured persons are charged for some services (including adult dental care). Out-of-pocket payments formed 21.3% of total health expenditure in 2004. Self-reported unmet need for medical care was 7.3% in 2006 (12.2% for dental care) compared with the EU average of 3.1% (5% for dental care). The figure for the poorest socio-economic groups is 4.5 greater

than for the better-off (9 x for dental care), with richer households having better access than poorer households.

According to the authorities, the availability of family physicians is good, with 99.8% of the population able to make an appointment within 3 days, while the availability of certain special medical services (both ambulatory and in-patient) is problematic. On the other hand, according to a longitudinal survey, the share of patients who had to wait for an appointment with a specialist doctor for over one month increased from 14% in 2003 to 25% in 2007, and the share of patients who had to wait for an appointment with their family doctor for three or more days increased from 18% in 2003 to 22% in 2007. Ongoing efforts are being made to shorten and prioritise the waiting lists for specialised care. Additional resources are being allocated to services with the longest waiting lists, while central waiting lists have been established for some services for people with urgent needs. The free primary health care counselling phone was launched in 2005, but there is still a lack of awareness.

There are also considerable geographical differences in access to PHC. Access to family doctor services is better in rural areas than in the capital city of Tallinn. The authorities want to ensure that PHC is available close to the place of residence.

Uninsured persons are entitled to receive emergency care paid by the state. In 2007, health insurance was introduced for all unemployed persons participating in active labour market measures. The government wants to ensure the equal availability of PHC and planned special medical care to everybody on a voluntary basis from local governments.

5.1.3. Quality

Longitudinal national surveys carried out jointly by the EHIF and the Ministry of Social Affairs show a positive trend in the development of patient-centredness in the health care system. The quality of medical care received was assessed as ‘good’ or ‘rather good’ by 69% in 2007, while 23% considered it ‘bad’ or ‘rather bad’.

A development plan has been drawn up to ensure a more purposeful development of primary health services by supplementing current services with others (such as nursing care) and creating cooperation networks. The main objective is to facilitate access close to home.

Quality standards based on best practice and guidelines for in-patient and ambulatory nursing-care services and modern treatment for rehabilitation have been prepared. The operating licence issued by the Health Care Board ensures the conditions for providing quality services. The EHIF in cooperation with experts carries out quality audits. To measure the quality of hospital services, the EHIF together with the WHO have been developing a system of quality indicators.

An eHealth project has been launched, the aim being to create an Estonian-wide digital documentation system by the end of 2008.

Patients are free to select both the family physician and the person providing specialised medical care. In recent years, patient associations have been included in the preparation of some strategies and in the composition of certain national committees.

5.1.4. Sustainability

Total health care expenditure in 2005 was 5% of GDP (PPP $846 per capita) and is one of the lowest in the EU (exceeding only Bulgaria and Romania). In 2004, the share of public expenditure was 76% of total health care expenditure, and has decreased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 1.1% of GDP by 2050, still well below the EU average.

The reform of the health care system to reduce the number of hospital beds for acute treatment is not proceeding at the recommended pace. To ensure continuous optimisation of the hospital network, fully available and functional first-stage, nursing and rehabilitation care is needed.

The plan for supplementary measures commenced in 2005 with the control and optimisation of health insurance costs (cost-based prices and 'diagnosis-related groups' — DRGs) and an increase in the health insurance tax base (increase in the minimum social tax rate to the minimum wage level in 2009). Extending the groups of persons subject to social tax is also under consideration. As an incentive, family physicians can collect remunerable bonus points by monitoring the chronically ill and conducting preventive interventions. One important priority is disease prevention and health promotion to improve the public state of health.

After Estonia's accession to the EU, the mobility of health care professionals has become a problem.

5.2. Long-term care

5.2.1. Description of the system

No major changes have been made to the long-term care system from the previous reporting period. The health care system provides medical care, nursing care in institutions or hospitals, geriatric assessment, home PHC and home nursing care. These services are paid for by the EHIF. The welfare system provides care in institutions, day care centres, home care, housing services (e.g. house alterations, cleaning, food) and other social services. The municipalities are responsible for providing these services or purchasing them from state and local agencies and the private sector. Care-givers receive an allowance to reimburse care costs or alleviate their care burden. A social worker, together with the family doctor or a geriatric team, considers and chooses between forms of care based on the person's needs and financial situation.

With the growing ageing trend, the most vulnerable group is the over-65s in one-person households, whose relative poverty risk is the highest. As healthy life years are only 3.4 years for those over 65, they are also the most disabled. Consequently, long-term care is a major issue. As the report notes, not enough resources have been devoted to either health care or long-term care to improve the situation sufficiently.

5.2.2. Accessibility

Total long-term expenditure was 0.15% of GDP in 2005. Although slightly increasing, it is still among the lowest in the EU. As the provision of home care services and community social services for the elderly is the responsibility of the local municipalities, the accessibility and quality of these services varies greatly.

The most acute problem in nursing care is its insufficient availability caused by a lack of financing, particularly for domestic services. A strategy for integrated services for the elderly has been developed to solve the lack of available health and nursing services for the elderly requiring daily nursing care by creating centres to provide both nursing and medical care (hitherto separated).

5.2.3. Quality

Enhancing the quality of nursing and rehabilitation services for patients leaving active treatment, but also for the elderly and chronically ill, is one of the priorities for health and long-term care. In order to improve the availability of nursing care services, a development plan for a nursing care network and a concept for integrated long-term care are being implemented, which aims to cover needs by 2015.

5.2.4. Long-term sustainability

The present economic situation, with the steep fall in economic growth in 2008 in Estonia, will reduce the overall budget, which will also have an effect on the budget for social expenditure. This might in turn have a substantial effect on long-term care, which is mainly the responsibility of local governments. The financial base for local governments might decrease significantly and the rather high level of out-of-pocket expenses in long-term care (55% own contribution to costs) might lead to an increase in the burden of these costs for the population. The network for the provision of services complementing long-term institutionalised care is very small and would not be able to expand in the coming years. Ultimately, this will increase the social expenditure costs for households.

6. CHALLENGES AHEAD

- To continue increasing labour market participation among at-risk groups, through a combination of properly financed active labour market policies and promoting flexible forms of work.
- To reduce the high risk of poverty among families with children.
- To reduce the high risk of poverty among the elderly through an integrative, active inclusion policy (active ageing).
- To secure the long-term financial sustainability of the pension system so as to be able to provide more adequate pensions in future.
- To ensure that the current economic context and possible public sector expenditure cuts do not affect healthcare access, in view of the low health status of the population and the low overall expenditure; to use the current situation as an opportunity to improve the value for money in the system notably through stronger use of primary care, better coordination of services and promotion and prevention strategies to improving health status. In the medium run, to continue to address the geographical and socio-economic disparities in access, improve the quality of services and address human resources issues
- To arrive at an integrated and functioning model of long-term care for the elderly and cushion the financial impact of the crisis on this sector.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	9,6	44,6	**2000**	60,4	64,3	56,9	28,3	46,3	**2000**	12,8	13,8	11,8	23,9
2005	9,2	61,1	**2005**	64,4	67,0	62,1	29,1	56,1	**2005**	7,9	8,8	7,1	15,9
2008*f*	-2,4	64,8	**2007**	69,4	73,2	65,9	34,5	60,0	**2007**	4,7	5,4	3,9	10,0

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	61,5	74,3	12,0	16,1	n.a.	n.a.	14,9	**1995**	n.a.	n.a.	n.a.		-
2000	65,5	76,2	12,8	17,0	n.a.	n.a.	8,4	**2000**	5,3	77,5	19,9	**2005**	6,6
2006	67,4	78,6	13,2	18,3	49,4	53,7	5,0	**2006****	5,0	76,9	20,5	**2006**	7,3

s: Eurostat estimate; p: provisional; **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004			
										Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	25,2	17,1	6,7	5,4	n.a.
2000	14,0	45,3	32,1	1,3	11,9	2,7	6,6	**2010**	25,0	-0,6	0,1	0,4	n.a.
2006	12,4	45,2	31,2	0,9	12,1	1,0	9,5	**2030**	34,4	-2,3	-1,9	0,8	n.a.
								2050	47,2	-2,7	-2,5	1,1	n.a.

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	19	18	16	33	20.0p	26.0p	26.0p	14.0p	5.5p	**2005**	18
male	17	-	15	21	24.0p	-	29.0p	14.0p	-	**2006**	12
female	22	-	17	39	19.0p	-	23.0p	14.0p	-	**2007**	8

People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	11,2	11	10,9	11,1	**2000**	5,9	6,7	5	**2000**	14,2	16,3	12.1u
2004	9,6	9,5	10,2	8,7	**2004**	5	5,6	4,4	**2004**	13,7	20,5	n.a.
2007	7,2	6	6,1	5,9	**2007**	2,3	2,9	1,7	**2007**	14,3	21	n.a.

**: excluding students; i: change in methodology; b: break in series* *u - data lack reliability due to low sample size*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,65	0,68	0,63	***Aggregate replacement ratio***	0,47	0,4	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
11	9	9	DB/DC	/	-	100	/	22	-	-0,1

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)* *p - provisional value*

Ireland

1. SITUATION AND KEY TRENDS

2006 and 2007 saw GDP growth of 5.7% and 6% respectively, compared to an EU average of 3.1% and 2.9%. However, a dramatic deterioration in the Irish economy during 2008, driven by a collapse in the domestic housing market and exacerbated by the financial crisis, means the Commission services' January 2009 economic forecast has estimated that real GDP will contract by 2% in 2008 and 5% in 2009.

The employment rate increased to 69.1% in 2007 before contracting slightly in 2008 with a further contraction of -4% expected in 2009. The female employment rate stood at 60.6% in 2007 while the rate for older workers increased to 53.8%. Unemployment remained stable in 2006 and 2007, at 4.5% and 4.6% respectively, but is estimated by the Commission to have averaged 6.5% in 2008 and to increase further to 9.7% in 2009. Youth unemployment increased from 8.6% in 2006 to 9.2% in 2007 and it is likely that it increased further in 2008.

In 2007, 18% of the population were at risk of poverty (down from 21% in 2004), compared to an EU average of 16%. The number of children at-risk-of-poverty was the same as the EU average at 19% while 29% of those over 65 were at risk of poverty, compared to an EU average of 19%. While only 6% of employed persons were at-risk-of-poverty in 2007, the rate for those who were unemployed was 43%.

Expenditure on social protection in Ireland remained static at 18.2% of GDP between 2004 and 2007, significantly behind the EU average of 27%. This difference can be partly accounted for by the significant growth in GDP in Ireland during this period and the fact that Ireland spends proportionally less on old age due to its lower age profile and reliance on private pension provision.

Life expectancy at birth for Irish people increased to 79.7 years in 2006 (from 77.2 in 2001), with an expectancy of 77.3 for men and 82.1 for women. Life expectancy at age 65 was 18.6 in 2006, up from 18 years in 2004. Infant mortality rates have dropped to 3.7 in 2006 from 5.1 in 2003 and 6.2 in 2000. Ireland had the lowest dependency ratio in the EU in 2008 at 16.3 compared to the EU average of 25.4. Although this rate has decreased slightly from 16.4 in 2004, it is expected to rise significantly to 43.6 in 2060 (albeit still below the EU average) as a result of the projected rapid ageing of the population in the coming decades.

420 000 people, or 10% of the population, classified themselves as being of non-Irish nationality in 2006, up from 5.8% in 2002, and made up approximately 16.3% of the labour force. Although inward migration[33] is still occurring in Ireland, the NSR noted a 50% decrease in March 2008 compared to a year earlier while overall inward migration for 2008 is expected to be 60% less than in 2007. The report also states that non-Irish nationals face a higher risk of poverty (23.5%) than Irish nationals (16.6%).

[33] Ireland uses the term 'migration' in its national report to describe the movement of both intra-Community workers and non-EU nationals.

2. OVERALL STRATEGIC APPROACH

The strategy adopted draws much of its focus from pre-existing plans, especially the National Action Plan for Social Inclusion, 2007 – 2016, which represents Ireland's integrated approach to social protection and social inclusion policy. The NSR incorporates a number of high level goals from the national action plan, including the adoption of a specific poverty related target.

The report was formulated before the publication of *Budget 2009,* following which the full impact of the recent economic downturn on public finances started to emerge. The budget was aimed at achieving fiscal stability while maintaining capital expenditure on critical infrastructure and protecting those who are most vulnerable. Within that context, it contained a number of changes which will have an impact on the actions outlined in the NSR including additional expenditure in priority areas, particularly social welfare and capital expenditure in the areas of health and education, coupled with cuts in other areas, such as to the capital childcare programme, the abolition of the automatic right for those aged over 70 to a medical card, and the placing of a limit on the number of language support teachers in schools. However, the economic situation in Ireland has deteriorated further since *Budget 2009* was announced and further significant cuts in public expenditure (including the public sector payroll bill) have been signalled by the Government for 2009 and 2010.

Ireland has adopted similar priority areas for achieving the three overarching objectives as in 2005, while some new initiatives that will contribute to the objectives are also mentioned, such as additional childcare places and a new national sustainable development strategy (in the context of linking to the EU's Sustainable Development Strategy). Otherwise, many of the actions described are similar to 2005 reflecting, the long-term nature of the priorities identified.

There is little description in the report of how the ESF can contribute to achieving the overarching objectives. Notwithstanding this, an ESF-funded *Equality for Women* measure has been announced since the publication of the NSR, and this will also address the issue of gender mainstreaming. In relation to governance, no specific consultation process was engaged in prior to the preparation of this report although there was an extensive consultation process in advance of the national strategies and plans, introduced in 2007, on which the report is largely based, and there was also significant consultation on the *Green Paper on Pensions*.

3. SOCIAL INCLUSION

3.1. Key trends

The at-risk-of-poverty rate in Ireland fell from 21% to 18% between 2004 and 2007, just above the EU average of 16%. However, when the poverty rate is anchored at a fixed moment in time (2005), the at-risk-of-poverty rate drops to 12% (compared to EU average of 14%), reflecting the significantly above-inflation rise in median incomes during this period. The rate for older people in 2007 was 29% (compared to an EU average of 19%), down from 40% in 2004. The rate for children also decreased between 2004 and 2007, falling from 22% to 19%, the same as the EU average. Lone parents continued to have a higher than average rate at 40% in 2007 (compared to an EU average of 34%) although this fell significantly from 56% in 2004. Two-adult families, on the other hand, had at-risk-of-poverty rates below the EU average in 2007 for one, two and three-child units of 10%, 12% and 20% respectively.

According to national EU SILC figures, the rate for people with disabilities fell to 37% in 2007 from 51.7% in 2003.

The relative at-risk-of-poverty gap decreased from 20.3% in 2005 to 16.4% in 2006 but rose slightly to 18% in 2007, though this remained below the EU average of 22%. The Gini co-efficient reduced slightly to 31% in 2007, just above the EU average of 30%, while the ratio of income distribution was the same as the EU average at 4.8. The role of social transfers can be seen in the fact that 33% of the population were at risk of poverty in 2007 before social transfers, compared to 18% after. This 15 percentage point reduction in the at-risk-of-poverty rate compares to a 9-point reduction across the EU.

Illustrating the important role played by employment, 6% of employed people over the age of 18 were at risk of poverty (compared to 8% in EU) in 2007, compared to 43% for those not in employment (42% in the EU). 11.5% of children and 7.9% of adults lived in a jobless household in 2007, compared to 10.4% and 8.8% respectively in 2001.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Some progress in relation to *child poverty* has been made. There was a decrease in the at-risk-of-poverty rate, and the provision of childcare places and additional grant-aid assistance to schools to address educational disadvantage were singled out as contributing to this. Despite this progress, however, Ireland still has some distance to travel in meeting its own targets and it remains to be seen whether further progress will be hampered by expenditure cuts in this area.

Given the importance of employment, child poverty is also linked to *access to quality work and learning opportunities*. While the employment rate continued to rise for most of the period covered, this did not apply equally to disadvantaged groups such as lone parents and people with disabilities. Progress in increasing employment for these groups is dependent on implementing planned reforms to encourage participation in education, training and employment and these will, in turn, depend on putting in place the necessary supports, especially childcare and retention of secondary benefits, particularly the medical card, for people with disabilities. Improvements in the quality of employment will also depend on the full implementation of the National Skills Strategy, especially in relation to lifelong learning.

Progress in relation to employment is also linked to progress in improving *access to services*. The report details developments across a range of services, many of which are targeted at disadvantaged areas and groups. Further analysis of the impact of these developments is hampered by a lack of data. In relation to the *social inclusion of migrants*, there have been a number of developments, such as the establishment of the Office of the Minister for Integration and the publication of an integration strategy. However, analysis of progress is hampered by the lack of data on migration in Ireland. The economic downturn is also having an impact on the nature of the migration challenge in Ireland as the number of people entering Ireland for employment slows and the number of immigrants who find themselves without employment increases.

3.3. Key challenges and priorities

Ireland has identified the same broad policy objectives in 2008 as in 2005, reflecting the long-term orientation of the policies and progress to be made. They are:

– Child poverty;

– Access to quality work and learning opportunities (activation measures), with a focus on lone parents and people with disabilities;

– Social inclusion of immigrants;

– Access to quality services, with a focus on the Homeless.

3.4. Policy measures

Child Poverty: The main target is to reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating it by 2016. Although not a specific child-related target nor framed using the at-risk-of-poverty measure[34], the inclusion of an overall target is a positive step. The report sets out an integrated strategy which includes a range of actions and targets covering early childhood development and care, improving health and education outcomes and income support. In many cases implementation is already under way or at an advanced planning stage. However, whether these measures are fully implemented will depend to a great extent on the resources allocated in these changed economic circumstances. Specific targets have been set in relation to the childcare strategy and child income support against which progress can be measured. Details of funding are given for childcare investment and income support, including both universal and targeted supports, but not for the other policy areas covered.

Access to Quality Work and Learning Opportunities: The main aim is to target 50,000 people and reduce by 20% the number depending on long-term social welfare payments for their total income by 2016.

The main policy measures to achieve this target are active engagement with the unemployed/inactive and improving access to learning opportunities. Priority will be given to preparing people with disabilities and lone parents for education, training or employment opportunities while those workers with low skills will also be targeted. Specific quantitative targets are set for employment and training of people with disabilities and also for access to lifelong learning opportunities such as *youth reach* and *back to education* places. Despite increased income thresholds for receipt of *family income supplement* and proposals to reform the *one parent family payment*, there is a need for further progress on removing tax- and welfare-related disincentives to employment and recently commissioned research on financial disincentives for social welfare claimants of working age may help to address this. Making further progress on all of the above areas is inextricably linked to progress on other priorities, including access to services, especially childcare and other supports. The recent significant rise in unemployment in Ireland will also pose additional challenges to those outlined in the NSR, especially in terms of financial and human resources, and it remains to be seen whether this will affect the roll-out of activation measures for other inactive groups.

Social Inclusion of Migrants: No targets are mentioned in relation to this objective and policy measures will be focused on: facilitating participation in employment, education supports, and follow-up on the National Action Plan against Racism.

---

[34] Consistent poverty is a nationally developed indicator which measures a combination of monetary risk of poverty and material deprivation. It is the indicator used for poverty-related targets but is not comparable across the EU.

The measures outlined in the report are more strategic than before, exemplified by the appointment of an Office and Minister for Integration. This is an innovative response and has been listed by Ireland as an example of good practice. A more strategic approach by relevant Departments is also evident, in particular the Department of Education and Science. The economic downturn may also affect the nature of the challenge in relation to migration, given evidence that the number of migrants entering Ireland is falling while those who remain are being disproportionally affected by the general rise in unemployment (the proportion of non-Irish nationals claiming unemployment benefit increasing from 12% in January 2007 to 18.7% in December 2008). The lack of reference to targets for this priority is apparent, as is the lack of data available on which to base them (which is linked to a difficulty in including migrants in large scale surveys due to small sample size).

Access to Quality Services: No target is given for this priority although there is a list of comprehensive measures covering areas such as education, employment, health care, housing, homelessness and income support, which are targeted at the most vulnerable groups. The targeting of health-related actions at disadvantaged groups and areas is also apparent, for example, with the National Intercultural Health Strategy which has been listed as a best practice measure. Special attention has been given to homelessness – an area in which the report indicates progress in relation to reducing numbers (although non-government organisations working in this area dispute this). Achieving the target of eliminating long-term occupancy of emergency accommodation by 2010 will be critical in this regard. A new homelessness strategy has been developed to help achieve this but an implementation plan is now a priority. Access to employment services could become more of an issue as unemployment continues to increase, particularly for the 16 -24 cohort which has been most affected by rising unemployment,.

The issue of gender is specifically addressed under this priority, with reference to the National Women's Strategy. Again, some financial allocations are included, and a breakdown of funding under the NAPinclusion and the social inclusion chapter of the NDP is given in the Annex.

3.5. Governance

While the decision not to engage in a separate consultation process in advance of this NSR received some adverse publicity in Ireland, the report details an extensive consultation process undertaken in 2005, which subsequently informed the social partnership negotiations, the NDP and the 2007 National Action Plan – upon which the current NSR is largely based. In addition, extensive consultation is planned for the European Year for combating poverty and social exclusion (2010). Despite this, there is uncertainty as to the extent to which stakeholders are involved in an 'ongoing structured dialogue in all stages of the policy-making process', although the role of the social partners in the *Towards 2016* steering group is mentioned. Ongoing involvement of people experiencing poverty, or groups representing them, which are outside the social partnership structure, occurs in the annual Social Inclusion Forum.

Overall coordination of implementation and monitoring of social inclusion policy is achieved via the cabinet committee on social inclusion, chaired by the Taoiseach (Prime Minister), and a senior official group which reports to it. The Office for Social Inclusion, which will shortly be merged with the Combat Poverty Agency, is responsible for day-to-day monitoring and reporting on the implementation of these various strategies and reports to the cabinet

committee. Some social inclusion policy competence has been devolved to local authorities but coordination of this is less structured than at national level.

4. PENSIONS

4.1. Key trends

The pension system in Ireland has two main components; the state-run social welfare system, on the one hand, and an occupational or private pension system, on the other. Reform of the pension system is largely on hold pending the publication of a new framework for pension policy, due by the end of 2008. This framework will build upon the 2007 *Green Paper on Pensions* and the subsequent extensive public consultation.

Recent changes to the pension system consisted primarily of improvements to pension rates, which increased by 16.7% in the 2005–2008 period. State pension increases are not index linked but the Government has committed to raising the level of the state pension to €300 per week by 2012, a level which would bring the rate to approximately 40% of Gross Average Industrial Earnings (GAIE). However, this target is likely to be impacted by the current budgetary situation, with an increase of just over 3% announced for the contributory pension in 2009. Recent increases resulted in the aggregate replacement ratio in Ireland increasing to 0.47 in 2006; just below the EU average of 0.49.

While all people over 65 in Ireland have public pension coverage, this is not considered sufficient to guarantee an adequate income in retirement. Instead, Government policy envisages supplementary pension cover for 70% of those at work between 30 and 65 years of age by 2013. According to the latest figures the level was 61% in 2008, up slightly from 59% in 2002. The lack of progress in meeting these targets is a key issue to be addressed in any new pension framework. Nationality is also a factor determining pension coverage; the proportion of Irish nationals aged 20–69 with private pension coverage increased to 58% in 2008 (from 53% in 2002), the equivalent rate for non-Irish nationals decreased from 34% to 28% in 2008. The disparity in coverage between the employed and self-employed has narrowed slightly, with 56% of employed persons and 46% of self-employed persons being covered in 2008, compared to 53% and 41% in 2002.

Pensions receive favourable tax treatment in Ireland, mainly to encourage private and occupational provision. Pension contributions (up to a limit of €150 000) and investment returns are tax exempt and, although tax is nominally payable when the pension is in payment, this is subject to an allowance of €20 000 per annum for a single person aged over 65, or €40 000 for a couple.

4.2. Key challenges and priorities

The 2007 Joint Report highlighted the need for Ireland to maintain pension adequacy while widening coverage and maintaining sustainability.

In relation to adequacy, recent increases mean rates of public pension provision have continued to grow in real terms. The average income of pensioners is now 34% of GAIE and the government has committed to maintaining this growth until at least 2012. These rate increases have contributed to a reduction in the number of pensioners considered *at-risk-of poverty* (as detailed below). However, the report does not mention the adequacy of private

pension provision which is especially topical given recent economic developments and the impact these could have on private pensions, especially DC pensions.

It is recognised that increasing adequacy can lead to further challenges in relation to sustainability and this issue, along with coverage, has seen little progress since 2005. The October 2007 *Green Paper on Pensions* was published with the objective of stimulating debate on the future development of pensions in Ireland and identified the ageing of the population and the sustainability of the public system as two of the most pressing issues to be addressed. The demographic challenge is exemplified by the fact that the current dependency ratio of 16.3 is estimated by the EU Commission to increase to 43.6 by 2060. This, together with the commitment to increase pension rates to address adequacy issues, will have consequences for the financial sustainability of the system, with public expenditure on pensions projected by the EU Commission to rise by 6.4 percentage points from 4.7% of GDP in 2004 to 11.1% in 2050[35]. While the Government continues to pre-fund this liability through the pensions reserve fund (with a market value of €16.4billion or 8.8% of GDP as at 30 December 2008), it is estimated this will only contribute about 3% of GNP annually towards pension provision from 2050. The impact of the unprecedented falls in stock market performance could also affect the value of the NPRF. Ireland is also making slow progress in meeting its own targets for supplementary pension coverage.

4.3. More people in work and working longer

Future changes in the population structure in Ireland imply that there is a mismatch between the spending demand facing the public pension system and its ability to meet these demands. Measures being considered to address this include increasing the share of the population at work and increasing the retirement age.

Ireland had an employment rate of 69% in 2007 while it exceeded the EU targets for both older and female workers with rates of 54.3% and 60.7% respectively. Despite the recent increases in these rates, there is room for further improvement but this will depend on, firstly, putting in place the necessary supports such as childcare for increased female participation and, secondly, improving skills and learning opportunities for older workers. Measures adopted by Ireland in that regard have been to extend the employment action plan to the 55-64 age group and developing a systematic programme of engagement to deal with those currently at the margins of the labour market.

In addition to increasing participation rates, increasing the retirement age would allow for contributions over a longer period and could, therefore, contribute to a considerable easing of spending pressures. Although the average labour market exit age in Ireland was 64.1 in 2006, considerably above the EU average of 61, measures have been taken to increase this further, for example by abolishing the pre-retirement allowance, raising the minimum retirement age in the public service to 65 from 60 and introducing a €200 earnings disregard for those in receipt of a means-tested state pension who wish to remain in employment after age 65.

4.4. Privately managed pension provision

It is estimated that 70% of the workforce in Ireland over 30 will require supplementary pension provision by 2013 if adequacy is to be ensured (the state pension should be adequate

[35] ECFIN-EPC Report, 2006. Revised figures are due to be released by the Commission in Spring 2009.

for the remaining 30%). In 2008 it was estimated that 61% of people working aged 30–65 had such supplementary cover.

A recent trend has been for employers to opt for defined contribution (DC), as opposed to defined benefit (DB), occupational pension schemes. It is estimated that the ratio of DB to DC schemes fell from 4.5:1 in 1996 to 2:1 in 2008, mainly because of the strict funding and accounting standards that apply to DB schemes in Ireland. The danger of this trend is that the risk is effectively transferred from the employer to the employee. This risk becomes particularly apparent in the current economic climate where there is a very real danger that the value of DC schemes will not be enough to guarantee an adequate income. Some reports have suggested that managed pension funds fell by as much as 33% in 2008. The potential impact of such a fall in value particularly affects workers who are due to retire in the near future, as there will be less time for any improved market performance to make up for previous losses.

However, there is also a risk to the significant number of DB schemes identified in the Green Paper as not meeting the funding standard, a situation which is likely to have worsened further since then. While such shortfalls might not be problematic in other circumstances, there is evidence that the current economic climate is placing great strain on the ability of employers to meet such shortfalls and, ultimately, on their ability to stay solvent.

4.5. Minimum income provision for older people

The adequacy of income for pensioners was identified as a challenge for Ireland in the 2007 Joint Report. The response of the Irish Government has been to continue its policy of above inflation increases in the basic rate. As a result, between 2005 and 2007 this rose by 16.7% in real terms, compared to a rise in inflation and GAIE of 9% and 8% respectively.

These increases have almost certainly had an impact on the trend in poverty rates for older people. For example, the number of those aged over 65 considered at-risk-of-poverty has declined from 41% in 2003 to 29% in 2007. Although this is still above the EU average, the gap has narrowed from 23% in 2003 to 10% in 2006. However, females continue to face a higher risk of poverty (33%) than men (24%).

4.6. Information and transparency

The Pensions Board provides information to the general public on pension provision and conducts publicity campaigns to increase awareness of the need for supplementary provision. Both trustees and employers are obliged by law to provide pension holders with a wide range of personal and scheme information including annual reports and audited accounts. Recent changes mean trustees will be obliged to issue annual benefit statements to scheme members. Moreover, the consultation process recently engaged in and the way in which it is feeding into the development of a framework for pension policy, via the publication of a report detailing the submissions received and the options for further action, is a good example of transparent policy making.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The health service in Ireland is a mix of public and private institutions and operates on the basis of residency. A medical card gives full eligibility for all GP, A&E, in-patient, out-patient, prescribed drugs, dental, ophthalmic and maternity services. Those without a medical card are eligible for some services, including in-patient and out-patient services in public hospitals. Primary health care (PHC) is delivered primarily via health centres and GPs. The health service is mainly financed through general taxation and private health insurance covers 47.6% of the population. The Department of Health and Children is responsible for the development of strategic policy while the Health Service Executive (HSE) is responsible for the management and delivery of services.

The *National Health Strategy, Quality and Fairness: a Health System for You*, launched in 2001, provides overall strategic direction. A reform programme was launched in 2003 to deliver on the goals of the strategy, primarily by reorganising and reforming the health service

Since the last report the main developments reported on include PHC and families, cancer control, acute hospitals, older people, and disability and mental health. The Offices of the Minister for Children and Youth Affairs, Disability and Mental Health and Older People have been set up to give policy direction to the respective policy areas. Some progress has been made on transferring activity from hospitals to community-based settings through expanded PHC, although much work remains to be done in that regard. A National Cancer Control Programme has been implemented, involving significant realignment of services across the country.

Life expectancy in 2006 was 79.7, up from 76.6 in 2000. The gender difference 2006 was 4.8 years (77.3 for males and 82.1 for females), a slight decrease from the 5.2 years recorded in 2000. Perinatal mortality rates were 7.9 in 2004 compared to an EU average of 6.4.

5.1.2. Accessibility

Limited progress has been made since the previous report in relation to accessibility. The proportion of the population in receipt of the medical card has remained static at 32.2%. The proportion of private income paid for health care was 21.7% in 2007. The lack of attention paid to health inequalities in the report, in terms of actions taken or improved outcomes, is striking given the concern expressed in the 2007 Joint Report concerning the substantial health inequalities that exist.

The Department of Health has committed to bringing forward a legislative framework in 2008 which will set out clear statutory provisions on eligibility and entitlement to the medical card, while improvements have also been made to assessment procedures. The government has also committed, during its lifetime, to indexing income thresholds to average earnings and allowing people with disabilities who enter employment to retain their medical card past the current limit of 3 years. However, no progress has been made on these commitments yet. A recent government decision means that the over-70 age group will no longer have automatic entitlement to the medical card but will instead have to undergo a means test.

In relation to disability and mental health, Part 2 of the Disability Act, which concerns the automatic entitlement of people with a disability to an assessment of need, came into effect from 2007 for children under 5. It is intended that these assessments will be rolled out to other children (to age 18) by 2010.

Improving acute hospital services is also a priority and additional capital funding has been invested in this area, although firm commitments in terms of targets and time-lines are not given. The National Treatment Purchase Fund, which aims to treat patients who have been longest on in-patient waiting lists, has been further expanded with a budget of €100m in 2008, from €5m in 2002. In relation to PHC, there is an overall commitment for 500 primary care teams by 2011. Progress is, however, slow and only 87 teams have been set up, although funding for additional teams in 2008 has been provided. The overall target is being reviewed in 2008.

5.1.3. Quality

The development of PHC, with access to services in the community, is one of the main measures envisaged to improve quality. Other planned developments include a policy framework for the management of chronic disease, a cancer control strategy, the continued development of mental health services, and a pre-hospital emergency care council.

In order to better inform the public, a health information strategy continues to be implemented while a Health Information Bill is also being drafted. A strategy for service user involvement in the health service has also been launched, including goals and actions for ensuring that service user/provider partnership is established. A statutory complaints procedure and a 'whistle blowing' safeguard also protect patients' interests.

Finally, a Health Information and Quality Authority was established in 2007. The aim of this body is to promote the delivery of high-quality health and personal social services by setting and monitoring standards for service delivery and by undertaking special investigations on patient safety issues.

5.1.4. Sustainability

According to the OECD, total health expenditure per capita increased from $796 in 1990 to $3 082 in 2006, representing an increase from 6.1% of GDP to 7.5%. The EU Commission (ECFIN-EPC, 2006) has calculated public expenditure at 5.3% of GDP in 2004, below the EU average of 6.4%, and estimated that it would increase to 7.3% by 2050 (compared to an EU average of 7.9%).

The scale of recent increases in expenditure on the health sector will be difficult to sustain, particularly in current economic conditions and given the improvements in services the government has committed to, not to mention the long-term issue of the ageing of the population. This was recognised by the Minister for Finance in a recent speech in parliament where he pledged to secure savings on health sector payroll, partly through the introduction of a voluntary early retirement scheme. It remains to be seen what effect this will have on costs in the future.

In relation to personnel issues, a significant development which could have a positive impact on efficiency was the agreement of a new employment contract with medical consultants which provides that a proportion of consultants will not have any fees from private practice

while others who do engage in private practice are obliged to have at least 80% public patients.

5.2. Long-term care

5.2.1. Description of the system

The long-term care system in Ireland includes, alongside primary and hospital care: home nursing, home help and care attendants, day centres, grants to adapt homes, therapy and rehabilitation, day hospitals, public residential care and private nursing homes. Access is based on need. Care in public facilities incurs a set charge while a means-tested grant is given to patients to pay for private nursing home care. Financial assistance for carers is available via the carer's benefit and carer's allowance schemes and the respite care grant. Care in the community is the authorities' preferred option with the aim of allowing people remain at home in accordance with their wishes. Healthy ageing (promotion and prevention at older ages) is also a stated aim. The ageing of the population and its effects on sustainability is considered one of the biggest challenges facing the Irish system.

5.2.2. Accessibility

Ireland is addressing the accessibility and affordability of long-term care through the *Fair Deal* initiative. Under this system, where a person is diagnosed as being in need of long-term care, an assessment will be made of their ability to contribute to the cost of that care and the state will meet the remainder of the cost. This personal contribution will be no more than 80% of their disposable income but may also include 5% of their assets, including up to 15% of the value of a private residence. A choice can be made between any approved private or public nursing home. The legislation for this scheme was published in October 2008 and is expected to be implemented in 2009. Geographical disparities in the supply of long-term care are reported outside the NSR.

5.2.3. Quality

The improvement of home care packages, including the services of nurses and therapists, is mentioned in the report although it appears that no additional funding has been provided in this area for 2009 and no details are given on the availability or coverage of such packages. The implementation of draft standards for all public and private nursing homes will begin following their consideration by the Department of Health and Children**.**

5.2.4. Long-term sustainability

The report offers no analysis of the costs of long term care although it does acknowledge that the financial model to support any new arrangements must be financially sustainable and that further data collection and evaluation is required. The Department has committed to progressing this work later in 2008. The EU Commission (ECFIN-EPC, 2006) has estimated that the cost of providing long-term care will increase from 0.6% of GDP in 2004 to 1.2% in 2050.

6. CHALLENGES AHEAD

- To continue to invest in services in tandem with welfare reforms in order to address inequalities and further reduce the risk of poverty, especially for disadvantaged groups.

Continued priority should be placed on childcare, especially in relation to affordability, including for those in employment.

- To continue to address the high risk of poverty and low employment rates of certain disadvantaged groups through targeted activation and training measures as well as though tax and welfare policies that encourage such groups to take up employment.

- Given the recent rise in those claiming unemployment benefits, to monitor the adequacy of the welfare system in meeting the income support needs of this group and ensure personalised responses and timely transfer to appropriate active labour market programmes.

- To quickly adopt a pensions framework policy which will ensure pension security, adequacy and sustainability, taking account of the impact the current economic downturn is having on private pension provision.

- To make progress on tackling issues of financial and geographical access to health care, in particular through the full implementation of the planned primary health strategy and home care packages on a nationwide basis, and also in relation to the rationalisation of medical card eligibility.

- To address the sustainability of the health care system through a more efficient use of resources in general and in tackling persistent health inequalities.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	9,2	131,0	**2000**	65,2	76,3	53,9	48,1	45,1	**2000**	4,3	4,3	4,2	6,8
2005	6,4	144,1	**2005**	67,6	76,9	58,3	48,7	51,6	**2005**	4,3	4,6	4,0	8,6
2008*f*	-2,0	140,1	**2007**	69,1	77,4	60,6	49,9	53,8	**2007**	4,6	5,0	4,2	9,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2005 instead of 2006)		Infant mortality rate	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	72,8	78,3	13,5	17,2	63,2	n.a.	6,4	**1995**	6,7	71,9	13,5		-
2000	74,0	79,2	14,6	18,0	63,3	66,9	6,2	**2000**	6,3	73,5	10,9	**2005**	2,0
2006	77,3	82,1	16,8	20,2	63.3b	65b	3,7	**2006**	7,5	78,3	12,4	**2006**	1,9

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	18,8	26,5	36,2	15,3	12,0	5,2	4,8	**2005**	16,3	15,5	4,7	5,3	0,6
2000	13,9	25,4	41,4	9,6	13,7	4,5	5,3	**2010**	16,7	-0,1	0,5	0,2	0,0
2006	18,2	27,4	41,1	7,6	14,7	3,8	5,4	**2030**	24,6	3,3	3,1	1,1	0,1
								2050	40,4	7,8	6,4	2,0	0,6

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	18	19	15	29	18	19	20	10	**4,8**	**2005**	20
male	16	-	14	24	18	-	20	10	-	**2006**	
femal	19	-	16	33	17	-	20	10	-	**2007**	12

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	10,4	8,8	7,4	10,2	**2000**	1,6	2	1	**2000**	N/A		
2004	11,8	8,6	7,2	10,1	**2004**	1,6	2	1	**2004**	12,9	16,1	9,7
2007	11,5	7,9	6,7	9,3	**2007**	1,4	1,8	0,9	**2007**	11,5	14,2	8,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,69			***Aggregate replacement ratio***	0,47	0,41	0,53

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions Estimate of current (2002)	pensions Assumption
-11	-10	-2	DB	-9	DC	100	55	9,5	10-15	6,4

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Greece

1. SITUATION AND KEY TRENDS

Real GDP growth was high (over 4% on average between 2001 and 2007), outstripping the EU-27 average (2.1% between 2001 and 2007). Sustained economic growth is reflected in GDP per capita expressed in purchasing power standards (PPS), which steadily improved to 97.2% of the EU average in 2008). The employment rate is rising, especially for women, but is still below the EU average at 61.4% in 2007 (EU-27: 65.4%), and exceptionally low for young people and for women (47.9% in 2007, EU-27: 58.3%).

The unemployment rate in Greece (8.3% in 2007) remains higher than that for the EU-27 as a whole. The latest data for 2008 show a further decrease in unemployment stemming mainly from a decrease in the unemployment rate for women (from 12.8% in 2007 to 10.9% in the second trimester 2008). Unemployment continues to affect mainly young people and women, together with vulnerable population groups (e.g. people with disabilities). The long-term unemployment remains high, at 4.1% in 2007 (EU-27: 3.1%) with a significant gender imbalance: 2.2% for men, 7.0% for women (EU-27:3.3). As a result of the global financial crisis, there is an indication of a potential increase of the unemployment rate for 2009. Economic activity, primarily in the tourism sector, is expected to slow down due to lower external demand.

Social protection expenditure stood at 23.6% of GDP in 2006, below the EU average. The share of social protection expenditure not spent on pensions continued to increase in 2008, to 17.9% of GDP from 17.3% in 2007; the Government's aim is to reach 18.4% by 2010. The at-risk-of-poverty rate remains high, at 20% against the EU average of 16% in 2007, and affects men and women proportionally. The risk of poverty for older people (aged 65 and over), although declining, is still high (23% in 2007 as against 28% in 2005; EU-27: 16% in 2007). In 2007, 7.9% of poor people lacked access to health care. The child poverty rate stood at 23% in Greece in 2007 (EU-27: 19%).

Foreign nationals (outside EU-27) are less hit by unemployment (7.5% compared to a total unemployment rate of 8.3% in 2007) but they are affected by a greater risk of poverty linked to undeclared and uninsured work.

2. OVERALL STRATEGIC APPROACH

In recent years, efforts have been made to improve the social protection system and specifically to respond to the needs of vulnerable social groups at risk of social exclusion and poverty. The NSR for 2008–2010 follows the rationale of the 2006–2008 NSR, and takes into consideration the input on social inclusion, on pensions, and on health and long-term care. It identifies three strategic directions: (1) reinforcement of policy coordination, implementation, monitoring and evaluation, and of participation by interested parties, (2) ensuring a decent socioeconomic living standard for vulnerable groups through: (a) upgrading their skills and integrating them into the labour market and (b) providing income and other support, and (3) ensuring high-quality social services for all, especially by modernising education, health, social security and welfare systems.

The strategic approach and the key challenges identified appear to go in the right direction. However, implementation needs to be accelerated. Efforts are being made to tackle social cohesion, e.g. by improving the functioning of the National Social Cohesion Fund to reduce poverty. ESF co-financing will be sought for many of the proposed interventions. Administrative and governance measures may improve the sustainability of the pension system but improving its fairness remains a challenge.

Health and long-term care systems are in need of greater attention, especially to quality assurance, rationalisation of spending (tackling the lack of coordination of both public and private providers) and ongoing assessment of services and needs.

3. SOCIAL INCLUSION

3.1. Key trends

Efforts to improve and extend the social protection system are evident but almost half of social expenditure is devoted to old age and survivors' pensions. The impact of social transfers on reducing the risk of poverty in Greece remains one of the lowest in the EU: this is one of the main challenges of the social protection system. In 2006, the impact of social transfers (excluding pensions) on reducing the at-risk-of-poverty rate in Greece was 2.0 percentage points (23.6% before social transfers (other than pensions) and 21% after social transfers), against an impact of 10 percentage points EU-wide (26% before and 16% after social transfers). The at-risk-of-poverty rate remains high (20% in 2007 against 16% for the EU-27). The percentage of jobless households remains low and is decreasing slightly, whereas in-work poverty is very high (14%), much higher than the EU-25 average (8% in 2006). Moreover, the child poverty rate stood at 23% (EU-27: 19%). Furthermore, in 2006, 7.9% of poor people in Greece (6.2% for the EU-25) were unable to access health care due to financial difficulties.

The proportion of people with low educational attainment, in 2007, was 24.8% among 25–34-year-olds (EU-27: 20.7%), but the gap was much higher for the 65+ population (81-.9%, EU-27: 63.8%). The percentage of low-achieving 15-year-olds in reading literacy was one of the highest in the EU, at 27.7% (2006) against 19.8% (2003). The rate of early school-leavers in Greece is slightly above the EU average, at 14.7% in 2007. Lifelong learning participation is one of the lowest in the EU and is progressing slowly.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Overall, Greece has made progress in social inclusion. The latest report states that 'the progress achieved is obvious in many respects, though some of the challenges remain'. The report gives the number of beneficiaries and the number of structures set up under the various measures and programmes, but no indication as to whether the participants ultimately found a job or whether the work of supportive social welfare structures facilitated the transition to employment for vulnerable groups.

Analytical references are made to a number of challenges which must be further addressed (i.e. strengthening employment, decreasing the high poverty rates of the working poor, older unemployed people, one-parent families and children, increasing access for people with disabilities and the social inclusion of immigrants, etc.). Although these challenges are dealt

with under the corresponding policy priorities, no specific quantified targets are set for them in the Report, with the exception of objectives set for increasing women's employment, decreasing the poverty and child poverty rates and decreasing the school drop-out rate.

3.3. Key challenges and priorities

The recently (2008) established National Social Cohesion Fund is the most important policy initiative on poverty and social inclusion in Greece. The Fund aims to provide monetary support to the most vulnerable groups to reduce poverty considerably in the next five years. No major initiatives such as 'make work pay' or 'welfare to work' policies or 'minimum income guaranteed' schemes have been introduced.

The report identifies four priorities: (i) increasing employment and the attractiveness of work, especially for women, young people, the long-term unemployed and vulnerable groups; (ii) tackling the disadvantaged position of certain people and groups with regard to education and training; (iii) reinforcing the family with emphasis on the wellbeing of children and support for the elderly; and (iv) promoting the social inclusion of people with disabilities, immigrants, and people or groups who are socially vulnerable owing to their cultural characteristics. Although the priorities point in the right direction, further efforts are needed to make existing policies more efficient. The Report recognises the need to fill the knowledge gaps as regards statistical and administrative data for those groups. Some newly established institutions are expected to fill some of these gaps.

3.4. Policy measures

Policy interventions are similar to those that have been implemented in recent years, such as: upgrading Public Employment Services (to transform the OAED's services into one-stop-shops); targeted active labour market policies for women, young people, vulnerable groups and older people (active ageing); and equality between the sexes / combating discrimination. Evaluations and impact assessments of the action taken are not yet available. The main challenges under the priority 'Strengthening employment especially for women, young people, long-term unemployed and vulnerable groups' have been identified, but new interventions that would improve efficiency are not evident. The quantitative objectives of these policies are to increase the total employment rate from 61.4% (2007) to 64.1% by 2010 and to 65% by 2013, the women's employment rate from 47.9% (2007) to 52% by 2013, the participation rate of registered unemployed persons aged 15–24 in active labour market measures to 100% by 2013, the percentage of long-term unemployed people participating in active labour market measures to 25% by 2013, and the percentage of vulnerable groups benefiting from active labour market measures from 9% in 2006 to 15% in 2013.

Progress on education and training has accelerated and specific measures are being introduced to deal with illiteracy, lifelong learning participation and school failure. Public investment in education and training is one of the lowest in the EU. The outlook for 2009 is 3.069% and the national target (set in 2004) of 5% by 2008 has now been put back to 2013. The target of reducing early school-leaving to 10% by 2010 (from 14.7% in 2007) has also been put back, to 2013. The number of 'all-day' schools is falling and appears to be insufficient.

Reinforcing the family, with emphasis on the wellbeing of children and support for the elderly, is also a priority. The report recognises the high inactivity rates among people of working age, which partly suggest both that work is particularly unattractive and that the inactive have a particularly low capacity for work. Yet very few activation measures are

proposed to facilitate their return to the labour market; greater efforts could be made. Regarding services to children and families in difficulty, no new interventions are planned. Most of the actions envisaged are a continuation of existing measures such as employment projects, psycho-social support, income support, childcare services and the programme 'help at home' for elderly people, co-financed by the ESF, to reconcile family responsibilities with the working life. Formal childcare provision for children aged 0-3 is very low and far off the Barcelona target (7%; EU target: 33%). There is an urgent need to increase provision and raise the quality of early childhood education and care.

Promoting the social inclusion of people with disabilities, immigrants, and people and groups who are socially vulnerable owing to their cultural and other characteristics is the fourth priority covered by the report. The interventions planned are based on a combination of new measures especially to promote integrated policies, together with existing measures such as integrated programmes for Roma people and for immigrants (e.g. the 'ESTIA' programme) and action to support health and social solidarity services. More efforts are needed to introduce targeted measures such as strengthening administrative capacity, raising awareness of immigration issues, certifying the educational and professional qualifications of immigrants, and providing support services to help them benefit more from participation in socioeconomic life.

Despite the continuation of existing activities, in-depth evaluations are needed to review and re-adjust some of the interventions to meet the specific needs of each sub-group and tie in with the different socioeconomic policies.

3.5. Governance

Consultation on the draft report was not based on structured involvement and participation by the various stakeholders, particularly regional and local.

Their involvement over the full policy cycle continues to remain limited.

Monitoring and evaluation mechanisms and arrangements are urgently needed. The report refers to the setting up of the National Council for Social Protection (NCSP), which is a positive step but is still pending.

4. PENSIONS

4.1. Key trends

The Greek pension system is a 'pay-as-you-go' system, although funds are allowed to keep existing surpluses, with pensions provided by a number of funds, which have the status of public bodies and form part of the Greek public sector. The system is highly fragmented and, as a result, the various benefit schemes provided for different occupational categories differ, not only across the funds but often within the funds. Some of the existing funds are primary funds that provide the main pension, and some are supplementary, lump-sum and provident funds. Most primary funds provide health cover in addition to pensions and some funds provide additional benefits such as family benefits. Older workers are insured by at least one primary fund but usually have supplementary coverage (which may be provided by another fund), while new workers only have one fund. Some workers contribute towards a lump-sum separation payment at the time of retirement. Civil service pensions are paid directly out of the national budget, while many public enterprises and banks have enterprise-specific funds.

A second tier consists of occupation-based auxiliary funds which provide supplementary pensions. The primary pension funds typically provide a replacement rate of between 70% and 80%, while the supplementary funds provide a replacement rate of 20%. Thus, the total replacement rate is usually 90% for 35 years of insurance. This is often not the norm, however, as several primary and supplementary pension funds provide more generous benefits.

The statutory retirement age is 65, but some funds are still in the process of adjusting upwards to this standard. As regards contributions, the standard contribution rates for those insured after 1992, for a primary pension, are 6.67% for the employee, 13.3% for the employer and for those insured after 1992, and 10% for the government. Farmers contribute 7% to OGA, which receives an additional 14% from the government. The standard rates for supplementary pensions are 3% for the employee and 3% for the employer. Lump-sum separation benefits are financed exclusively by employees. Some funds (especially those for public enterprises and bank employees) have set higher contribution rates, as have those for workers in heavy and unhealthy professions that typically allow earlier retirement.

In 1996, a means-tested supplementary pension scheme (EKAS) was introduced for those with very low benefits. In 2004, the calculation of pensions stemming from contributions paid to multiple funds was made uniform. Stricter rules were also imposed for civil servants' pensions. Replacement rates were gradually lowered from 80 to 70%, the retirement age for women was increased to 65, and the calculation of benefits shifted from the final salary to the average of the last five years. Finally, in 2008, a new law adjusted the statutory retirement age upwards for certain groups and merged the existing 175 funds to just 13.

'Second-pillar' schemes (occupational pensions) are small in Greece and were prohibited until recently. The Pension Act of 2002 introduced some favourable arrangements for occupational pensions, including exempting contributions from taxable income, and in 2005 three occupational pension schemes for small professional groups were allowed to operate. In order to supervise the occupational pension funds, two bodies have been set up: the Occupational Insurance Division of the Ministry of Employment and Social Protection and the National Actuarial Authority. There is currently no legal provision for voluntary savings via private pension (third-pillar) schemes, although the Monitoring Service for Private Insurance has been funded.

The relative median income ratio for people aged 65 and over relative to the income of the age group 0–65 was 83% in 2007, compared to 79% in 2005. The recent Law 3655 of April 2008 on 'Managerial and Organisational Reform of the System of Social Security' unifies the different funds (primary and supplementary), equalises retirement ages for some insurance funds and introduces limits on early retirement. The new law also aims to improve maternity provision and combat undeclared work and evasion of social security contributions. It provides for a new intergenerational solidarity fund (AKAGE), to be used after 2019 to strengthen the viability of the pension system. Finally, issuing a social security identification number (AMKA) to each insured person, to be used for all transactions with the social security system (employment, health, income transfers), as of 1 June 2009, will contribute to the viability of the system by simplifying administrative procedures and cutting overheads.

4.2. Key challenges and priorities

The main challenges identified in the 2007 Joint Report relate to the sustainability of the pension system and to overcoming its fragmentation. Raising employment rates, especially for

women and older workers, and curbing contribution evasion were highlighted as key priorities. Some progress has been made in addressing these challenges but efforts should continue at a faster pace. The 2008 Law is a step in the right direction, i.e. equalising conditions for all employees, but further progress is needed to reduce the variation in replacement rates across funds. The gross replacement rate calculated according to the ISG methodology for Greece in 2006 was 105 (115 for the net replacement rate). The rate is expected to fall by 12 percentage points between 2006 and 2046 (compared to a fall of 7 p.p. for the net replacement rate). This figure hides the great variation in outcomes for different funds and different contributory histories. The net replacement rates must become more uniform for similar careers across all socio-occupational groups.

It will be necessary to monitor progress on institutional changes regarding sustainability. The pension expenditure rate as a percentage of GDP (ESPROS, Eurostat data) in 2006 was 11.9% (EU-27: 11.9%). According to projections, pension expenditure is expected to double to 24.8% of GDP by 2050. Hence more efforts are necessary: in particular it is necessary to improve incentives to work longer and to contribute to social protection throughout one's career, by tightening the link between contributions and benefits and tightening eligibility criteria for early retirement.

4.3. More people in work and working longer

The national standard age of retirement is 65 for men and 60 for women, raised to 65 for women entering the labour force as of 1993, and at this age requiring a minimum of 15 years of contributions. Workers with a contribution record of 37 years can retire on full benefit regardless of age. There are more favourable provisions for people who work in heavy or unhealthy occupations and for parents with dependent or disabled children. The minimum pension requires 15 years of contributions. For people working after age 65 and up to 68, there is a higher accrual of 3.3% per year. Working mothers (insured by IKA) can benefit from an additional six-month maternity leave. Seniority (including non-contributory periods) at retirement for new flows of retirees in 2006 was 25.1 years (27.5 years for men and 20.8 years for women), very low in comparison with other countries.

The employment rate for older workers (aged 55 to 64) is comparatively low (42.4% in 2007), with no clear signs of a strong upward trend despite high economic growth; the employment rate of women aged 55-64 is remarkably low, at 26.9% (EU-27:36%). In 2005, the median effective age of retirement was 61.7 years for men and 58.4 for women.

Recent legislation has attempted to limit the special provisions that allow early retirement before the 'normal' retirement age of 65. Active measures in place as regards ageing include a range of lifelong learning programmes addressed to old-aged workers, subsidies to firms as an incentive to hire male unemployed workers aged 50 years and over (and special programmes for female unemployed workers aged 45 years and over), and earmarked subsidies to firms for hiring unemployed people close to retirement.

4.4. Privately managed pension provision

There are currently five occupational funds operating in Greece, and two more are being set up. No reference is made to private schemes. The percentage of the working population contributing to a personal pension is very low, less than 2%. Voluntary (third-pillar) pensions are mostly provided by the life insurance industry. In life insurance schemes, lump sums are preferred to annuity benefits. In Greece, total premiums added up to 2.14% of GDP in 1999,

slightly less in the two years to follow, but then rose, to 2.17% in 2005 (the EU-25 average stood at 8.5% in 2005). Rapid expansion of the life insurance industry has been observed lately.

4.5. Minimum income provision for older people

The elderly (aged 65 and over) face a higher at-risk-of-poverty rate (23% in 2007, EU-27: 19%). Uninsured elderly persons receive pensions from the OGA, but several studies stress the inadequacy of minimum pension benefits, given the high rate of poverty among pensioners and particularly among single elderly women. However, no measure is mentioned in the NSR to address this problem.

4.6. Information and transparency

An IKA pilot project to inform people about insured time covered and contributions paid, in operation since May 2007, could prove a good means of promoting information services. There are no surveys or other sources measuring knowledge/competency with regard to income security in old age (nor is there any information on differences broken down by gender, age, or educational level). The NSR does not refer to any tools for monitoring and analyzing pension developments. As to the involvement of main stakeholders in decision-making, the NSR states that a social dialogue and public consultations with all relevant bodies (mainly political parties and social partners) preceded recent legal developments.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Greek healthcare system is based on the coexistence of the National Health Service (NHS), a compulsory social health insurance, and voluntary private health insurance schemes. Universal coverage of the population is provided by the NHS and a variety of social insurance funds. Primary health care (PHC) is delivered through PHC centres and hospital ambulatory (outpatient) services, secondary and tertiary care in general and specialised hospitals. Major developments from the previous period are: the reduction in the number of Regional Management Health Care Agencies (from 17 to 7); new legislation (Law 3457/2006) on pharmaceuticals, focusing primarily on the use of IT to monitor and coordinate pharmaceuticals consumption and expenditure across the 30 health insurance funds, secondary and tertiary healthcare units; and the enactment of Law 3580 of 2007 on procurement by healthcare units. The public private partnerships (SDIT) for building health and social care units are expected to boost local employment.

PHC is a priority co-financed by the structural funds. The development of an integrated information system for the national healthcare system may contribute to improving access to the system for all socioeconomic groups. Not enough health outcomes indicators are provided. In recent decades, life expectancy at birth has risen, to 77.2 years for men and 81.9 for women in 2006, which is above the EU-27 average (72.2 for men and 81.9 for women). Concerning inequality, the NSR does not provide data on gender, occupation/working conditions, housing or living conditions.

5.1.2. Accessibility

Access for all and non-discrimination is guaranteed by law but accessibility problems remain, due to geographical disparities and variations in coverage by the social insurance funds and other sources. A mixed system of service delivery by public and private providers characterises both primary and secondary health care. According to household expenditure data, private expenditure in the form of out-of-pocket payments is substantial and has expanded fast. The unmet needs data (unmet needs and self-reported health needs) are a continuous problem. Expenditure on health has increased rapidly over the last two decades: from 5.7% of total household expenditure in 1993/94 to 7.2% in 2004/05 (of this, two thirds concerns direct payments to physicians and the rest drugs expenditure, including co-payments, and hospital care; data from the National Statistical Service). The multiplicity of funding also accounts for the lack of coordination of purchasing policies and system inefficiencies. No reference is made to how the pension reform will affect health insurance.

The NHS is still characterised by inequalities owing to the oversupply of specialists (but undersupply of nurses) mostly concentrated in the large urban centres and by significant direct costs faced by patients in the private sector and in the NHS (under the table payments) Furthermore, there are still waiting lists in public hospitals particularly in urban areas. Regarding health and women, there is no reference to specific measures incorporating a gender dimension or promoting women's health.

5.1.3. Quality

Reference is made to the Health and Welfare Inspectorate in charge of carrying out periodic inspections of health and care units (the emphasis is primarily on physical amenities and operational aspects). These inspections do not assess the outcome of treatment and interventions and a national framework for assessing the efficiency and effectiveness of medical care is needed. There is no national service regulation laying down the performance standards required across sectors (which could also provide a basis for uniform costing of services and provider reimbursement). Given the fragmented character of the NHS, there is discontinuity between ambulatory and secondary care, with defective information transfer and poor medical records. Care coordination remains a problem owing to the lack of national regulations.

The need to upgrade quality by means of accreditation procedures, standardisation, and evaluation procedures is noted in the report and will be part of future planning. A draft bill dealing with quality issues is under preparation but there is no indication of plans/targets or timelines for implementing and devising on uniform quality assessment and improvement mechanisms.

5.1.4. Sustainability

Total health expenditure as a percentage of GDP (9.1% in 2006[36]) is above the EU average[37], while expenditure has stabilised recently. The public share of total health expenditure was 61.6% in 2006, coming from the state budget and social security. The remaining 36.4% of total health expenditure comes from private payments. Private expenditure appears very high and indicates access and service use inequalities. Despite increased total health expenditure,

---

[36] OECD Health Data 2008 — Version: June 2008.

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

health status indicators have not improved. Modernisation efforts emphasise efficient ICT use, education, and measures promoting electronic government but, without appropriate monitoring of the implementation and evaluation of these plans, there is a risk of overspending and developing some services (private) more than others (public) with potentially difficult consequences for accessibility, due to the lack of effective monitoring/evaluation and a needs-based resource allocation without uniform standards for that allocation. Reference is made in the NSR to recent legislation on procurement to improve the sustainability of the system but documentation regarding expected impacts on expenditure is lacking. Care coordination remains a problem for the sustainability of the system with adverse consequences for vulnerable group accessibility, because of comparatively high private expenditure borne disproportionately by the poor.

5.2. Long-term care

5.2.1. Description of the system

The LTC system is mixed, including direct social service provisions, care needs coverage through insurance funds, tax exemptions and indirect care provision. LTC services include rehabilitation, social care, 'Care at Home', and occupational and empowerment activities managed by public and private institutions. Programmes co-financed by the Structural Funds such as 'all-day' schools, counselling, education and training for the disabled and 'care at home' for the elderly will continue in order to allow working women with dependent family members to adequately cover their working hours. The national strategy aims to improve the 'social' model in place of the 'clinical' model, e.g. deinstitutionalisation of mental patients, mainly developed at local level, and to improve the effectiveness of health and LTC systems by extending the scope of PHC. Improvement of coordination between the systems is needed.

5.2.2. Accessibility

The general aim is to favour care at home for the elderly and contribute to reconciling family life and work for women. Service providers are concentrated in urban centres. Increasing demand for care services, due to changing family patterns and growing female employment rates, combined with demographic ageing and a steadily increasing number of single elderly people, is met by female migrant labour (either as co-residing or day-care minders. The NSR does not provide data on differences in access to care by gender, age, health status, ethnic minorities and geographical location in relation to population needs. It is problematic that increased funds are being allocated without a rational needs assessment. On the coordination of care services with medical and rehabilitation services, the Report states that further development of specialised centres (for disabled and elderly people and other vulnerable groups) will be co-funded by the EU.

5.2.3. Quality

The Report mentions the development of a 'Quality Charter for Social Services' by the Ministry of Health and Social Solidarity. The aim is to develop methodologies and tools for the evaluation of services, pooling information and promoting coordination. As in the case of health care, reference to quality issues is linked to the operation of the Health and Welfare Inspectorate and to accreditation of non-profit institutions providing long-term care services by the Social Protection and Solidarity Institute supervised by the Ministry. The legislative framework for the accreditation and evaluation of NGOs and voluntary organisations providing LTC is in place. Implementation gaps and insufficient LTC health professionals

(rural areas) are a challenge to uniform provision and to the quality of services. Cost-effectiveness assessment or needs assessment by users of the services is needed. Accreditation and procurement are important; however, uniform quality assessment and performance assessment of the new centres and old institutions are needed but are not referred to in the NSRs.

5.2.4. Long-term sustainability

It is difficult to assess total LTC expenditure because of the multiplicity of providers and forms of provision. A large part of LTC is informal and family-provided, and hence hard to assess in cost terms. The mixed financing system of formal long-term care is further complicated by differences in the financing rates, which vary according to the type of care and the provider's legal status. Cost-controlling mechanisms are weak and there is no comprehensive framework for cost evaluation (based on either needs assessment or demographic projections). Coordination between medical and care services, and the many factors involved in measuring quality in social care is lacking. The NSR expresses the intention of the relevant authorities to use all available national, EU and other international resources efficiently in order to meet demand. In addition, an increase in employment of carers, an assessment of the resources made available and the promotion of public-private partnerships (SDIT) is expected to contribute to the improvement and expansion of new care units.

6. CHALLENGES AHEAD

- To promote an active inclusion approach combining active employment measures and the promotion of quality jobs, adequate income support and access to services for all citizens and especially for vulnerable groups. To take concerted action to combat child poverty and promote the wellbeing of children;

- To improve governance, to promote the mobilisation and full participation of all relevant stakeholders, and to increase the effectiveness and efficiency of social expenditure by establishing concrete mechanisms and procedures for overall coordination, monitoring and evaluation of the social policy initiatives under implementation and for impact evaluation and strategic future planning;

- To increase action to tackle poverty among the elderly, and, in particular, meet the need for a uniform safety net against poverty in old age (a safety-net pension based on income and other relevant criteria so as not to create distortions against working at older ages). The National Cohesion Solidarity Fund should take immediate effect to address poverty;

- To address the sustainability of the overall pension system, by continuing to harmonise the conditions across different pension funds, improve administrative efficiency and governance, and tighten the link between contributions and benefits. To address the adequacy of income for all current pensioners;

- To improve the cost-efficiency and quality of health services, to ensure coordination between care levels and funding arrangements, to establish an effective monitoring and regulation mechanism in the public and private sectors, and to effectively reduce inequalities in access;

- To enhance the provision of long-term care services and to establish mechanisms (uniform quality standards and performance-management tools) for evaluating the quality of the services provided in both the public and private sectors.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4,5	84,1	**2000**	56,5	71,5	41,7	27,6	39,0	**2000**	11,2	7,4	17,1	29,1
2005	2,9	92,8	**2005**	60,1	74,2	46,1	25,0	41,6	**2005**	9,8	6,1	15,3	26
2008*f*	2,9	94,1	**2007**	61,4	74,9	47,9	-	42,4	**2007**	8,3	5,2	12,8	22,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	75,0	80,1	15,9	18,2	65,8	69,2	8,1	**1995**	8,6	52,0	n.a.		-
2000	75,5	80,6	16,1	18,4	66,3	66,9	5,9	**2000**	7,8	60,9	37,2	**2005**	4,6
2006	77,2	81,9	17,5	19,4	66.3b	67.9b	3,7	**2006**	9,1	61,6	35.4**	**2006**	5,8

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	19,9	52,1	26,0	4,5	8,8	3,8	4,8
2000	23,5	49,7	26,5	6,2	7,4	5,4	4,8
2006	24,2	51,3	28,7	4,6	6,2	4,5	4,7

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
		Total social expend.	Public pensions	Health care	Long-term care
2004	27,8	8,9	5,1	5,1	n.a.
2010	28,2	-0,2	n.a.	0,3	n.a.
2030	38,5	0,2	0,8	0,8	n.a.
2050	57,0	1,3	1,7	1,7	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
	SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	20	23	19	23	26p	29p	26p	24p	**6p**	**2005**	20
male	20	-	18	21	26p	-	25p	24p	-	**2006**	20
femal	21	-	19	25	26p	-	26p	24p	-	**2007**	20

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	5,3	8,8	6,4	11,2	**2000**	6,2	3,6	10,2	**2000**	18,2	22,9	13,6
2004	4,5	8,5	6,2	10,7	**2004**	5,6	3	9,4	**2004**	14,9	18,3	11,6
2007	3,9	8	6	10	**2007**	4,1	2,2	7	**2007**	14,7	18,6	10,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,83	0,88	0,83	***Aggregate replacement ratio***	0,4	0,46	0,42

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
-7	-12	-12	DB	/		NA	/	20	/	

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Spain

1. SITUATION AND KEY TRENDS

Economic growth has been very dynamic in Spain in recent years, reaching an average GDP growth of 3.7% in 2007 (EU25: 2.9%). However, as a consequence of the global financial turmoil, economic growth rapidly decelerated in 2008 (to 1.2%) and it is projected to contract by 2% in 2009.[38] The low growth in productivity hampers the competitiveness of the economy. Employment prospects reflect the economic and financial situation in general. While in 2007 activity and employment continued to rise, at 71.6% (EU: 70.5%) and 65.6% (EU: 65.4%) respectively, job creation is expected to decline sharply from +3% in 2007 to -0.7% in 2008 and -3.9 in 2009. The previous downward trend in unemployment is also changing rapidly, due to rise from 8.3% in 2007 (EU: 7.1%) to 11.3% in 2008, 16.1% in 2009 and 18.7% in 2010.[39] The long-term unemployment rate of 1.7%[40] in 2007 remains one of the EU's lowest (average is 3.0%). Spain faces very high labour market segmentation as the proportion of fixed-term contracts is twice the EU average (31.7% in 2007, EU average: 14.5%).

Despite the economic growth in recent years, the number of people below the at-risk-of-poverty threshold has remained practically unaltered, (20% in 2007[41], EU average: 16%). Children (24%) and the elderly (28%, 30% of older women) are particularly at risk. Inequality of income is above the EU average (S80/S20 ratio: 5.3 in 2006, EU25: 4.8) and the percentage of working poor was 11% in 2007 (EU: 8%).

The population continues to grow, mainly as a result of migratory flows. In 2007, 15.1% of the population aged 15-64 had a foreign background, of which 4% were EU25 and 11.1% third country nationals. The population aged 15-64 with a foreign background have a higher employment rate (more than 69% for both groups, 65.6% for nationals), although they face a higher risk of job quality. Spain will have to deal with the effects of an ageing society (17% of a total population of more than 46 million is over 65). Although lower than in previous forecasts, the projections show a significant rise in the old-age dependency ratio (24.1% in 2008, 24.4% in 2010 and 58.7% in 2050. Life expectancy at birth remained among the EU's highest in 2006 (men: 77.7, women: 84.4).

Social expenditure as a percentage of GDP continues to be significantly below the EU average (20.9% in 2006[42]**,** EU: 26.9%). Old age and survivor benefits accounted for 8.4% of GDP.[43] Spain has one of the highest rates of early school leavers in the EU (31.0% in 2007, EU average: 15.2%), with significant regional and gender differences.

---

38 ECFIN Interim forecast, January 2009.

39 ECFIN Interim forecast, January 2009

40 1.96% in 2007, according to national data (Spanish Labour Force Survey).

41 19.7% in 2007, according to national data (National Statistic Institute, Living Conditions Survey). To note that, for the first time in 2007, the data computes the ownership of the first residence, which throws significant differences in the at-risk-of-poverty rate for the elderly. .

42 ESSPROS 2006

43 ESSPROS 2006

2. OVERALL STRATEGIC APPROACH

The Spanish SPSI Report builds on two premises: the validity of the challenges and priority objectives identified in the Report 2006-2008 and the need to update and reinforce them, while addressing emerging social needs (resulting from migration flows and an ageing population) to increase social progress, progressively reduce social inequality and prevent social exclusion. There are clear links between the five NAPincl priority objectives and the strategies on pensions and health and long-term care, and the aim is to coordinate the social protection and social inclusion OMC and the National Reform Programme. The social and labour market objectives and policies are presented as interlinked and mutually reinforcing, combining measures to boost economic activity and employment and to address the needs of vulnerable groups, as well as to boost the equity and efficiency of public expenses. Particular attention is paid to the gender impact of the measures proposed.

The Report was adopted by the Council of Ministers. The drafting process was coordinated jointly by the Ministries of Education, Social Policy and Sport and of Labour and Migration, in close cooperation with the Ministry of Health and Consumer Affairs. The social partners and NGOs were closely involved in preparing the new NAPincl, which also benefited from improved coordination between the various tiers of public administration. The Report on Pensions was presented to the social partners, whose contributions will feed into the social dialogue process during the new negotiation phase of the 'Toledo Pact'.

The Spanish report includes a chapter, under the inclusion part, on the ESF contribution to the objectives of the NSR, through 19 regional and 3 national programmes to address obstacles to general participation in the labour market and social inclusion of the most disadvantaged groups.

In order to tackle the global economic crisis, the government has confirmed that the social policy budget planned for 2009 will be maintained. It also recently adopted a series of ad-hoc measures (not included in the NSR), including schemes to boost economic activity, support to families (e.g. scope to postpone mortgage payments for the unemployed under specific conditions) and support for employment and contracting (i.e. adoption of a temporary Guidance, vocational training and labour insertion Plan, bonuses to boost indefinite contracting of those unemployed with family responsibilities, the promotion of public employment in cooperation with local authorities and an increase in the budget to implement the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency).

3. SOCIAL INCLUSION

3.1. Key trends

One of the main consequences of the global economic and financial turmoil in Spain is the steadily rising unemployment rate, which is likely to seriously affect the proportion of unemployed persons in poverty (37% in 2007)[44] and the share of people living in jobless households (6,2% in 2007) in the months to come.

[44] Population: 16 years and over in unemployment

The general rate of people at risk of poverty remains high (in 2007, 24% before and 20%[45] after social transfers), despite the overall economic and labour market progress in recent years. The elderly (28%)[46] and children (24%) are particularly at risk. The indicators available show that child poverty results from a complex interaction between several factors, including work intensity (a relatively low rate of 5,3% of all children lived in jobless households in 2007, but 71% of these jobless households with dependent children were under the poverty threshold in 2007) and household structure (in 2007, 37% of households with more than three dependent children were at the risk of poverty). In relation to education, progress has been achieved regarding childcare and the schooling rate, but Spain lags behind on student performance and retains a high early school leaving rate (31.0% in 2007, EU average: 15.2%). Public expenditure on education is lower than the EU average (4.23% of GDP in 2005, EU average: 5.04%).

The working poor accounted for 11% in 2007[47] (EU25: 8%). Definition of working poor is a combination of aspects related to household structure, job quality and unstable flow of income (note the high segmentation in the Spanish labour market, with a very high share of fixed-term contracts, particularly for women, young people, people with a migrant background and people with disabilities).

Societal aspects triggered by the shift in the age structure and by immigration flows are significant. Spain is one of the countries with the highest life expectancy, showing a clear link between the health status and the economic situation of individuals. Worth noting is the health status of specific groups, like the Roma population, who, despite the progress achieved in recent years, still suffer from health problems and chronic illnesses to a greater extent than the population average. The Roma[48] also face problems related to labour market integration and access to housing.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The 2006-2008 NSR identified five priority areas (still valid in the 2008-2010 Strategy), related to access to the labour market, improvement of minimum income, equity and quality of education, social inclusion of immigrants and assistance to persons in a situation of dependency). The Report includes information on the progress made in policy plans and measures regarding each priority, providing key data to support the progress achieved. However, an effective assessment of the impact of the measures and policy actions will take some time, due to the very broad scope of the priority areas.

In line with economic growth, progress in access to the labour market has been consistent in recent years. Implementation of measures such as the Agreement on Growth and Employment and the Law on Equality between Men and Women has specifically helped integrate women and vulnerable groups into the labour market.

---

45 19.7% in 2007 according to national data (National Statistic Institute, Living Conditions Survey).

46 To note that, for the first time in 2007, the data computes the ownership of the first residence, which throws significant differences in the at-risk-of-poverty rate for the elderly.

47 Data for 2007, not yet available for all MS, show that the rate of working poor has increased to 11% in Spain.

48 Non official data estimates the total Roma population in Spain between 650.000 and 700.000 people.

The Report gives detailed information on the increase of the statutory minimum wage (paid to 0.73% of full-time employees in 2007) and minimum pensions. Currently at €600, the minimum wage corresponds to approximately 43% of average gross monthly earnings. An increase is expected to positively influence the low-wage trap. The NSR also describes a financial incentive designed to help integrate into the labour market potentially active persons in need.

The Report also gives a detailed description of the increase in scholarships in 2007 and the progress concerning access to childcare and pre-schooling. The high early school leaving rate is partially addressed by implementing the Reinforcement, Counselling and Support Programmes, although the NRP target for 2010 (to reduce the rate from the current 31.0% to 15%) seems unattainable. However, some other factors are worth considering, such as the positive effect that rapidly rising unemployment will have on the school drop-out figures for economic reasons.

Implementation of the Strategic Plan for Citizenship and Integration 2007-2010 and the Fund for the Reception and Integration of Immigrants and their Educational Support is also described. It reports a slowdown on implementation of the Law on the promotion of personal autonomy and care for people in a situation of dependency, mainly due to institutional coordination problems. Specific support measures for vulnerable groups are worth noting, such as the National Plan for Awareness-Raising, the Prevention of Gender Violence (2007-2008) and the creation of the State Council of the Roma People.

3.3. Key challenges and priorities

The strategy aims to consolidate progress on social policy, ensuring continuity with the previous NAPincl. The selected priorities entail combining strategies to increase access to secure employment with enabling services and income support to minimise the risk of creating traps. Nevertheless, the objectives are very broad, and positive results will only stem from sustainable and sustained measures and a reinforced coordination between national and regional administrations.

The overall objectives are to: 1) enhance access to the labour market, taking into account the gender perspective, and focusing on potentially active vulnerable groups; 2) guarantee a minimum financial income for all citizens; 3) provide an education policy that makes equity part of access to and quality of the education system; 4) improve social inclusion of people with a migrant background and 5) guarantee equity for people in a situation of dependency.

The report includes an annex on the contribution of the 2007-2013 ESF strategy to social inclusion policy. It focuses in particular on the programme 'Fight against Discrimination', which aims to promote equal treatment, opportunities regarding social inclusion and labour market integration and create a national ESF Social Inclusion Network.

3.4. Policy measures

The report lists a comprehensive set of measures linked to the five overall objectives. Gender issues are also taken into account.

Implementation of the Law on Equality includes measures to promote employment for women (54.7%, EU average: 58.3% in 2007), with specific schemes for women over 45, and to foster the work/private life balance. A specific strategy addressing the integration of people

with disabilities into the labour market (2008- 2012) is planned. Implementation of the new system of vocational training and training schemes for disadvantaged groups will continue.

Financial support measures are planned, such as the Active Income for Insertion Programme (designed to support labour market integration of those in financial need) as is a progressive increase in minimum pensions and the minimum inter-professional wage in real terms to increase purchasing power for the least qualified workers. Nevertheless, the effects of these measures could be overshadowed by the new economic situation.

The report describes targeted measures supporting infant education, boosting financial support to students, enhancing success at school at all levels and ages, developing special programmes for immigrant students, increasing the attractiveness of technical and vocational education and preventing early school leaving.

The Strategic Plan for Citizenship and Integration 2007-2010, approved in February 2007, includes twelve areas of action: reception, education, employment, housing, social services, health, infancy and youth, equal treatment, women, participation, raising awareness and co-development. Specific objectives and measures are being identified in each area. Support measures for local entities, public and non-profit organisations are also planned. In light of the new economic situation and rising unemployment, it is worth mentioning the recently established programme for voluntary return of migrants.

Schemes to provide care in rural areas, prevent situations of dependency, support training for family and professional carers, etc., linked to the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency, will be implemented. Measures to boost institutional coordination are also planned.

The NAPincl also includes specific measures designed to boost social inclusion and labour market access for vulnerable groups, such as the elderly, young people, the Roma, returned migrants, prisoners and ex-prisoners, etc.

3.5. Governance

Drafting of the NAPIncl was coordinated by the Ministry of Education, Social Policy and Sport. All stakeholders, including the Economic and Social Council, social partners and NGOs, (through the State Council for Social Action NGOs and the State Council for Roma) were actively involved, and coordination has been improved, both at horizontal level (ministries) and vertical level (regional and local authorities). The Plan was approved by the Council of Ministers.

4. PENSIONS

4.1. Key trends

The Spanish pension system relies on public earnings-related schemes (mandatory) financed by social contributions from workers (4.7% of earnings) and employers (23.6% of earnings). Pensions are calculated on the basis of revenue earned in the last 15 years before retirement and are adjusted annually in line with the consumer price index. Employees can extend their working career beyond the 65-year limit through, for example, part-time contracts or incentives to access retirement beyond 65. Early-retirement is possible from the age of 61 (60

under specific transitory provisions). The relative median income ratio of people aged over 65 in 2007 was 0.76 (EU: 0.82).

Private pension plans are voluntary and cover both individual and occupational pension funds. In 2006 nearly 9.8 million people were covered by private pension plans (8 million people covered by individual plans).

Since the previous full report, the system has continued to show a surplus of well over 1% of GDP, as a consequence of revenues increasing faster than expenditure. This has allowed additional allocations to be made to the Global Reserve Fund introduced in 1997 to deal with future projected financial strain (currently totalling €55.900 million, 5.32% of GDP).

The social security system was recently reformed through several legislative initiatives. Law 40/2007, which establishes longer minimum periods of contributions taking into account only the actual days of contribution, toughens the requirements for early retirement, applies effective controls to avoid fraud in incapacity protection, changes death and survival benefits and introduces new incentives to extend working lives. There is also a move to simplify the Social Security System integrating all schemes in the General Scheme and the Self-employed Scheme, in order to secure enough contributions for adequate pensions[49] . Law 20/2007 brings social protection of self-employed-workers and salaried workers closer. Lastly, Organic Law 3/2007 introduced important social security measures to reconcile work and family lives, including the new paternity benefit.

4.2. Key challenges and priorities

The population increase, as a result of migration flows (4.7 million from 1996), has positively influenced the old-age-dependency ratio and the working-age population (and thus the people registered in the social security system). However this positive effect will not last as migratory flows are projected to stabilise at a lower level and immigrant workers will reach the retirement age. In fact, the old-age dependency ratio for Spain in 2050 is expected to be 58.7%, above the EU25 average.

Measures already adopted and changes made to the system raised the standard of living for pensioners, improved and rationalised certain schemes and the conditions for accessing pension benefits and have encouraged more people to work longer.

The accumulation of funds due to surpluses in the social security system (5.32% of GDP in 2008) is projected to last until 2023, an increase of 8 years compared to the projection made in 2005. From 2023 until 2029 the reserve fund will compensate unbalances on income. Despite this ‘time bonus’, the process of reforms must continue, since public finances will be under great pressure as public pension spending is expected to increase from 8.6% of GDP in 2004 to 15.7% in 2050.

In terms of adequacy, the statutory scheme provides a high replacement rate for low or average wages (about 91% of gross replacement rate and 97% of net replacement rate for a worker retiring at 65 after 40 years of contributions) but it will decrease in the future as the change in gross theoretical replacement rates (2006-2046) for statutory pensions is -9.

[49] Law 18/2007, of July 4th, on the integration of self-employed workers from the agricultural scheme in the self-employed Scheme).

On the other hand, the minimum contribution has increased and minimum supplements are progressively being financed from the general budget (100% planned for 2013).

Although sustained economic growth and rising employment during past years has enabled Spain to make significant progress, demographic trends and other challenges are expected to translate into pressure on public finances. Economic and labour market conditions are rapidly deteriorating and all economic indicators point to a further weakening of the economy. Over 2008 there has been a marked jump in unemployment in Spain, which has been even more pronounced for immigrant workers.

Under these circumstances, the importance of further reforms must be stressed as current projections of the pension system — although better than previous projections — could change if the situation worsens. The need to continue the reform process is recognised and the Spanish Government and the social partners have already started a new negotiation process within the Toledo Pact to tackle the pending challenges outlined.

4.3. More people in work and working longer

Overall employment increased by almost 10% since 2000, up to 65.6% in 2007, mainly driven by an increase in employment of women (13.4 % since 2000, 54.7% in 2007, still below EU average) and foreign workers. The employment rate of persons aged 55-64 also increased (7.6% since 2000 to 44.6 % in 2007).

The effective labour market exit age in 2007 was 62.1 years, above the EU average. The main pathways of early exit from the labour market are unemployment and early retirement. The share of exits through unemployment can exceed 25% and the share of exits due to long-term sickness or disability is often higher than 25%. The effective average retirement age for new pensioners is 63.6 years.

The average number of contributory years for new retirement public pensions was around 40 for men and 30 for women.

The new law introduces new requirements to qualify for partial retirement, conditions for early retirement, incentives for voluntary postponement of retirement after 65 and criteria for calculating disability pensions. However, the process of strengthening the link between contributions and benefits must continue, as must the increase in the number of contribution years taken into account when calculating the corresponding retirement pension benefit. This benefit is currently calculated according to the amount of contributions made by workers and employers during the 15 years prior to retirement. Moreover, it is important to further facilitate flexible and gradual retirement, as well as further restrictions in early retirement schemes.

4.4. Privately managed pension provision

Supplementary pensions are underdeveloped in Spain. They are optional and designed to supplement public pensions on a voluntary basis. As lump-sum payments represent the largest share of pay-outs in pension schemes, the government has changed the fiscal incentives for pension funds to encourage the use of annuities after retirement, instead of lump sums.

4.5. Minimum income provision for older people

Minimum contributory pensions have income guaranteed by a 'top-up' benefit and amount to €6538/year in 2006 (€7.99.7/year in 2008) for those over 65 years or plus (or €7920 in 2006 / €9222.5 in 2008 for 65+ with a dependant spouse), representing 27% of the total number of pensions (20.2% for the new pensions). Implementation of the measure to increase by 26% the minimum contributory pensions over the period 2004-2008 continues, and now reaches 36% of beneficiaries with a dependent spouse and 28% of single beneficiaries.

Non-contributory pensions and other means-tested welfare pensions act as basic universal provision, covering 11.4% of pensioners.

Recent reforms of minimum and survivor pensions have translated into fewer gender differences in living standards and poverty risk. The increase in minimum pensions has reduced the number of persons on a low income and the share of pensioners who are not eligible for earnings-related pension is decreasing.

Nevertheless, according to 2007 data, the risk of poverty of older people (31% before, 28% after social transfers) is still much higher than for the population as a whole, especially for women (30%), a trend that has gradually increased in recent years. Gender differences in the at-risk-of-poverty rate are even greater for people over 65 in single households (49%, women 52%). Nevertheless, the poverty gap of older people is lower, which highlights the role of minimum benefits to fight poverty among older people. Reducing gender differences in living standards and poverty risks of old people is an objective that needs to be pursued.

4.6. Information and transparency

In terms of transparency and information for citizens, workers are being offered substantial information on their pension rights, in particular via the social security website, which is continuously updated.

Reform of the pension system in Spain is based on social dialogue. The Toledo Pact is the product of the political and social consensus on reforming the social security system. There is a joint commitment to regularly monitor and evaluate the progress made on reforming the pension system.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The National Health System (NHS), defined as a mix of central government and regional government services, provides universal coverage. It is a decentralised system under which 17 autonomous regions run healthcare services, the Ministry of Health monitors and ensures the equity of the system and the Interterritorial Council of the NHS (ICNHS) has a coordination role. Primary health care (PHC) is publicly managed and delivered in health centres. Patients register with a general practitioner (GP). GPs refer patients to specialists, who refer them to hospital care. Outpatient ambulatory centres provide outpatient specialist care, and in-patient care is provided in hospitals which are publicly owned. It is a tax-based system, free at the point of access. Co-payments apply to pharmaceuticals except for retired and disabled people.

Patients can choose their GP within their area of residence. Private voluntary supplementary insurance covers 4.7% of the population. Civil servants can choose from three publicly funded mutual funds (70% state funding and 30% contributions) and either public or private provision. In June 2008 a major Pact for Health was signed by the Ministry of Health and all autonomous regions in the Inter-territorial Council with the aim of reinforcing the NHS. This agreement addresses crucial issues, such as improving human resources policy; creating a common portfolio of services; designating services and reference units; rationalising healthcare spending; establishing a common vaccination calendar; fixing a maximum waiting-time guarantee; increasing the quality and facilitating innovation in health services; facilitating universal access to palliative care; boosting preventive care and implementing policies to counter illicit drug consumption.

5.1.2. Accessibility

The Spanish population is almost universally covered (98.3% in 2006) by the NHS. Though care is free at point of access except for pharmaceuticals, data show that private, notably out-of-pocket expenditure is high (21.5% of total expenditure in 2006), which is closely related to extensive waiting lists. Spain is one of the EU countries with the least inequality in access to health care for all income levels. Since 2000, illegal immigrants have also been granted access by simply entering their names in a municipal census. However, it is important to highlight that, whilst decentralisation can ensure more adaptability to local needs, to some extent it has also resulted in regional differences in provision. To prevent such disparities, the Spanish Government approved a new decree in September 2006 which established a portfolio of common standardised services for the NHS countrywide and will use social cohesion funds to compensate some regions. Moreover, the Ministry of Health will boost primary health care by implementing the Strategic Framework for the Improvement of Primary Health Care, which will be in force over a six-year period (2007-2012). A new law on Sustainable Development in Rural Areas was also approved in December 2007, which lays down measures to improve primary health care in rural areas, such as better access to modern technologies and improvement in urgent and emergency care. Schemes to facilitate the full cover of immigrants by the NHS, part of the Strategic Plan for Citizenship and Integration 2007-2010, are also being carried out.

5.1.3. Quality

According to the bi-annual national health surveys, the Spanish NHS scores high in terms of efficacy, efficiency and equity in access. A quality plan for the NHS was drawn up to guarantee maximum levels of quality in health care in all regions on an equal basis. It involves developing strategies with all stakeholders (e.g. staff and patients) to ensure clinical excellence. Strategies include greater use of ICT. In 2007, the Spanish authorities revised a former plan to gather and monitor data on effectiveness. The main concern is the length of the waiting time for surgery and specialist care, which is partly due to having one of lowest number of beds — 338 per 100 000 inhabitants in 2005 in the EU. In June 2007, 9.33 and 37.7 patients per 1000 people awaited surgery and specialist care respectively. The Ministry of Health therefore set criteria indicators and a minimum basic and common national requirement for waiting time lists for specialists, diagnostic and therapeutic tests and surgery. Several measures have been carried out to address waiting lists: paying extra hours or fees-for-service to public health professionals within their own public institutions; contracting out services to private institutions, financed publicly and contracting out services to other public institutions with shorter waiting lists.

5.1.4. Sustainability

Total healthcare expenditure (8.4% of GDP and 2458 US$ PPP per capita in 2006) has grown more or less constantly over the past decade. Total public expenditure on health in 2006 corresponds to 71.2% of total health care expenditure[50]. Several measures to rationalise spending have been adopted or planned by the autonomous regions, e.g. rational criteria for purchasing management; policies ensuring quality and rational use of medicines; mechanisms to promote responsible demand and encourage healthy lifestyles; improved access to the best scientific information available; consolidation of plans to make the most up-to-date medical tools available to healthcare professionals; additional support for the Evaluation Agencies of Healthcare Technologies; improvement of resources and decision-making capacity in primary health care; development of Information and Communication Technologies ICT and other rationalisation measures.

5.2. Long-term care

5.2.1. Description of the system

Traditionally the family had the main role in care giving, but socio-demographic changes are making the provision of long-term care services an ever more pressing concern for the authorities. Demand for long-term care has increased in Spain as a result of the growing number of people over 65 years of age, the higher survival rate of the chronically ill, changes in the structure of families and the entry of women into the labour market. Hence, various laws have extended the range of services in this area over the past decade. They now include: PHC at home, day centres, temporary stays in residential homes, residential homes, telecare and financial aid to dependents and carers. A new Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency was approved in December 2006. This new Law created the Autonomy and Dependency Care System (SAAD), designed to increase coverage to all people in a situation of dependency (from disabled children to adults to the dependent elderly, some 1 300 000 people) by 2015 through a large boost in provision. The SAAD aims to ensure equal access by using a common dependency scale and defining a standard catalogue of services (wide range of home care, assistance and adjustment, day centres, night centres and residential care). It also aims to improve the integration of health and social services. Services may be supplied by public or private providers agreed by the public Administration and each region organises service supply. Financial benefits will be granted and family carers will enter the social security system and attend training courses when they are caregivers. User charges are to be based on income and income brackets. The government recognises that this process will take some time and effort to accomplish. Since the Law entered into force, the central government has approved implementing regulations, previously agreed in the Territorial Council as the central operational body. A dependency evaluation scale, a minimum level of protection guaranteed by central government, and the amounts of financial benefits were laid down last year. The intergovernmental cooperation framework was also approved, together with the central government budget allocation criteria to finance autonomous regions. Services to help people in a dependent situation are mostly carried out by autonomous regions but are financed fifty-fifty by central and regional governments.

[50] Source: OECD and WHO data

5.2.2. Accessibility

The Law provides for progressive implementation until 2015 when it will be implemented in full. The target is that by this date, all Spanish dependants will be universally covered. This ambitious new System of Dependency and Care (SAAD) has begun to be implemented, although it shows regional disparities and delays. During the first year in which the Law was in force, 72% of beneficiaries covered were aged over 65, nearly half of whom were over 80 years old. As of July 2008, 536 342 people had requested to be accredited as dependent and 326 015 have already been recognised as beneficiaries (high and severe dependence degree).

5.2.3. Quality

To boost quality, an accreditation of centres, services and entities working in the field is required. By the end of 2008 the Territorial Council is expected to have adopted the common accreditation criteria, which cover equipment and material as well as human resources, to be applied by all the autonomous regions. In July 2008, a Special Commission for the improvement of quality within SAAD was created. However, public and political debate in recent months has revolved around regional disparities in access. In this context, a crucial aspect covered by the Law is patient involvement in monitoring long-term care.

5.2.4. Long-term sustainability

The services provided by the Law on Dependency are financed by the Central State, the autonomous regions and by co-payments from users proportional to income and patrimony. For 2007-2008, State contributions totalled €1 271 million. The 2009 Central State budget will include €1158 million under this heading, which represents 33% more than 2007. The new Plan for Improving Economy and Employment recently approved by the government reinforces the budget with an additional €400 million. Funding totalled about 0.57% of GDP in 2005 (before the Law on dependency came into force), and expenditure is now expected to increase by 1% of GDP by 2015. Authorities have noted that implementation of the Law will create 300 000 new jobs. However, family care is still the predominant and most accepted form of care both by carers and care recipients. In this respect, there are strong ties of intergenerational solidarity between family members with regard to care tasks. Informal carers in Spain are predominantly married women, housewives aged about 50 years with primary education. It is worth mentioning that families face substantial out-of-pocket payments for contracting care from private providers and/or informal home care workers (unqualified, immigrants), due to the low level of coverage of public services.

6. CHALLENGES AHEAD

- To break the intergenerational transmission of poverty, in particular by reducing the high rate of early school leavers. Although several measures implementing the Education Law address this issue, achieving the 2010 target will require substantial and comprehensive efforts.

- To intensify efforts to promote the active inclusion of vulnerable groups, such as the elderly, immigrants, young people, the Roma population and people with disabilities, with a gender-based approach, in light of the expected effects of the financial downturn and rising unemployment.

- To monitor the sustainability of the pension system in view of the economic downturn, further strengthen the link between contributions and benefits and improve incentives to work longer.

- To enhance the provision of long-term care and to counter regional disparities.

- To shorten waiting times for care services provided by the NHS.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5,0	97,3	**2000**	56,3	71,2	41,3	32,5	37,0	**2000**	11,1	7,9	16,0	24,3
2005	3,6	102,0	**2005**	63.3b	75.2b	51.2b	38.3b	43.1b	**2005**	9,2	7,1	12,2	19,7
2008*f*	1,2	101,7	**2007**	65,6	76,2	54,7	39,1	44,6	**2007**	8,3	6,4	10,9	18,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,3	81,5	16,0	19,8	64,2	67,7	5,5	**1995**	7,4	72,2	23,5		-
2000	75,7	82,4	16,5	20,4	66,5	69,3	4,4	**2000**	7,2	71,6	23,6	**2005**	1,2
2006	77,7	84,4	17,9	22,0	63.7b	63.3b	3,7	**2006**	8,4	71,2	21,5	**2006**	0,6

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	21,6	43,9	28,6	16,5	2,0	1,6	7,4	**2004**	24,1	20,1	8,6	6,1	0,5
2000	20,3	44,7	29,4	11,6	4,9	1,4	7,9	**2010**	24,4	-0,4	0,3	0,2	0,0
2006	20,9	41,3	31,2	12,5	5,7	2,0	7,3	**2030**	34,3	3,3	3,3	1,2	0,0
								2050	58,7	8,5	7,1	2,2	0,3

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	20	24	16	28	24	25	27	21	5,3	**2005**	20
male	19	-	15	26	24	-	27	21	-	**2006**	18
female	21	-	17	30	24	-	27	20	-	**2007**	17

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	6,4	7,4	6,6	8,3	**2000**	3,7	2,3	6	**2000**	29,1	34,7	23,4
2004	6,3	7,3	6,7	7,9	**2004**	3,4	2,2	5,1	**2004**	31,7	38,5	24,6
2007	5,3	6,2	5,8	6,7	**2007**	1,7	1,1	2,5	**2007**	31,0	36,1	25,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,76	0,77	0,76	***Aggregate replacement ratio***	0,47	0,52	0,48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-12	-9	-9	DB	/	-	89	/	28,3	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

France

1. SITUATION AND KEY TRENDS

GDP growth, which is lower than the Community average, reached 2.2% in 2007, with a forecasted 0.7% for 2008 and –1.8% for 2009. The rising employment rate was 64.6% in 2007, but remains low for young people (31.5%) and older people (38.3%). In 2007, the female employment rate (60%) reached the Lisbon objective. However, employment growth in recent years conceals an increase in lower-quality jobs: temping and fixed-term contracts accounted for 10.6% of paid employment in 2006 and the working poor accounted for 6.4%[51]. The unemployment rate was 8.3% in 2007, but the regular downward trend observed since 2005 was interrupted in the middle of 2008. Estimated at 7.8% in 2008, the unemployment rate could rise to 9.8% in 2009 as a result of the economic crisis. The female unemployment rate (8.9%) is over one point higher than that for men, and young people are particularly hard hit (19.4%). Long-term unemployment has fallen slightly, with levels of 4% in 2006 and 3.6% in 2007. The risk of poverty concerns 13% of the population (2007). Social protection expenditure represents 31.1% of GDP (2006), with expenditure on pensions accounting for the highest share (44.3% of the total), followed by health expenditure (29.9% excluding invalidity). The French population is still characterised by a high fertility rate (two children per woman in 2006). The demographic dependency ratio (between those aged over 65 and those aged 15 to 64) is set to increase from 25.8% in 2010 to 46.4% in 2050. Due to the lack of statistical data broken down by ethnicity and geographical origin, the report does not offer a specific analysis of minorities.

2. OVERALL STRATEGIC APPROACH

Following directly on from the previous report, the French authorities underline the convergence between the European objectives and the French model, which is based on the aim of high-quality, full employment and greater territorial cohesion. Their strategy is based on the three main general objectives of the open coordination method. The first thrust focuses on the aim of financial consolidation of the general social protection regime, with more employment for older people and the recovery of the health insurance system in parallel with a policy centred on better access to healthcare, prevention and efficiency. The French strategy also features the aim to improve small pensions, the issue of dependency and the three sections of the social inclusion strategy (return to employment for those with the poorest job prospects, social and occupational integration of young people, and housing). The interaction between the strengthening of social cohesion and the development of growth and employment is assured through measures to promote the active inclusion and employment of older people, and through the effects of family policy on population growth (however, the role of certain provisions concerning withdrawal from the labour market, aimed particularly at low-skilled women, should be noted). No explicit reference is made to the positive consequences of the strategy for growth and employment in terms of social cohesion, pensions and health, and the links with the sustainable development strategy are not explained. The report underlines the importance of governance. The strategy pays little attention to the gender dimension, and not

[51] 2006 national figures

enough detail is given on each specific measure and from the transversal point of view, particularly in the section on social inclusion. The issue of disability is mainly covered from the perspective of long-term care.

3. SOCIAL INCLUSION

3.1. Key trends

13% of the population was living below the poverty threshold in 2007. The stabilisation of this percentage since 2001 conceals the rising severity of poverty. 14% of women and 16% of children are affected. The rate is much higher for people living alone (18% for women), single-parent families (27%) and the unemployed (33%). The poverty rate before transfers (excluding pensions) is 26%, 24% for those aged 18 to 64, and 36% for children. Net income from social assistance amounts to 80% of the poverty threshold for a person living alone and a single parent with two children (70% for a couple with two children). Numbers drawing the "*revenu minimum d'insertion*" (RMI, minimum guaranteed income) dropped by 5.2% from June 2007 to June 2008, and the 12-month exit rate has increased slightly since 2004 (27.7% in 2006). Nevertheless, the percentage of people continuing to receive the RMI is rising (46% have been receiving it for over three years). In 2007, 10% of adults were living in a jobless household (11.1% of women and 8.7% of children). Two categories are very exposed to unemployment: the 15-24 age bracket (19.4% in 2007), and the foreign population[52] (14% of men and 18% of women). School failure has not decreased in comparison to 2005 (12.7% of young people and 14.6% of boys in 2007) and 33.5% of people aged 25 to 64 have a low educational level of attainment (18.3% of the 25-34 age bracket).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The report includes the results of numerous measures concerning the return to employment, the integration of young people and housing and, where appropriate, presents conclusions concerning the necessary adjustments. It also mentions developments during the period in question, in particular the "*Grenelle de l'insertion*" (Grenelle agreement on occupational integration) process, and the *revenu de solidarité active* (RSA, active solidarity income) and *contrat unique d'insertion* (single integration contract) experiments. While there has been substantial growth in the construction of social housing, around 70% of the increase since 2000 is accounted for by intermediate social housing for rent, with housing for more extreme social cases representing only 8% of the financed volume. Furthermore, reconstruction of the housing supply is outweighed by demolitions.

3.3. Key challenges and priorities

The stability of the poverty rate, the high level of unemployment, the number of poor workers, social integration difficulties and the social housing deficit justify the carry-over of previous objectives. The three priorities, which match the challenges identified in the 2007 Joint Report, thus target access and the return to employment for those with the poorest job prospects, the social and occupational integration of young people, particularly those living in depressed areas and who belong to visible minorities, and social housing (covering the

[52] National figures based on the following definition: people born as foreigners abroad and residing in France.

problem of housing unfit for habitation). The greater emphasis laid on employment does not cause the poor quality and precarity of many jobs to be disregarded; however, it tends to limit the multidimensional approach (for instance, little attention is paid to the reduction of social inequalities linked to health). No estimate is made of the overall effort by the State to pursue social inclusion policies, nor is any reference made to the contribution of the ESF. Yet social cohesion and the fight against discrimination constitute a substantial component of the ESF Country Operational Programme for regional competitiveness and employment (39% of the total appropriation of 4.494 billion euros). Furthermore 28% of the ESF budget is dedicated to improving access to employment for jobseekers, focusing in particular on the most fragile population groups. The discussions envisaged in the previous phase to set target figures in the fight against poverty gave rise in 2007 to the stated aim to reduce the time-anchored poverty rate by one third by 2012. A consolidated scoreboard is proposed with supplementary indicators and a breakdown by age, the objectives for which are currently being discussed. There are two gender-related indicators concerning the rate of poverty among women aged 75 and over, and the female rate of employment.

3.4. Policy measures

Under the first priority (encouraging the return to employment for those with the poorest job prospects), the RSA, which replaces the RMI and the single-parent allowance, is the key measure in the active inclusion strategy. It was generalised after a relatively short experimental phase and must guarantee recipients of minimum welfare benefits an increase in income if they return to employment and ensure additional resources for poor workers. Care must be taken to prevent certain beneficiaries from settling in precarious, low-quality employment. The report briefly mentions the active inclusion policy targeting the disabled (action plan launched in 2008). The other thrusts concern developing support, merging the national employment agency (the ANPE) and the unemployment insurance bodies in order to achieve more effective protection, particularly for vulnerable population groups, reforming vocational training to improve the connection between employment and training, improving and balancing training provision for the least qualified, and strengthening the transparency and governance of the system. A new simplification of subsidised contracts (with stronger support) and the modernisation of integration through economic activity (in order to make integration possibilities more relevant to the needs of people in difficulty) are announced, and aid for the creation of businesses has been increased. To offset the effects of the economic downturn, there are plans to re-launch subsidised contracts, bringing their number to 330 000 for 2009, an increase of almost one third. Various supplementary measures are set out, in particular the involvement of the business community, reflection on the mobility of jobseekers, priority access to crèche facilities for the children of anyone following an occupational integration pathway (not only the beneficiaries of minimum welfare benefits), the development of personal microcredit, and experiments to combat illiteracy. Actions are planned against ethnic discrimination (diversity label for employers, mentoring).

The second priority, namely the social and occupational integration of young people, must be backed by measures aiming to make schools more open to the world of work (reform of professional qualifications, prevention of interruptions in learning) and improve provisions for young people leaving school with no qualifications (school support, second-chance schools, centres run by the *Établissement public d'insertion de la défense*). Young people from disadvantaged areas benefit from specific measures (individualised support plans complemented by material aid, recruitment commitments by large businesses and professional federations, and stepping up the fight against school failure). This framework allows for frequent recourse to experimentation. A third section deals with young immigrants or young

people from immigrant backgrounds and their families. Overall, actions already in existence have been renewed or developed, but the problems of fragmentation, lack of clarity and, consequently, of efficiency in numerous measures, have not been fully solved.

In view of the ongoing imbalance between supply and demand, developing the supply of social housing and the renovation of housing form the third priority. Policy in this field is based on the Act of 2007 establishing the enforceable right to housing and the draft Act on action for housing and the fight against exclusion. The main thrusts are the development of social housing and tackling the problem of housing unfit for habitation and entail an area-by-area assessment and a special effort in deficit zones, in particular Île-de-France. A number of measures aim to make it easier for people to find housing and stay in it. Action has been stepped up with regard to housing unfit for habitation and the most rundown areas of social housing are being renovated. Provision is made for the development of adapted accommodation and the improvement of accommodation arrangements for highly vulnerable population groups under the objective to ensure a move towards ordinary housing. The issue of travellers (residential sites, suitable accommodation) is also covered.

3.5. Governance

The INAP was preceded by work conducted mainly by the *Conseil national des politiques de lutte contre la pauvreté et l'exclusion sociale* (National Council for policies to combat poverty and social exclusion) and in the context of the "*Grenelle de l'insertion*". This participative six-month process, aimed at giving new impetus to integration policies, is overseen by a multiparty monitoring committee. Apart from this initiative, progress in the field of governance is presented to the general public and the local authorities from the angle of the general revision of public policies and greater attention to the process in the parliamentary context. In the triple "consultation, dialogue and experimentation" stage before generalisation, emphasis is laid on social trials and assessment. The statistical annex, which is very comprehensive, presents in particular the scoreboard used to monitor changes in poverty in relation to the presidential commitment to reduce time-anchored poverty by one third by 2012. Reference is made to the establishment of targets for the supplementary indicators. However, the coordination of policies fragmented between national level and regional or local levels remains a major challenge. Little attention is paid to the dovetailing of policies, or to links between the various sections of the OMC (open method of coordination) and with the National Reform Programme (NRP). Nevertheless, the links between the OMC and the NRP are pointed out in relation to the occupational integration of those with the poorest job prospects.

4. PENSIONS

4.1. Key trends

The average age of exit from the labour market is 58.7 for men and 59.1 for women. Since 2003, the average retirement age has fallen and settled at 60.7 for men, in particular owing to early retirements following a long career. The aggregate replacement rate is 58% (with a significant difference between men, 61%, and women, 54%). The median standard of living for retired persons, taking account of income from assets and imputed rent, is 5% lower than for employed persons. In 2008, pensions were upgraded and the indexing mechanism was revised to take better account of changes in inflation. The reform initiated in 2003 (the Fillon Act) has preserved the structure of the system, based essentially on the statutory pay-as-you-

go systems, through an endeavour to ensure its financial sustainability and more equal treatment between the different systems, with the State undertaking to offset the risks of social exclusion. It relates to the demographic transition expected between the years 2005 and 2050 (with the retirement of the post-Second World War baby boomers). The Act establishes the principle of an increase in the insurance period in proportion with the rise in life expectancy, and provides for a meeting every four years to examine the situation on the basis of economic, social, demographic and financial data. The conclusion of the first four-yearly meeting in 2008 proved to be less favourable in the short and medium terms than had initially been forecast, with a deficit in the basic scheme of 4.6 billion euros in 2007 (probably 5.6 billion in 2008), half due to the success of early retirement following a long career (more than 400 000 beneficiaries since 2004). The deficit is expected to be greater than planned until 2015, mainly owing to the modest effects of the 2003 reform and of the subsequent measures on employment rates (mitigated success of the progressive retirement and of the employment/pension combination, and failure of pension bonuses to provide an incentive). However, the comparison of forecasts concerning the financial requirements of the retirement system between 2001 and 2007 shows a 50% reduction in the overall deficit expected in 2040. Long-term projections are more favourable than those for 2005 owing to a higher fertility rate, a better migration balance and a slower rise in life expectancy. The need for financing is expected to be 1.7% in 2050 with a demographic dependency ratio for retirements (52% in 2004) of 69% (and not 78%).

4.2. Key challenges and priorities

Pension expenditure represented 13.1% of GDP in 2007, with a forecast of 14.8% for 2050. The theoretical net rate of replacement should progress from 79.7% in 2006 to 62.2% in 2046 for a male employee retiring at the age of 65 after a full-time career on an average salary. This is one of the most significant changes among the Member States[53]. According to long-term forecasts, if the labour market does not become more accessible for older people, France will face the double challenge of adequacy (a drop in the theoretical net rates of replacement) and financial viability (a rise in expenditure in relation to GDP). Combating youth unemployment and achieving increased employment rates, particularly for older people, therefore offer the only solution. Two major reforms were initiated in 2007 primarily to align the special schemes with those of the public administration by 2012, particularly as regards the length of the insurance period. Although the financial impact is negligible on account of the small percentage of the labour force concerned (2%), this development helps to create a fair and harmonised system. The meeting of 2008 also focused on the following issues: increased period of insurance, the situation of those on small pensions, the management of retirement ages and keeping older people in employment. In addition to the effective application of the Act of 2003 with, by 2012, the duration of insurance being taken up to 41 years, the firm establishment of the early retirement provision after a long career and financial restructuring of the various branches of social security, a decision was made to step up action to encourage the employment of older workers. There is to be a progress report in 2010. In the context of the current economic slowdown, measures to increase the employment of older people which are under way or have already been confirmed will probably not suffice to achieve the Lisbon objective of an employment rate of 50% for older people in 2010. Given the current-account deficits of the general insurance scheme, the employment of older people will be crucial to long-term financial viability.

---

[53] It should be underlined that, unlike the AWG projections, the ISG projections assume a continuing reduction in the value of the point for the AGIRC and ARRCO supplementary insurance schemes.

4.3. More people in work and working longer

The employment rate for people aged 55 to 64, which has been increasing slightly since 2003, reached 38.3% in 2007 (40.5% for men, and a very low 15.7% for people aged 60 to 64). The improvement in the overall rate is mainly due to the rise in female employment among the post-war generations. The average period of contribution is 35 years and 9 months (40 years for men and 31 years and 9 months for women). The statutory retirement age (60 years) is relatively low. As entry to the labour market is often late, there is a conflict between the statutory retirement age and the minimum period of insurance. The national old-age pension fund has simulated the effects of a progressive increase of up to two years in the statutory retirement age for paid employees under the general scheme: the result would be a drop in the deficit from 13 to 8 billion euros in 2020. A number of statutory provisions for early retirement still exist. At the end of 2006, 700 000 people benefited from these, including 417 000 unemployed people aged 55 and over exempt from searching for employment. However, there has been a clear decrease in the proportion of people aged 55 to 59 since 2000, not including early retirement on account of a long career. Given the success of this measure, the period entitling contributors to a pension was raised to 43 years for 2009. The measures to encourage the employment of older people taken since 2003 have had modest results and a decision was made to reinforce them: a progressive increase in the minimum age for exemption from the search for employment (60 years in 2011), an increase in the pension bonus, the liberalisation and simplification of the employment/retirement combination, the discontinuation of automatic retirements and of age limits in the private sector, and reflection on this subject in the public sector. A parliamentary amendment in the context of the legislative debate on the social security budget has raised the age at which an employer can oblige an employee to retire from 65 to 70. Compulsory negotiations on the employment of older people are planned for industries and businesses, with a target figure for increasing employment among people aged 55 to 64 and a penalty in the form of an additional pension contribution in the event of failure. On the other hand, negotiations between the social partners failed to reach a successful conclusion on early retirement from employment of an arduous nature. As most workers declared that they were unsatisfied with their working conditions, this issue must also be tackled in the bid to lengthen working life. No measures have been taken to address the chequered pattern of the career paths of women and younger age groups.

4.4. Privately managed pension provision

In the private sector, schemes are established by sectoral or corporate collective agreement, or even on the employer's initiative, financed on a shared basis or by the employer and often with compulsory membership. For workers who are self-employed or come under special schemes, these schemes are offered by a professional organisation or association, with optional membership and financing by the members. The reform of 2003 authorised individual retirement plans. These schemes attract tax concessions and social benefits and are managed in accordance with directives on insurance to secure the rights of the beneficiaries. Although there has been some progress since 2003, these provisions are still of minor significance in France.

4.5. Minimum income provision for older people

The poverty risk rate for people aged over 65 (13%) was one point higher in 2007 than the rate for people aged 18 to 64; the gap widens after 75 years (16% for women). Two main mechanisms aim to guarantee a minimum income for the elderly. The minimum old-age

pension ensures a minimum income for those aged 65 and over, on a means-test basis and subject to place of residence, with no employment conditions (599 000 beneficiaries in 2006 for a monthly amount of 633 euros for a single person, a level relatively close to the poverty threshold at 50% of the median standard of living but higher overall taking account of imputed rent). It is to undergo a 25% revaluation by 2012 in relation to 2007 in order to support the poorest pensioners. The aim of the second measure, namely the minimum contribution, is to increase the pensions of those who have completed a low-salary career or take their pension after the age of 65 (only 40% have had a full career). It concerned 4.4 million people in 2004 (over 40% of private-sector pensioners). It amounts to 584 euros per month (638 euros for a full career), plus any amounts payable from supplementary pension schemes. In both cases, women are in the majority at over 60%. The government has carried over to 2008 the objective of a net rate of replacement of 85% of the SMIC (minimum wage) after a complete full-time career with contributions paid on the basis of the SMIC. Account is taken of random events in a recipient's working life (periods of unemployment, illness, early retirement validated without penalty) and whether they had children. Various tax and health measures and long-term care also contribute to the standard of living of older people.

4.6. Information and transparency

Access to information, perceived as a priority which could help beneficiaries to reconsider their age of retirement, led in 2007 to pension estimates being sent to those insured under the compulsory schemes. This information will be generalised from 2011. Since 2000, public debate has been fuelled by a standing body, the *Conseil d'orientation des retraites* (Pensions Advisory Council), which represents the main stakeholders. Its reports, which are public, have paved the way for the recent reforms.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Life expectancy at birth is high, with a pronounced difference between men (77.3 years in 2006) and women (84.4 years), almost two and three points respectively above the European average. Life expectancy for people in good health is 62 years for men and 64.3 years for women (2005), and life expectancy at 65 years is 18.2 years and 22.6 years respectively. Infant mortality is falling steadily (3.8/1000 in 2006). The French system, which is underpinned by solidarity and universality, covers the entire population mainly on a professional basis and, since 2000, subsidiarily on a residential basis. The basic insurance schemes, which are financed by social contributions and taxes, cover around 75% of expenditure, with better coverage of long-term illnesses (100% coverage for reimbursable procedures and services, within the limits of the social security rates, therefore excluding additional charges – in particular the hospital charge – and fees which exceed the set amounts). 85% of the population has a supplementary insurance scheme of an either professional or personal nature; the underprivileged benefit from free supplementary sickness insurance (CMUC), but 7.7% of the population has no supplementary insurance. The basic principle is to reimburse insured persons, but direct billing ("*tiers payant*") to the sickness insurance funds or supplementary insurance funds is possible, and is the rule for hospitalisation.

5.1.2. Accessibility

Access to healthcare is a growing problem from a financial and geographical point of view. Since the 1990s, governments have limited reimbursement, leaving the supplementary insurance funds to cover 12.9% of expenditure, with 9.1% still to be paid by insured persons (2005). The CMUC covers 100% of health expenditure without advance payment for those on low incomes (7.4% of the population). For those on incomes slightly higher than the eligibility conditions for the CMUC, assistance to pay for supplementary insurance is provided in the form of tax credit. Although the rate of failure to receive care for financial reasons has been decreasing since 2004 (from 4.7% to 3.7% of the population in 2006), considerable contrasts still exist between social groups as regards access to care, particularly eye and dental treatment (less well covered by the compulsory schemes), and access to specialists, who account for most cases of the set fees being exceeded. The social gradient of health inequalities is significant and despite efforts to ensure cover and incentives to take out supplementary insurance, a heightened access problem for low-income groups can be observed, with certain practitioners refusing to treat patients under the CMUC (41% of specialists and 39% of dentists in 2006). Geographical disparities in care provision owing to practitioners' freedom to select their place of practice constitute a further source of inequality and trigger measures which are still not enough to encourage practitioners to establish their practice or create groups of health professionals in deficit zones. This situation may deteriorate due to the foreseeable fall in the number of active doctors and the growing demand for care due to the ageing population. Furthermore, in some areas, virtually all practitioners exceed the rates set for fees. However, the medical profession opposes the introduction of geographical regulation.

5.1.3. Quality

The main missions of the *Haute autorité de santé* are (High Authority for Health) to assess the medical service provided in terms of treatments, products and services, develop recommendations for good professional practices and ensure the provision of high-quality care by professionals through the accreditation procedure of health establishments. The *Agence française de sécurité sanitaire des produits de santé* (French Health Products Safety Agency) monitors the quality of products, from their production to the surveillance of risks after they are placed on the market. The formalisation of health strategies using thematic plans (cancer, chronic illnesses, rare illnesses, environmental factors, risk behaviours and addictive behaviours) and targeted programmes (Alzheimer’s, diabetes, nosocomial infections, palliative care, emergencies, smoking, nutrition) help to improve quality standards. Efforts to ensure coordination by appointing a reference doctor to guide patients over the age of 16 in their health choices constitute a means of improving quality (and regulating expenditure). The selected doctor can be a general practitioner or a specialist, and may be free to set their own fees, and the patient can change doctors subject to a prior declaration. In contrast, the future computerisation of medical records to facilitate medical monitoring, opposed by the Ethics Committee, is uncertain.

5.1.4. Sustainability

The discrepancy between income and expenditure remains the main challenge despite the decrease in the deficit between 2006 (5.9 billion euros) and 2007 (4.6 billion euros). However, it is expected to rise again in 2008 and 2009. National health expenditure represented 11.2% of GDP in 2005 (8.9% for the publicly-funded part), i.e. 3 374 dollars per inhabitant measured in PPP. In 2007, expenditure increased by 4.2% in comparison to 2006.

Since 2004, the financial accountability of insured persons has been reinforced, which for certain categories of people can negatively affect access to care, with a fixed financial contribution per procedure which is not reimbursed by supplementary insurance schemes (capped at 50 euros per year for consultations and 50 euros for other procedures – people under the age of 18, pregnant women and CMUC beneficiaries are exempt). Cost control is also based on the medicine-based management of expenditure, with an assessment of the "medical service provided" adjusting the rate of cover, the revision of the nomenclature of technical procedures, endeavours to manage prescriptions by promoting the correct use of healthcare, the regular revision of medicine prices and the promotion of generic medicines. The medical agreement of 2005 set the target of saving one billion euros, particularly in fields where consumption is very high (psychotropic substances, antibiotics); an amendment in 2006 changed the target to 1.4 billion euros. There is no coercive regulation through the control of medical practices based on proof, nor are there any measures to tackle the dramatic increase in charges exceeding the statutory fee over the last ten years. As regards the overall development of healthcare, the structuring of primary care should be improved, refocusing on the out-patient sector and with improved connections between non-hospital care and hospitals to ensure the continuity of healthcare and avoid unjustified use of hospital structures.

5.2. Long-term care

5.2.1. Description of the system

The system is based on double insurance coverage. Sickness insurance finances the care provided by residential homes for disabled or dependent residents, long-term care units in hospital services for patients who cannot live independently and nursing care for people at home. This care is covered directly by the sickness insurance scheme under the "*tiers payant*" system. Accommodation is charged to the person or covered by social security if their means are insufficient. In addition to this, two mechanisms which are mainly financed by the State and the local authorities offer grants (depending on income and dependence levels) to meet the expenses incurred by a loss of independence at home or in residential care: the *prestation de compensation du handicap* (disability compensation benefit), and the *allocation personnalisée d'autonomie* (personalised independence allowance, APA) for dependent elderly persons. Old-age pension insurance funds also pay out household benefits as part a social welfare provision. The development of home assistance comes at a cost (excluding APA cover) in the form of tax and welfare benefits. Elderly or disabled people also use the ordinary care system, as do other insured persons, and represent a considerable drain on public funds.

5.2.2. Accessibility

The reforms in progress aim to increase residential care facilities for disabled and elderly people, although not fast enough to cover needs and keep pace with the growing numbers of dependent elderly people. The accommodation costs for people in care exceed their personal income in 80% of cases. The remaining amount charged to the dependent elderly person is high (25% on average for home and residential care taken together), thus creating inequalities of access to long-term care. Consideration is being given to reforming prices and aggregating tax benefits and aids.

5.2.3. Quality

The focus here is on improving the medical supervision of establishments and the qualifications of paid workers, and on support for family carers (introduction in 2007 of a one-year period of unpaid family support leave, and an increase in day care and temporary residential facilities as part of the Alzheimer's plan). The problem of qualifications and quality of home-care services still remains. Furthermore, better account must be taken of the diverse needs of dependent people staying at home, in particular as regards technical assistance and the conversion of accommodation.

5.2.4. Long-term sustainability

The increase in the public cost of long-term care has led to more resources being allocated to the *Caisse nationale de solidarité pour l'autonomie* (solidarity contribution of 0.3% paid from wages by an additional, unpaid day's work, additional contribution of 0.3% to social security contributions deducted from certain income from assets and investments). The number of people over the age of 60 (12.8 million in 2007) is expected to reach 20.9 million in 2035 and 22.3 million in 2050. The number aged over 75 is expected to double over this period. The number of dependent elderly people should increase by 40% by 2040 as a result of this demographic trend. This is dealt with in a number of ways: encouraging the use of private insurance, redirecting aid to those on lower and average incomes by taking account of assets when deciding on entitlement to cover for long-term care, creating a fifth branch of the welfare system in order to standardise the financing and governance system, and reassigning surplus from the family section to dependence. The plans to decompartmentalise the medical and welfare sectors through the creation of regional health agencies should increase the number of places. Lastly, the promotion of jobs in the welfare sector must be encouraged (400 000 jobs to be filled by 2015), with emphasis on quality and working conditions. This poses a double social challenge, as the workforce in this sector is largely female, and is characterised by fragmented work of an involuntarily part-time nature and low qualification and remuneration levels.

6. CHALLENGES AHEAD

- To promote active inclusion, in particular access and lasting return to the labour market of persons who are furthest removed from it, paying particular attention to the effective occupational and socio-economic integration of young people and visible minorities, and also with a view to ensuring territorial cohesion.

- To overcome the housing crisis, especially in the hardest-hit urban areas.

- To ensure pension adequacy and financial viability by reinforcing the measures to encourage the employment of older workers.

- To consolidate the financial viability of the health system by further pursuing the reforms aimed at improving coordination and rationalisation of care while preserving broad access and correcting geographical disparities.

- For long-term care, to coordinate the various funding bodies, in order to guarantee the long-term solvency of the system and reduce the remaining cost payable by individuals, thereby ensuring greater equality of access.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,9	115,3	**2000**	62,1	69,2	55,2	28,6	30,0	**2000**	9,1	7,6	10,9	20,1
2005	1,9	110,8	**2005**	63,1	68,8	57,6	30,7	38,0	**2005**	9,7	8,8	10,7	22,7
2008*f*	0,7	105,7	**2007**	64,6	69,3	60,0	31,5	38,3	**2007**	8,3	7,8	8,9	19,4

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	73,9	81,8	16,1	20,6	60,0	62,4		**1995**	9,9	79,7	7,6		-
2000	75,3	83,0	16,8	21,4	60,1	63,2	4,5	**2000**	9,6	79,4	7,1	**2005**	1,7
2006	77,3	84,4	18,2	22,6	62.7b	64.1b	3,8	**2006**	11,1	79,7	6,7	**2006**	1,5

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	30,3	43,5	28,3	7,9	10,0	4,5	5,9	**2004**	25,3	26,7	12,8	7,7	0,0
2000	29,5	44,4	28,8	7,2	9,1	4,7	5,9	**2010**	25,8	0,0	0,1	0,3	n.a.
2006	31,1	44,3	29,9	6,9	8,6	4,3	6,1	**2030**	39,0	1,9	1,5	1,2	n.a.
								2050	44,7	2,9	2,0	1,8	n.a.

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	13	16	12	13	17	15	17	19	**3,8**	**2005**	13
male	12	-	11	12	17	-	18	19	-	**2006**	13
femal	14	-	13	14	16	-	17	19	-	**2007**	13

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	9,2	10,3	8,9	11,6	**2000**	2,9	2,4	3,6	**2000**	13,5	15	12
2004	9,6	10,8	9,5	12,1	**2004**	3,9	3,5	4,3	**2004**	14,2	16,1	12,3
2007	8,7	10,0	9,0	11,1	**2007**	3,3	3,1	3,6	**2007**	12,7	14,6	10,9

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,9	0,93	0,89	***Aggregate replacement ratio***	0,61	0,61	0,54

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
-18	-16	-16	DB	/		100	/	20	/	

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Italy

1. SITUATION AND KEY TRENDS

A slight improvement was recorded on the labour market, with an increase in employment from 58.4% (2006) (57.6 2005 data of the summary sheet) to 58.7% (2007), but with a significant gender gap (70.7% for men vs. 46.6% for women). In the same period, unemployment decreased from 6.8% (7.7 2005 data of the summary sheet) to 6.1%. The general activity rate fell by 0.2 percentage points to 62.5% in 2007. This is still well below the Lisbon target, and the gender gap is substantial: 50.7% for women (it was 50.8% in 2006) and 74.4% for men.

Despite the recent increase, the employment rate for older workers (aged 55-64) was 33.8% in 2007 (45.1% for men and 23% for women), far below the Lisbon target of 50%. Overall youth employment is 24.7% (29.6% for men, 19.5% for women). Unemployment indicators have continued to post a year-on-year decrease, falling from 10.1% in 2000 to 6.1% in 2007, with a significant gender gap (4.9% men, 7.9% women). The breakdown by age group shows 20.3% for those aged 15-24 and 2.4% for those aged 55-64 respectively. Due to the impact of the crisis in the labour market, no net job creation is projected for 2009. Unemployment is due to reach 6.7% in 2008 and 8.2% in 2009.

In 2007, Italy's at-risk-of-poverty rate was 20%, 1% more than in 2004. The breakdown is 21% for women and 18% for men respectively; by age group, 25% for children aged 0-17 and 22% for people aged over 65.

Significant gender gaps and regional imbalances still characterise the Italian labour market, as does the persistently high presence of irregular jobs and the increase in flexible jobs, especially for younger generations. 65% of Italian poor households and 68% of poor people are concentrated in the South. The poverty risk is higher for children in large families living in the South (36.7%) compared to the national average (27.1%)[54].

In 2006, Italy spent 26.6% of its GDP on social protection. This expenditure primarily targeted old age and survivors[55] (60.5%), sickness and health care (26.8%), while unemployment, housing and social inclusion measures are chronically underdeveloped. Due to ageing and a low fertility rate (1.35 in 2006), Italy is expected to face major adverse demographic pressure over the coming decades. The old-age dependency ratio (30.5% in 2008) is expected to reach 59.2% by 2050, with social expenditure expected to rise by 1.8%.

Life expectancy at birth (2004: 77.9 for men and 83.8 years for women), and healthy life expectancy (2005: 65.8 for men and 67.0 for women — provisional values) are high and above the EU average. Infant mortality, at 3.8 per 1000 in 2007, is slightly below the EU average.

---

54 ISTAT reports in the document '*la povertà relativa in Italia nel 2007' ;* 4 November 2008'

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

Immigrants in Italy constituted 5.8% of the total population in 2007 (51% women, and 49% men), up from 2.3% in 2001.

The Italian government adopted a number of measures aimed at bringing some relief to families and businesses most directly affected by the crisis, while trying to accelerate public investment. Measures to support disposable income of households and restore consumer confidence include a one-off cash transfer to low-income households, extensions of unemployment benefit payments to atypical workers, tax relief on performance-related pay and tariff freezes for some utilities. The total cost of these measures is around 0.25% of GDP in 2009. In addition, a monthly € 40 "social card", already foreseen in the 2009 budget law, supports low-income households purchase certain goods and services as from the fourth quarter of 2008.

2. OVERALL STRATEGIC APPROACH

The report highlights the importance of ensuring the long-term sustainability of public finances, while promoting stronger economic growth. Therefore the strategic priority is to reduce public spending, eliminate waste of resources and redirect public spending to those who need it most. A second priority is to raise employment rates of women, young people, and older workers given the need to substantially increase employment to ensure sustainability of the public system and increase individual freedom of choice. A third priority is to promote family-friendly policies, with both more purchasing power and better reconciliation of work and family life. Finally, there is an accent on the regional dimension, focussed on the decentralisation of competencies through the reform of the welfare system that will be implemented in parallel with fiscal federalism.

Recent political changes led to certain measures under the 2006-2008 priorities set by the previous government being discontinued. The 2006-2008 NSRSPSI priority number 4 “reducing regional disparities”, is essentially confirmed as part of the horizontal approach and through the reference to the Lisbon National Reform Programme, where the regional dimension and disparities are widely addressed, along with an in-depth on the use of Structural and National Funds within the National Strategic Reference Framework (NSRF) 2007-2013. Regional gaps are still very evident in Italy, with southern regions lagging behind in areas such as education, employment, health care and access to health and care services.

The draft report is more akin to an explanatory document than a programming document. With some exceptions in the chapter on social inclusion, it does not set any targets, quantitative indicators or deadlines. This is partly do with the fact that a new *White Paper* on the future of welfare in Italy will be presented soon. It follows the consultation launched by the Minister of Labour, Health and Social Policies last summer through the *Green Paper* and will identify a new model of welfare, with specific priorities, measures and means to reach the objectives.

Social inclusion priorities cover (1) the homeless and those living in extreme poverty, (2) families in difficult conditions, (3) child poverty, and (4) immigrants, Roma and Sinti. Concerning the generalised gender gaps, the NSR recognises that this is an issue in Italy but the policies proposed do not seem to fully address the existing challenge.

The objective on ‘governance’ is explicitly mentioned and the draft underlines the need for more coordination between national, regional and local authorities through a permanent

agency. An important role will be given to all stakeholders in implementing the various policies and measures. Except for social inclusion supported by concrete data, more details are needed to better explain the link to the Lisbon strategy. The importance of the Structural Funds in implementing social inclusion policies and reducing regional disparities is highlighted. The document refers to the Structural Funds and to the need to coordinate measures between the various tiers of government and management, particularly given the number of operational programmes (24 co-financed by the European Social Fund). It also refers to the National Strategic Reference Framework (NSRF) and the importance given to social inclusion, as a macro-objective of the NSRF. The final aim is to improve living conditions and access to services for all citizens.

3. SOCIAL INCLUSION

3.1. Key trends

The deceleration of the inflation provides some relief to low-income households but the risk of job losses and, to a lesser extent, consumer credit restraint will affect households and individuals living conditions. The total at-risk-of-poverty rate after social transfers in 2007 is 20%, but as high as 25% for children under 18 years of age. The number of children in jobless households has declined steadily over recent years, down to 5.9% in 2007 (2.9% less than in 1999). The number of people in jobless households fell over the same period to 9.2% in 2007. The incidence of poverty is overwhelmingly concentrated in the South and affects mainly large households, households whose head is unemployed, and women or men with low educational levels. In general, women are more at risk of poverty, and the gap increases with age.

The percentage of early school leavers, although decreasing, is still high and well above the EU average (19.3% in 2007), with a substantial gender gap (15.9% for women and 22.6% for men). The poor performance in terms of educational attainment and employment signals the difficulties young people experience in the transition from school to work. This is reflected in the concentration of unemployment among young people (the unemployment rate for people younger than 24 years is 20.3% compared with a rate of 4.9% for people aged 24 or more).

It should be noted that the rate of fixed-term contracts is close to 45% for new employees.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The objectives of the draft 2008-2010 report differs from the priorities of the 2006-2008 report, as the political change led to modify some measures and strategies. In particular, the former priority ‘reducing regional disparities’, one of the 2007 Joint Report challenges as the multidimensional nature of poverty is correlated with regional disparities, is now part of the horizontal approach. Other challenges previously identified, like ‘increasing the level of participation on the labour market especially for women, young people and older workers’, are not dealt in-depth as the report refers to the PNR as indicated in the Common Overview. The new measures lack targets and indicators, which should be provided with the *White Paper.* Therefore, the amount and source of financial resources for the proposed policies are not identified.

The draft document lacks a complete assessment of progress with respect to the 2006-2008 report targets. It lists the measures adopted after 2006, such as: socio-educational services for children; a national family plan; improvement of advice centres and clinics for households; a national fund and family care for frail people; qualifications of household assistant workers; a national plan for public social housing and, increased resources for employment of people with disabilities. Other measures target immigrants, e.g. a fund and schemes for social inclusion of immigrants and Roma, providing housing support, and cultural mediators to improve the social inclusion of immigrant students.

3.3. Key challenges and priorities

Social inclusion policy is based on an approach which emphasises economic growth as an instrument to reduce poverty. It underlines the need to improve coordination between policies, and between national, regional and local authorities. It focuses on the four national priorities mentioned above. A comparison between the 2006-2008 and 2008-2010 reports shows that the new first priority 'extreme poverty and homeless people' can be covered by the previous priority 'reducing poverty'. Families in difficult conditions represent one component of the previous objective on 'ensuring a better access to rights and services'. Similarly, child poverty is one aspect of the former priorities 'ensuring a better access to rights and services' and 'reducing poverty' and 'immigrants, Roma and Sinti' and one aspect of the priority on 'vulnerable categories'.

3.4. Policy measures

The measures identified in the document under the four selected priorities, if properly implemented, could help reduce poverty and social exclusion. However, the frequent lack of sound analytical background and impact assessment of previous policies, coupled with weak targets and indicators, makes it difficult to judge their adequacy. The measures will be mainly funded from the national budget and the Structural Funds, but the allocation of financial resources to specific measures is not always clear. There is a foreseeable risk of fragmented management and difficult evaluation.

Under the first priority on 'Extreme poverty and homeless people', great attention is paid to the need to monitor the situation of homeless people, and specific measures will be taken, such as a national survey on statistics, needs, reasons and services concerning homeless people, a national programme to recognise a legal residence for homeless people in collaboration with municipalities, the possibility for homeless people to access measures and services targeting vulnerable people (e.g. the social card), national guidelines to fight extreme poverty in urban areas and a national round table open to people experiencing poverty.

No additional resources are yet defined to support this priority. The regional and local authorities and NGOs will be involved through an open method of coordination.

As far as the second priority on 'Families in difficult conditions' is concerned, Italy is committed to reducing the at-risk-of-poverty rate. This priority will be pursued mainly through a national plan of public housing that favours low-income and large families, families with disabled people or seniors and immigrants with low income. A second scheme is the social card giving reductions on food, energy and gas costs to the poorest people. The bonus (€480 in 2008 for each beneficiary) is available to nearly 1 300 000 residents with Italian citizenship. To qualify, recipients must be older than 65 years and on a very low income (< €6 000 per year); poor families with the same income and at least one child aged less than 3 or

older than 70 with low income (up to €8 000). The social card is mainly financed by a new tax on the profits from specific business monopoly sectors (so-called 'Robin-tax'), and will be managed centrally by a national agency.

Regional and local authorities are involved in the national plan of public housing, as well as in social inclusion plans, according to the current legal framework.

The third priority is 'Child poverty'. The key existing measure, i.e. a national plan for socio-educational services, has been retained. The plan covers a series of schemes for children, including nurseries and 'crèches', and is implemented jointly by the State, regional and local authorities.

The still-awaited 2008-2010 national action plan for childhood and adolescence will include income support to households, reconciliation of work and family life, care for relatives, reduction of early school leavers and the fight against child exploitation, striking a balance between prevention and alleviation approaches.

The resources have yet to be identified. The draft refers to the 2007-2013 National Strategic Reference Framework, which identifies policies on nurseries in South Italy as a specific target.

Regarding the fourth priority on 'Immigrants, Roma and Sinti', the National Fund for the social inclusion of migrants, addressing in particular social and housing difficulties and provided for in the 2007 budget law, has been confirmed up to projects implemented with 2007 budget. Financial resources target the inclusion of foreign children in school, and specific attention is given to children from ethnic minorities.

Priority will be given to teaching Italian, access to regular employment and housing. Regarding ethnic minorities, and in particular Roma and Sinti, the schemes under the 2007–2013 National Strategic Reference Framework should help better assess the socio-demographic and economic situation of existing ethnic communities, as well as improve the services for them (e.g. education, vocational training, employment, health and social services), the selection, analysis and transfer of good practices against discrimination and the schemes and campaigns to stop prejudices and stereotypes against the Roma people.

As previously mentioned, no targets and indicators are given for most of the measures and priorities contained in the 2008-2010 draft report. Moreover, the gender perspective is not properly explored: references are made concerning the participation to the labour market and reconciling job and family life and health care. Schemes such as support to female immigrants, which was funded by the National Fund for Social Inclusion of Immigrants, have disappeared in the draft 2008-2010 document. This happened despite the fact that all relevant indicators for Italy continue to point to a significant gender gap regarding poverty and living conditions.

3.5. Governance

The Report underlines the need to improve coordination between policies, and an open method of coordination between national, regional and local authorities (through a permanent agency that will take on a significant role when the expected rules on fiscal federalism are enforced by law). These objectives will allow the national, regional and local governments to identify shared courses of action, plan initiatives and corresponding financial resources in a

coordinated manner, create an adequate monitoring and evaluation system, correlate the national plan for social inclusion with regional and local plans, integrate social and employment policies for the most vulnerable categories and define basic levels of service delivery to ensure fair access for all citizens to civil and social rights nationwide.

The document reaffirmed mechanisms for multi-level governance based on subsidiarity, networking and partnership principles that: a) involve private, public and social sectors; b) give regional and local stakeholders the main role in regional cooperation; c) give centralised offices the role of strategic national coordination, supported by sub-national offices.

4. PENSIONS

4.1. Key trends

The 1995 pension reform contained public expenditure on pensions, which is set to increase from 14.2% of GDP in 2004 to only 14.7% in 2050 and the gross replacement rate to decline from 80% in 2006 to 77% in 2046. The gross replacement rate will be declining as a consequence of considerable ageing of the population. The effective labour market exit age in 2007 was 60.4 while life expectancy at birth in 2006 was respectively 78.2 for men and 84 for women.

The current pension system is primarily based on the 1995 reform, which introduced defined contribution benefits. The contribution-based method only applies in full to new entrants to the labour market after 1995. Workers with at least 18 years of contributions at the cut-off date remain in the earnings-related regime. Law No 243/2004 set the age requirement at 65 and 60 years for men and women respectively[56] and allowed only those with 40 years of contributions or 35 years of contributions and 60 years of age to retire earlier. As a result of the very long transition period under the 1995 reform, until 2013-2015 people will continue to retire on the basis of the more generous earnings-related regime; starting from that date defined-contribution methods will have a large and increasing weight to determine the amount of benefits and will be fully phased in only from 2033-35 onwards.

The 1995 reforms aimed to increase the amount of savings invested in pension funds. Despite legislative intervention, the number of workers enrolled in private pension funds has remained low. For this reason, the 2004 pension reform and Law No 296/2006 introduced further measures to boost the second pillar in two ways, by providing higher fiscal incentives and a silence-as-assent for transferring the TFR[57] to pension funds. Joining private pension funds remains on a voluntary basis.

4.2. Key challenges and priorities

The draft document focuses on pension expenditure in Italy and provides adequate statistical information on the stabilisation of pension expenditure over the past decade, and on mid- and long-term spending projections. It clearly identifies that, following the 1995 reforms, the main

---

[56] It should be recalled that, as regards public employees, the European Court of Justice stated in November 2008 that by maintaining in force a provision by which they are entitled to receive the old-age pension at different ages depending on whether they are male or female, the Italian Republic has failed to fulfil its obligations under Article 141 EC.

[57] See footnote 1

challenge is to ensure adequate pensions for future pensioners, in particular as the replacement rates already fall substantially for a 40-year career. Given that most careers in Italy are substantially shorter, this represents even more of a challenge.

The draft NSR also provides long-term projections on how much second pillar pensions will contribute to ensuring adequate replacement rates for pensioners. However the assumptions underlying the calculation contribute to increasing replacement rates expected from defined contribution private pension schemes. Given the current profile of the labour force, the rise in atypical work and the limited take up of private schemes, it appears rather unrealistic to consider regular lifelong contributions as the reference model to assess the future adequacy of pensions.

The NSR identifies a sensible strategy based on three pillars:

– Improve employment rates for all categories of workers;

– Improve coverage of supplementary pensions;

– Improve social security for those not well covered (atypical workers).

While progress is being made on the last point, it is not clear which policies will address points 1 and 2 above.

4.3. More people in work and working longer

The draft NSR rightly points out that more needs to be done in this field and that policy strategies should be developed in the future. However it does not develop such strategies.

Several measures are being taken to expand coverage: increased contributions from atypical workers, introduction of care credits and more scope to reconcile all contributory periods into a single fund. These measures should help improve the pension entitlements of most people who rely on short-term and atypical contracts, at least during part of their working life.

Concerning prolonging working life, the report mentions several regional and local individual policy measures that have been introduced over the past few years, also with a contribution from the ESF. It would be extremely interesting and useful to evaluate these experimental programmes carried out at regional and local level.

The document does not address in a satisfactory way the key issue of raising employment rates, particularly for women. Continuing the process aimed at harmonising the effective retirement age for men and women should also be better tackled in the document, since it would help reduce the gender gap in pension entitlements and boost the employment rates of older workers.

The importance of these challenges has been stressed in the context of the Lisbon Strategy. The 2008 Spring European Council asked Italy to focus on increasing the provision of childcare and elderly care facilities with a view to reconciling work and family life and fostering labour market participation of women. A more comprehensive active ageing policy strategy is indeed essential to increase employment of older workers and to improve pension adequacy.

4.4. Privately managed pension provision

The report shows that the situation is unsatisfactory, especially given the low coverage rates among young and low-income workers, women, and, more generally, small firms and southern regions. Privately managed pensions (statutory, occupational or individual) must be developed for these categories, but the document stops short of addressing the implications of its own analysis.

4.5. Minimum income provision for older people

There is a wide regional variation in the proportion of elderly people living below the poverty line, with as many as 23% of elderly people in southern regions, in contrast to 8.2% and 6.9% in the North and the Centre.

Recent legislation also provided for an upgrading of minimum contributory pensions. In detail, according to Law No 127/2007 implementing the 2007 Protocol on Welfare, pensioners over 64 with an income up to 1.5 times the minimum contributory pensions (i.e. up to €8 504 in 2007 and €8 640 in 2008) were entitled to an additional lump sum of €327 in 2007, going up to €420 in 2008. Increases have also been legislated for all types of non-contributory pensions, but only for pensioners over 70 years of age. The yearly increase amounts to €156. As a result, in 2008 public assistance pensions for this category of pensioners reached €580 per month.

The current government has also just introduced a further measure for low-income pensioners: a pre-paid electronic card of €480 per year (see social inclusion part).

4.6. Information and transparency

If private pension schemes are to cover larger proportions of workers than they currently do, information and transparency on all pension entitlements appear of paramount importance. The government is moving towards a system which would allow all pensioners to view their overall situation at any moment, but this is not yet operational. Further efforts are needed so that all categories of workers are aware of and understand the possibilities offered by complementary pensions.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

In Italy there is a public National Health Service (NHS), financed via general taxation. Since 2001, responsibility for local governance of health care has been devolved to the regions. The NHS retains the authority to define the framework of strategies and national policies, together with the basic benefit package (Livelli Essenziali di Assistenza, LEA) that must be provided uniformly throughout the country. Regions are responsible for organising and administering the healthcare system. Local health authorities, both community and hospital authorities, are responsible for delivering healthcare services. Funds are distributed from the central budget to the regions according to a series of parameters (population, frequency of health utilisation by age and sex, territorial epidemiological indicators). Nonetheless, health spending per capita

($2614 in 2006) still varies substantially from region to region. Some regional taxation also helps finance the system. There are co-payments but no pre-payments under the NHS.

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

Within this context, the draft report highlights the following two priorities: a) to increase the role of prevention and shift the focus from hospital to local and ambulatory care, and b) to reduce regional imbalances by monitoring regional financial management and quality (efficiency, appropriateness, equity) at regional level. These are, in fact, two priorities which, at least according to official documents, are shared by all major stakeholders at national and regional level.

5.1.2. Accessibility

Out-of-pocket payments covering cost-sharing for public services, pharmaceuticals and private healthcare services amounted to 20.4% of health expenditure in 2007. Since some concern has been expressed about the impact of cost-sharing on vulnerable groups, there are exemptions from co-payments based on age, income, disability/dependency and chronic or rare diseases. Local authorities (municipalities) cover the institutional care costs of people on low incomes. There are still long waiting lists for hospital and specialised care. The NSR draft only refers to the introduction of the 2006 National Plan aimed at reducing waiting times, without reporting on the results of implementation in different areas of the country.

There are differences in the quality of services offered between regions. This problem has been further exacerbated since 2001 and has lead to patients migrating to obtain highly specialised care from the best regions.

Access to dental care is also a major problem due to the very low proportion of dentists operating within the public sector (only 8% of the total), and the comparatively very high cost of private dental care.

The co payments system described in 2006-2008 report is still applied, whilst the 10 € contribution paid for every specialist prescription has been cancelled; consequently, the Government resources allocated to the NHS have been increased for years 2009, 2010 and 2011.

5.1.3. Quality

The NSR provides a detailed description of the methodology and procedures put in place to monitor the quality of healthcare service provision across the country. It highlights very strong North-South differences.

The NSR does not specifically refer to the implementation of priorities set by the 2006-2008 NSR but some important measures, such as the vaccination to prevent cervical cancer (‘papilloma virus’) for 12 to 13 year-old girls, has been implemented during 2008.

5.1.4. Sustainability

Total health expenditure is around the EU average at 9% of GDP in 2006, up from 8.1% in 2000. It is slightly below average at 2614 per capita PPP$ in 2006. Public healthcare expenditure as a share of total healthcare expenditure was about 77.0% in 2007. According to 2006 EPC/EC projections, public healthcare expenditure is expected to increase by 1.3 percentage points of GDP by 2050 due to population ageing.

Financial stability is a major concern, particularly as there are big differences between the regions and the highest spending regions do not have the best outcomes in terms of quality and efficiency. Quantitative and qualitative data confirm that a number of central-northern regions are well equipped to efficiently and effectively manage their healthcare systems. Therefore the government is introducing cumbersome procedures to ration resources, allocate funding only to well performing regions, and withhold funding until underperforming regions reach the required quality standards. The central government will transfer money in instalments, which in certain cases is conditional on completion of an evaluation procedure. While it is certainly necessary to force improvements in the rational use of resources in underperforming regions, these new procedures could penalise high performing regions.

The NSR also gives a lot of attention to prevention measures. There is a National prevention Plan 2005-2007, and at the end of 2006 all regions had implemented at least 50% of the plan, producing a real impact (improved cancer screening and more calculations of individual cardio vascular risks of individuals).

5.2. Long-term care

5.2.1. Description of the system

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

Even in this area the new *White Paper* on the future of welfare in Italy should provide more indications and measures to overcome regional disparities, to reach the aims of integrating social and health assistance, integrating services and it will indicate adequate tools.

Public expenditure on long-term health care is expected to increase by 0.7 percentage points of GDP by 2050. No data are available for long-term care expenditure as a % of GDP.

5.2.2. Accessibility

The plan ignores coverage issues and proposes a model of long-term care, which is not related to explicit data concerning the situation on the ground. There is no mention at all of: a) the profile and territorial distribution of the disabled and frail elderly in need of long-term care; b) future projections of dependent elderly by age group and gender; c) coverage levels of institutional and home care services across the country.

The absence of this kind of information undermines the reliability of the report. To provide a clear example, the report makes no reference at all to the increasing use of immigrant labour, known as '*badanti*', to care for elderly people living at home. Italian families have

increasingly resorted to migrant women who in many cases working illegally[58], because of the insufficient supply of public services.

It is important to note the very limited development of home nursing services (‘*Assistenza domiciliare integrate’*) and the considerable gap between central-northern and southern regions. Similarly, the existence of often very long waiting lists for access to residential care is not mentioned at all.

5.2.3. Quality

There is a lack of general standards for the quality of social care, both at home and in institutions. In the light of the Constitutional Reform of 2001, central government is responsible for defining and guaranteeing basic social and health standards across the country. This remains an issue of heated political debate between national and regional levels of government, but the draft report does not say how the government intends to address it. The absence of national standards also undermines effective and comprehensive monitoring of regional performance. It substantially reduces the scope to redress current regional disparities and leaves the option to regional governments’ political discretion in a context of shrinking public resources, both at national and sub-national levels. The report acknowledges an improvement in the quality of long-term care services with respect to the 2006-2008 National Plan, but yet again no specific evidence is provided to support this claim.

To improve the quality of current long-term care arrangements one can hardly ignore the need to provide adequate training programmes for immigrant care workers. A number of regions promote experimental projects in this area but the report makes no mention of them.

5.2.4. Long-term sustainability

Long-term care is financed both by the NHS and the social policy fund, distributed from central government to local authorities. However, there is a clear recognition that, given the trend of demographic developments, resources are insufficient. Despite this, the draft report does not provide an overall assessment of the resources needed to guarantee the services it includes in long-term care system throughout the country.

Some regions have set up a dedicated fund for ageing people in dependency situations, aimed at financing services and allowances, within the framework of essential health services. A measure has been approved by the national parliament (National Fund for not-self-sufficient persons) in 2007 for 2007, 2008, and 2009 which amount to 100, 300, and 400 million Euros respectively. But the report does not mention central government commitments after 2009 making reference to future measures and means provided by the White Paper. The issue is very important and needs to be properly addressed, especially considering that the government’s economic and budgetary plan for 2009-2013 (Law No 133/2008) does not contain spending commitments in this policy area.

6. CHALLENGES AHEAD

- To reduce regional disparities by improving co-ordination between national and sub-national measures and adequate allocation of resources.

[58] Caritas "Immigrazione dossier statistico 2008" p.272

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

- To improve efficiency by a more rational use of resources and to improve health and LTC service organisation and coordination, whilst reducing geographic differences in provision.

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

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,6	116,9	**2000**	53,7	68,0	39,5	26,4	27,7	**2000**	10,1	7,8	13,6	27
2005	0,6	104,7	**2005**	57,6	69,9	45,3	25,7	31,4	**2005**	7,7	6,2	10,1	24
2008*f*	-0,6	97,6	**2007**	58,7	70,7	46,6	24,7	33,8	**2007**	6,1	4,9	7,9	20,3

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,9	81,3	15,8	19,6	66,7	70,0	6,2	**1995**	7,3	70,8	26,6	-	-
2000	76,6	82,5	16,5	20,4	69,7	72,9	4,5	**2000**	8,1	72,5	24,5	**2005**	5
2006	-	-	-	-	65.8b	67.0b	3,8	**2006**	9,0	77.0**	20.4**	**2006**	4,7

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2007 instead of 2006*

3. Expenditure and sustainability

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

Eurostat	Total expen-diture* (% of GDP)	Old age and survivors	Sickness and health care	Unem-ployment	Family and children	Housing and social exclusion	Disability
1995	24,2	63,4	23,2	3,0	3,2	0,1	7,1
2000	24,7	63,2	25,1	1,7	3,8	0,2	6,1
2006	26,6	60,5	26,8	2,0	4,5	0,3	5,9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004			
		Total social expend.	Public pensions	Health care	Long-term care
2004	30,5	26,2	14,2	5,8	1,5
2010	31,0	-0,5	-0,3	0,2	0,0
2030	42,4	1,1	0,8	0,9	0,2
2050	59,2	1,8	0,4	1,3	0,7

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	20	25	18	22	22	25	25	19	5,5	**2005**	19
Male	18	-	16	18	24	-	25	17	-	**2006**	20
Female	21	-	19	25	22	-	25	20	-	**2007**	20

	People living in jobless households				Long Term unemployment rate				Early school-leavers			
	Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	7	10,8	9,1	12,4	**2000**	6,3	4,8	8,4	**2000**	25,3	28,8	21,9
2004	5,7	9,1	7,9	10,4	**2004**	4	2,9	5,5	**2004**	22,3	26,2	18,4
2007	5,8	9,2	7,9	10,6	**2007**	2,9	2,2	3,9	**2007**	19,3	22,6	15,9

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,86	0,89	0,84	***Aggregate replacement ratio***	0,49	0,56	0,37

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	Statutory pensions (or Social Security)	Occupational & voluntary pensions	
									Estimate of current (2002)	Assumption
3	-3	-17	DB&NDC	14	DC	100	11,4	32,7	5,70	6,91

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Cyprus

1. SITUATION AND KEY TRENDS

Cyprus continues to demonstrate a positive economic performance, matched with overall favourable labour market situation. Poverty and social exclusion do not emerge as major problems, while pockets of exclusion are encountered within certain socio-economic groups. GDP growth has shown a progressive increase over the past few years, reaching 4.4% in 2007. Total unemployment rate of 3.9% is reasonably lower than the EU average of 7.1% (it remains relatively higher for women - 4.6%). Youth unemployment has taken a downward trend, standing at 10.1%, and is lower than the EU average of 15.3%. Employment rate of older workers (between the ages 55-64) is in a steady increase, reaching 56% in 2007 (with 73% for men and 40% for women). Overall employment rate is above the EU average with 71% (62.4% for women). Total activity rate also remains above the EU average at 74%.

Risk of poverty is at the same level with the EU average (16% in 2006). In work at-risk-of poverty is below the EU average with 7%. However, the risk of poverty rate for the age group over 65 reaches up to 52%, the highest by far among all EU countries, with the risk rate for persons living in one-person households reaching 70% within this age group.

Life expectancy at birth is above the EU average with 78.8 for men, one of the highest among all EU countries, and 82.4 for women. Same holds for life expectancy at 65, with 17.7 for men and 19.7 for women. Number of healthy life years at birth is on average 59.5 for men and 57.9 for women. Infant mortality rates have shown substantial decrease over the past decade, dropping to 3.1 per thousand in 2006. Old age dependency ratio is expected to rise from 18% in 2010 to 44.5% by 2060.

Total social protection expenditure of Cyprus was observed as 18.1% of the GDP in 2006. When broken down by main functions, it is seen that a major share is devoted to old age and survivors benefits (8.3% of the GDP), followed by sickness and health care (4.6% of the GDP). Disability expenditure constituted only a minute part of the total social protection expenditure (0.7% of the GDP). Pension expenditure amounted to 6.8% of the GDP in 2006 and is expected to reach 19.8% of the GDP by the year 2050.

According to LFS data, 17.7% of the labour force[59] in Cyprus is composed of foreign nationals. When the figure is broken down by nationality, the share of those born in another EU25 country is observed to be 6.4%, while those born outside the EU25 correspond to 11.2%. Of the total number foreign nationals, 52.1% state their main reason for immigration as seeking employment while a large proportion of the immigrant population (40.2%) is composed of unskilled workers.[60] Employment rate gap between persons born inside and outside the country is -0.6.

Public sector health expenditure presents a particular challenge. Cyprus has a very low percentage of public contribution to the total health expenditure (43.2% of the total spending)

[59] the population between the ages 15-64

[60] Population Census of 2001 of Cyprus (national data)

and majority of the spending on health is covered through individual out-of-pocket payments, giving rise to inequalities in access to quality health care.

Concerning the recent financial crisis, the Government has assessed that the Cypriot economy is not expected to suffer any major detrimental consequences in the financial sector. However, economic activity, primarily in the construction and tourism sectors, is expected to slow down due to lower external demand. The downward revised national real GDP growth projection for 2009 is 3%. Although sufficient data is not yet available to judge the impact of the crisis and its effects on vulnerable groups, no major deterioration is expected in the short term.

2. OVERALL STRATEGIC APPROACH

In line with the general priorities set in its National Reform Programme, Cyprus identifies a set of specific priorities in its National Strategy for the term 2008-2010. Reduction of the risk of poverty, active inclusion of vulnerable groups in the labour market, prevention of the social exclusion of children, and modernisation of certain government departments come forward as important priorities for Cyprus. Reform of the education, health and pension systems, and the restructuring of the welfare and employment services constitute more tangible objectives which are currently promoted within the above spectrum.

The challenges and priorities identified in the Cypriot National Strategy for 2006-2008 and the Joint Report of 2007 remain relevant, especially with regards to risk of poverty and social inclusion of disadvantaged groups. The challenges regarding the proposed reform of the health system also stay relevant, due to slow progress. The pension system reform, aiming to ensure the sustainability and adequacy of the system, is advancing satisfactorily, and Cyprus is encouraged to continue further with the implementation of the agreed package.

Emphasis on measures for vulnerable groups has improved. However, there is still room for further improvement. Policies towards the training, adaptation and inclusion of immigrants and mainstreaming of persons with disabilities can be further enhanced. Gender equality is addressed in greater detail in accordance with the Government's National Action Plan for Equality, while further progress in the area is encouraged. Quantitative targets are limited mostly to reduction of poverty, and there are no quantitative targets addressing the gender pay gap which was at 25% in 2005. Health and long-term care systems are in need of greater attention, especially concerning equal access and quality.

Setting up of an interdepartmental committee for monitoring and evaluating the implementation of the 2008-2010 National Strategy is a positive development in ensuring adherence to the policy objectives.

3. SOCIAL INCLUSION

3.1. Key trends

Cypriot population is facing an unevenly distributed risk of poverty. Total risk of poverty is at 16% comparing favourably with the EU average. 11% of the children aged 0-17 are at risk of poverty after social transfers, compared to 20% before transfers. Poverty risk for those aged 18-64 is 11% while the rate reaches up to 52% for the 65+ age group. Poverty risk for persons living in one person households is 43% (52% for women) and 70% for those over 65 even after social transfers. At-risk-of-poverty gap is 19 for the total population and 22 for the age

group 65+. The poverty threshold for one person households is €8.719 and €18.311 for a standard family[61].

According to 2007 figures, 3.7% of the children between the ages 0-17 live in jobless households. The corresponding adult rate (aged 18-59) is 4.5%. Youth unemployment is at 10.2%.

National data indicate that persons with tertiary education account for 30.5% of the population aged 25-64. Persons with low educational attainment account for 27.9% of the population, while the number drops down to 14.8% for the age group 25-34, comparing well with the EU average. The percentage of early school leavers in the age group 18-24 is 12.6%[62] compared to the EU average of 14.8%.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

In view of its positive economic and labour market performance, Cyprus seems well equipped to tackle the risk of poverty, although some challenges persist. There has been a slight decrease in risk rates over the past few years, together with diminishing youth unemployment and increasing employment rate for older workers. Progress concerning the integration of vulnerable groups to the society has been modest. On the other hand, Cyprus initiated certain institutional measures to address governance and administration problems, an area where further progress is expected.

3.3. Key challenges and priorities

The 2008-2010 Cypriot national strategy for social inclusion makes a sincere effort in identifying and acknowledging the policy deficiencies encountered in the previous years. In light of this approach, and taking into consideration the issues addressed in the 2007 Joint Report, Cyprus identifies correct challenges and priorities.

Reduction in the risk of poverty and social exclusion is taken on board as the first priority. Measures addressing the wage gap between men and women, quantitative targets for the reduction of the risk of poverty, and plans towards taking action for the problems faced by persons with disabilities and for refugees are positive developments.

Integration of vulnerable groups into the labour market is also a priority. Within this framework, Cyprus aims to improve the active involvement of different social groups through schemes targeting entrepreneurship, vocational training, flexible employment and further development of the social care network.

Prevention of social exclusion of children is addressed as a specific priority as well. Reform of the system of education is given importance. A need to counter domestic violence and juvenile delinquency is also recognised.

Institutional modernisation is presented as another national priority. There are plans for the reorganisation of the Ministry of Education and the Social Welfare Service while upgrading of the Public Employment Service is under way.

---

61 Two adults with two dependent children under the age of 14

62 Students abroad are not included among the reference population

Budgetary considerations have been given on most of the policy measures, clearly highlighting the contribution of Structural Funds. It is particularly noted that ESF provides significant contributions to a large array of policy interventions, especially concerning gender equality, social inclusion of vulnerable groups, and vocational training of the youth. Overall, the general approach of Cyprus is in line with the overarching objectives for social protection and social inclusion.

3.4. Policy measures

Ten quantitative targets have been set by the Government, particularly regarding the risk of poverty. Most of these targets approach the key challenges with serious commitment. An ambitious reduction of twelve points in the risk of poverty among persons aged 65 and over (from 52% to 40%) is targeted by 2011. The target for the reduction of the risk of poverty for persons living in one-person households is three points (from 43% to 40%) however no specific targets have been set for the elderly living in such households (who are currently facing a risk of poverty at 70%). The target for the reduction of the risk of poverty among single-parent families is four points (from 34% to 30%). The target for the rate of female employment is to reach 63% from the current 62.4%.[63] The Government is also targeting a reduction in the proportion of early school-leavers (from 12.6% to 11%), however the target does not necessarily address the high rate of early school-leaving among men (which currently stands at 19.5%).

The Cypriot National Strategy for 2008-2010 outlines numerous policy measures, especially regarding the social inclusion of vulnerable groups. Although budgetary consideration has been given to most items, proposed policy measures do not always elaborate on tangible expected outcomes and how different policies relate with and impact on each other.

There are plans to develop actions targeting the wage gap between men and women (which stood at 25% in 2005) through schemes enhancing women's entrepreneurship and the reconciliation of work and family life, however no quantitative targets are set. Provision of subsidies towards childcare services is a positive step to encourage higher activity rates among women. Promotion of flexible forms of employment, with the financial support of ESF, comes forward as a promising project in addressing the employment of women and the youth.

Reform of the education system comes forward as an important priority. It is welcomed that the reform plans also take into account the need to improve the educational means available for children with special needs. Further progress regarding the New Modern Apprenticeship programme, another project co-funded by the ESF, is keenly expected.

Disability awareness has partly improved through policies targeting accessibility and self-employment of persons with disabilities. Plans to enhance mobility through more accessible transport services and urban infrastructures are especially significant. Measures towards the active inclusion of persons with mental disabilities can be further improved. Different policy measures for disabilities should be brought under an overarching policy framework to achieve greater efficiency.

---

63 It needs to be noted that employment rate in Cyprus is already above the Lisbon target. However, a gender employment gap is evident considering that male employment currently stands at 80% while the targeted female employment rate stands at 63%.

Emergence of a programme for the prevention and treatment of domestic violence is a further development. Strengthening of the programme through awareness-building activities may further benefit victims of domestic violence.

Recognition of the victims of trafficking and sexual exploitation is another important improvement. The matter has often been a neglected problem in Cyprus, and more comprehensive policies are needed to address the issue. Measures for post-trauma assistance and prevention of re-victimisation need to be taken into consideration, together with public awareness raising campaigns.

Elaboration of certain social inclusion schemes for refugees and immigrants is a positive step, however a more comprehensive framework needs to be established. Although this is recognised by the Cypriot authorities, progress appears slow. Further measures to prevent economic exploitation of refugees and immigrants need to be taken.

The Cypriot national strategy for social inclusion reports on a national awareness raising programme in anti-discrimination, diversity and equality. This is a significant development which needs to be strengthened and proliferated. Considering that Cyprus is starting to make some progress towards social inclusion in gender, disability and age, less visible forms of discrimination, such as sexual orientation, should be taken on board among policy priorities.

3.5. Governance

Preparation of the National Strategy Report was concluded under the coordination of Social Welfare Services of the Ministry of Labour and Social Insurance. An interdepartmental committee has been set up for monitoring and evaluating the implementation the 2008-2010 strategy. An enlarged committee is expected to meet annually with social partners, local authorities, and other related agencies.

4. PENSIONS

4.1. Key trends

The General Social Insurance Scheme (GSIS) constitutes the main pension system in Cyprus. The Social Pension Scheme is also part of the statutory pillar, while the Special Allowance to Pensioners (SAPS) supplements the GSIS pension and the Social Pension. 19.6% of the total number of GSIS pensioners receive the minimum pension which currently amounts to €4000 (less than half of the poverty threshold for single households). SAPS is a measure developed to provide subsidiary financial assistance to low pension earners. When SAPS is added to the minimum GSIS pension, the final figure corresponds to €5538. Social Pension is a separate measure to address those over the age of 65 with no pension income from any other source. It is a non-contributory scheme and 98% of the recipients are women. It amounts to €4735 including the SAPS assistance.

The pensionable age for all employees is 65. However, those who have completed a prescribed period of insurance are entitled to pension at the age of 63 without actuarial reduction of the pension. Currently, around 70% of insured persons are awarded pension at the age of 63. Compulsory retirement age for civil servants has been set at 63, whereas the age for those in public education, police and military stays 55 to 60.

The aggregate replacement ratio is 0.29 by 2007 figures, which is the lowest among all EU countries. Risk of poverty is highest for the age group over 65 (52%) and is even higher for persons aged 65 and over living in single households (70%). Although the Government has concluded certain increases in the GSIS and SAPS minimum rates, the impact of this on the risk of poverty of pensioners has not been substantial.

4.2. Key challenges and priorities

long-term indicators are taken into consideration, the future adequacy and sustainability of the pension system is seen to be under serious pressure. Pension expenditure currently amounts to 6.8% of the GDP (2006), however projected evolution of pension expenditures indicates that it is expected to reach 19.8% of the GDP by the year 2050 (following a 12.9% increase). Gross theoretical replacement rate for Cyprus in 2006 was 46% (52% for net replacement rate) for an average worker retiring at age 65. Change in gross theoretical replacement rate is expected to take place at 14% between 2006 and 2046 (16% for net replacement rate). Pension system dependency ratio (number of pensioners for every 100 contributor) is expected to increase from 26 in 2004 to 64 in 2050.

Cyprus acknowledges this challenging picture. To enable sustainability and prevent depletion of the pension reserve, the Government is planning a gradual increase in the contribution rates (1.3% every five years from 2009 to 2039 until the contribution rate of long-term benefits reaches 23.4% from the current 14.3%). Minimum contribution periods are planned to be increased as well. Current pension reserve ratio was observed as 7.8 in 2007 and was expected to fall into deficit by -8.1 in 2050. Under the proposed measures, the Government is expecting this ratio to be 2.9 by 2050.

If the measures prove effective, sustainability of the pension system will be strengthened in the long run. However, high levels of risk of poverty among the elderly population make it difficult to implement short-term measures to relieve the burden on the current system. Restructuring of the SAPS on the basis of a needs-assessment method may facilitate the more effective transfer of benefits to those pensioners experiencing relatively higher levels of poverty. Measures addressing the sustainability and efficiency of the pension system can be further supported through policies targeting higher and longer employment and especially the employment of women.

4.3. More people in work and working longer

The employment rate of older workers currently accounts for 56% of the total number of people aged 55-64. This rate is higher than the EU average and Cyprus has already achieved the Lisbon targets, yet a gender gap is seen to exist when the employment rate concerning older male workers (73%) is compared to that of older female workers (40%). The Cypriot national strategy for the period 2008-2010 makes no detailed reference to measures targeting the promotion of the employment rate of older workers. Policies to encourage longer working lives, especially for women, may improve the pension dependency ratio and contribute to the sustainability of the overall system.

4.4. Privately managed pension provision

GSIS constitutes the main pension scheme in Cyprus for private sector employees. About 35% of the private sector employees are covered by occupational provident funds, though benefits are in the form of lump sum payments upon retirement, and not in the form of

monthly pensions. A law was enacted in 2006 to establish a general framework for occupational retirement benefit funds, but no substantial practical development has been recorded. Although the Government encourages the promotion of privately managed occupational retirement schemes to supplement the overall pensions architecture, the collective bargaining process with the private sector representatives is not expected to lead to a break-through.

4.5. Minimum income provision for older people

There is a high risk of poverty for the age group 65 and over (52%). Figures are even higher for people of the same age group living in one-person households (70%). The Government targets to reduce the average risk of poverty for 65+ to 40% by the year 2011. However, no specific targets have been set for the elderly living in single households.

The Social Pension provision for persons with no other source of income is inadequate when compared with the poverty threshold of Cyprus, and does not address the risk of poverty faced especially by elderly women (who constitute 98% of the recipient population under this scheme). The Government is concerned that any increase in the Social Pension may create disincentives for longer employment and contribution to the GSIS. Any such disincentives may be addressed via, *inter alia*, policy measures targeting higher female participation in the labour market and the GSIS.

4.6. Information and transparency

Simplification of the social insurance legislation in 2009, creation of a website for the Social Insurance Administration (SIA) and opening of new local offices for the SIA are some of the developments that have been taking place to achieve greater access to information. Establishment of a comprehensive information and transparency policy may further facilitate the Government's efforts in the area of achieving better access to information.

Within the context of the proposed reform package, inclusion of social partners in the decision-making process seems to have taken place adequately and effectively through tripartite negotiations aiming to achieve consensus between the different parties.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Health care system in Cyprus lies on two separate pillars. Public Health Services under the Ministry of Health provide free or subsidised health care to a large share of the population (around 65-70%). Another pillar is the private sector which has grown significantly in size and coverage. Public contribution to the total health expenditure takes place at a rate of 44.3% while majority of the spending on health is covered mainly through individual out-of-pocket payments to private sector medical services. Absence of a universal coverage framework leads to inequalities in access to quality health care.

Recognising the structural problems of the current system, the Government initiated a reform process in 2001 for health care. A General Health System (GHS) is yet to be created to regulate and coordinate public and private medical services to provide universal coverage.

Developments regarding the reform have been disappointingly slow, and implementation has long been pending, however further progress is expected.

5.1.2. Accessibility

Due to the current structure of the health care system, achieving equality in access to health care for all social groups is a challenge. Self-reported unmet need for medical care is close to the EU average with 3.2%. However, the figure reaches 6.3% with regards to dental care. In both categories, it is observed that the unmet need is highest for the first three income quintiles. When self-perceived health status is taken into consideration, it is seen that 18.9% of the persons in the first income quintile declare bad health, while the figure drops down to 2.2% in the fifth quintile. Overall, figures are indicative of a greater density of unsatisfactory access to health care for lower income earners. Although it is likely that other vulnerable groups also suffer from the regressive impact of the inequalities in access to quality health care, specific data to measure such impact on the basis of gender, nationality, and disability is not present. It needs to be highlighted, however, that all accident and emergency departments of public hospitals provide emergency services free of charge, irrespective of residency status.

It is expected that the introduction of the GHS, together with the Health Insurance Organisation (HIO) will contribute to ensuring greater equality in access to health care services. The scheme is envisaged to achieve universal coverage and establish a system of family doctors (local GPs) to act as a first point of contact with health services. The Government needs to look closely into the distribution of financial costs under the new system to assess the expected impact of the reforms.

5.1.3. Quality

The 2007 Joint Report had identified the absence of a comprehensive quality assurance system as a significant challenge for the health care system in Cyprus. The Ministry of Health established a central committee for quality control and risk management in 2003, but an integrated quality control system has not yet been introduced. On the other hand, public hospitals operate patient welfare committees which provide a medium for the patients to express concerns. It is unclear to which degree these committees have contributed to the improvement of patient rights and satisfaction. The Government is expected to further strengthen its efforts in improving the current accreditation procedures and clinical guidelines aimed at developing quality standards for both public and private health care providers. In this regard, development of uniform quality assessment structures is encouraged.

5.1.4. Sustainability

Total health care expenditure amounted to 6.3% of the GDP in 2004, 2.49% of which was covered through public expenses. The rest of the health care spending took place through individual out-of-pocket payments and to a small extent private health insurance schemes. Based on the 2004 data on public health expenditure, the projected public spending by 2050 was expected to reach 4% of the GDP. However, considering that Cyprus has undertaken a health reform to enable universal coverage through GHS, these projections would need to be revised.

The National Strategy Report of Cyprus for 2008-2010 does not make any detailed references to the long-term sustainability of the new GHS policy. It is submitted that HIO will act as the administering agency for the financing of the system, through a fund supplied by the

contributions of care recipients, their employers and the State. It is very likely that the transition from the current health care structure to GHS will incur pressure on the public expenditure on health. As such, a comprehensive impact assessment study is necessary to determine the expected long-term consequences of the GHS and to analyse the future sustainability of funds and resources.

5.2. Long-term care

5.2.1. Description of the system

Government-run structures for the elderly and the disabled, community/municipal care facilities, and private care facilities provide the main long-term care services in Cyprus. Between 2005 and 2007, an 11% increase has been noted in the number of persons being provided with long-term care in these institutions. Government subsidy is provided towards long-term care costs for public assistance recipients. Long-term care expenditure was calculated as 0.11% of the GDP by 2005 figures. National data from 2007 indicates a carer ratio of 1.98 per every person receiving care, which is showing a worsening trend due to a decline in the number of carers providing service. The Government is expected to develop a framework for home nursing by 2010 and promote community mental health nursing facilities. A national centre for mental health with long-term care facilities is planned for 2013.

5.2.2. Accessibility

There is no clear data on the accessibility of long-term care facilities in Cyprus. Equality in access to long-term care is not possible to estimate due to a lack of data on the extent of the coverage by age, sex, socio-economic background and geographical distribution.

Regarding the specific area of long-term care for persons suffering from mental disabilities, the Government operates care facilities in three cities, with a limited number of care recipients. Voluntary social welfare organisations are supported by the Government for the operation of certain care facilities for persons with disabilities.

Government has prioritised deinstitutionalisation of long-term care services, and plans to encourage community care and family care. Certain monetary benefits (although mostly limited to lump sum provisions) are available for family members who accommodate and provide care for the elderly and persons with disabilities. Diversification of the range of benefits provided towards family-care can further incentivise and strengthen the deinstitutionalisation process.

5.2.3. Quality

The 1991 Homes for the Elderly and the Disabled Law prescribes certain standards for the operation of private and community care facilities (mandatory registration, regular inspection of premises). A new legal framework is expected to be prepared for home-care provided by voluntary organisations and other private bodies. It would be advisable to establish a comprehensive regulatory framework to provide detailed quality assurance and accreditation mechanisms for the long-term care sector.

5.2.4. Long-term sustainability

Cyprus operates a subsidy scheme for long-term care recipients who are dependent on public assistance. The Social Welfare Services also finance a grants-in-aid scheme through which voluntary bodies and local authorities involved with long-term care are supported. An estimate of the current and projected extent of individual (out-of-pocket) spending on long-term care services is not available. As such, there is no concrete information as to how costs in long-term care are shared or how different social groups are affected by the costs incurred through out-of pocket payments.

Overall, main financing and budgeting mechanisms for long-term care are currently poorly developed and sufficient data is not available to assess financial sustainability. The Government is expected to conduct a study in 2009 on the financing of long-term care to develop a comprehensive approach.

6. CHALLENGES AHEAD

- To continue to improve the position of women and vulnerable groups, especially persons with disabilities, immigrants and asylum seekers, through comprehensive mainstreaming policies for active inclusion in employment and social life and equal access to services;

- To continue the efforts towards achieving better governance and increased social participation in the development, implementation, monitoring and evaluation of policy interventions;

- To address the high risk of poverty among people aged 65 and over, promote further female employment, encourage longer working lives, and ensure the long-term sustainability of the pension system;

- To rapidly proceed with the introduction of the General Health System to guarantee effective universal care coverage, contain out-of-pocket payments incidence on vulnerable groups, whilst ensuring the long-term sustainability of the new structure;

- To improve monitoring, impact assessment and quality assurance mechanisms in the provision of services, concerning *inter alia* health and long-term care, in both the public and private settings.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5,0	88,8	**2000**	65,7	78,7	53,5	37,0	49,9	**2000**	4,9	3,2	7,2	10,1
2005	3,9	90,9	**2005**	68,5	79,2	58,4	36,7	50,6	**2005**	5,2	4,3	6,5	13,0
2008*f*	3,6	89,3	**2007**	71,0	80,0	62,4	n.a.	56,0	**2007**	4,0	3,4	4,6	10,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	9,7	**1995**	n.a.	n.a.	n.a.		
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	5,6	**2000**	5,7	41,6	55,7	**2005**	3,3
2006	78,8	82,4	17,7	19,7	64,3	63,2	3,1	**2006****	6,1	43,2	48,6	**2006**	3,2

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	17,7	16,4	6,9	2,9	n.a.
2000	14,8	48,7	27,2	7,2	6,3	7,1	3,4	**2010**	18,0	0,1	1,1	0,2	n.a.
2006	18,4	46,1	25,7	6,1	10,8	7,4	3,9	**2030**	27,4	4,1	5,3	0,7	n.a.
**: including administrative costs; **: under the assumption that benefits are adjusted in l*								**2050**	37,7	11,8	12,9	1,1	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	16	12	10	51	20	16	18	23	4,5	**2005**	16b
male	14	-	8	47	18	-	17	21	-	**2006**	13
femal	17	-	12	54	21	-	19	24	-	**2007**	10

	People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	3,9	4,9	3,4	6,3	**2000**	1,2	0,5	2,2	**2000**	18,5	25	13,9
2004	2,6	5	3,8	6,1	**2004**	1,2	0,9	1,6	**2004**	20,6	27,2	14,9
2007	3,9	4,7	4,2	5,2	**2007**	0,7	0,8	0,7	**2007**	12,6	19,5	6,8

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,57	0,6	0,56	***Aggregate replacement ratio***	0,29	0,34	0,34

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
16	14	14	DB	/	-	86	/	16,6	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Latvia

1. SITUATION AND KEY TRENDS

Economic growth in Latvia has been considerable (peaking at 11.9% in 2006). However, it slowed abruptly in mid-2007 and GDP contracted by 2.3% (estimate) in 2008. The latest forecast projects a contraction of 6.9% in 2009. Inflation (15.3% in 2008), although falling now, is still the highest in the EU. Labour market has been resilient, although with unemployment rising in the third quarter of 2008, it is expected that employment will decrease and unemployment increase significantly during 2009-2010. Disadvantaged groups and young people are likely to see a reversal in employment gains.

Growth in itself did not prove sufficient to tackle poverty and inequality in Latvia. Although the at-risk-of poverty rate in 2007 improved slightly (at 21%) compared with 2006 (23%), it is still the highest in the EU. The risk is higher for women (23%) than for men (19%). Older people, especially women, face a higher incidence of poverty. It should be noted that the at-risk-of-poverty threshold is among the lowest in the EU. Although average earnings grew considerably, having a job is not enough to avoid poverty: in-work poverty is high (10%), especially for part-time workers (26%). Inequality of income is among the highest in the EU (the S80/S20 ratio being 6.3%). The Gini coefficient (35) also confirms very high income inequalities and an increasing trend until 2007.

Demographic prospects are bleak; the population has steadily fallen since 1991, with outward migration[64] adding to natural causes. Life expectancy at birth is low (65.4 for men and 76.3 for women in 2006) and infant mortality is high (8.7 per 1000 live births), though it decreased until 2006 (7.6 per 1000). Healthy life expectancy in 2006 was 50.5 years for men and 52.1 for women. Remaining life expectancy at 65 was 12.7 years for men and 17.3 for women. The current old age dependency ratio is below average (25% in 2008), but this will not continue and projections for 2060 are not favourable (64.5%). Expenditure on social protection and pensions is among the lowest in the EU and declining, at 12.2% and 6.1% of GDP in 2006. Total age-related social protection expenditure is projected to decline.

2. OVERALL STRATEGIC APPROACH

The overall approach taken by the National Strategy Report on Social Protection and Social Inclusion for 2008-10 (NSR) emphasises its links to Latvia's Development Plan, which aims to achieve a balanced and sustainable development and ensure the country's competitiveness. In view of the downturn in the economy, and high levels of poverty and inequality, Latvia has identified the following broad priorities for future action:

– To facilitate more efficient participation and inclusion into the labour market;

– To improve income support systems;

– To promote access to quality services.

[64] Mostly intra-Community mobility.

For pensions, the main effort will be directed to increasing adequacy. In health care, existing strategies e.g. to attract and retain much-needed human resources, will continue to be implemented. One improvement on the 2006 National Strategy Report is that the priorities are now linked to quantified targets and indicators. In the face of a recession, given a lack of information on how the measures will be financed, there are concerns that they might prove over-ambitious. Although the NSR stresses the need to work out an integrated strategic approach to implementing social inclusion policies, it is still fragmented. It comprises separate initiatives and lacks a coherent approach. A clearer assessment of progress towards 2006-08 priorities and explanations about the need to change them would have been beneficial. The focus on the gender perspective has improved. Mainstreaming is emphasised as the main tool to achieve gender equality and general equality (age and disability included). The contribution of the Community Initiative *EQUAL* in tackling discrimination is acknowledged. The NSR refers to the national Lisbon Programme, but does not link in to the Sustainable Development Strategy. This results, for example, in a lost opportunity to find a better balance between a focus on housing benefits (helping to meet heating expenses) and improving poor housing insulation.

There is no explicit recognition that the economic downturn will create new challenges. A likely scenario involves higher unemployment, fewer jobs — with public sector staff cut by 10% across the board (to be followed by further cuts), and a break in customary wage growth. Recent sharp cost of living increases, coupled with higher indebtedness, also have an impact on the situation of households. The very different economic background has major policy implications: because of lower revenues, fewer resources will be available for the planned policies. There will be a need to prioritise, whilst avoiding unnecessary hardship for the disadvantaged. Secondly, recent labour market trends will be reversed. This will increase expenditure: more unemployment benefit payments and increased demand for active labour market measures. Also, local government and other public services need adequate capacity and resources to cope with the increased work loads. The need for social assistance will grow.

3. SOCIAL INCLUSION

3.1. Key trends

Latvia's social protection system underwent significant reforms in the mid-1990s to ensure its sustainability, although changes have been slower in health care. Living costs have increased considerably, particularly food, housing, transport, health and education. Although inflation pressures could be abating soon, they have not gone yet: in October 2008, the prices of heating (+16.5%), gas (+68.9%), electricity, food and clothing were still increasing. Poverty and income inequality in 2007 were among the highest in the EU. Younger people saw slight improvements as regards poverty (21%), while the situation of older people deteriorated (aged 65+: 33%). The incidence of poverty is high among households with children, especially three or more (46%). The risk was also extremely high for the unemployed (57%), men in particular (66%). Note that the at-risk-of-poverty threshold (value for a one-person household in PPS: 3356) is among the lowest in the EU. Material deprivation, notably economic strain, is considerable. However, long-term unemployment has decreased significantly (to 1.6%). The share of people living in jobless households, children included, is slightly below the EU average.

In-work poverty is high. Finding better ways to make work pay has been a longstanding issue, as taxation on low wage earners is relatively high and marginal effective tax rates do not

perform well. Thus unemployment traps reveal that income taxed away on transition to full-time employment varies from 83% to 100% in 2006 (being highest for lone parents and single-earner couples, who also experience 100% earnings loss when moving to a job from inactivity). The net income of jobless social assistance recipients in 2006 (as a percentage of the poverty threshold) seems high for lone parents (1.3%) and for couples with 2 children (1.1%). The proportion of early school leavers decreased slightly at 16% in 2007 but is still high. So are the numbers of people who report that in the last 12 months they had a need to visit a doctor, but did not do so.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

No significant progress was achieved in ensuring access to education and the labour market for children and disadvantaged youth, especially, access to resources and services for families with children and for pensioners. Note that recent economic growth, together with the labour market programmes supporting first employment and providing career counselling, helped to improve the overall employment situation of young people, but the impact of the economic downturn might change this trend. Some measures were introduced for children with special needs and those with learning difficulties. Action was taken to improve the provision of services, notably care. Increases in family benefits and pensions, together with wage increases, tackled the poverty risk for some families in 2007, but did not prevent an increase in poverty for pensioners (38%, from 35% in 2006). Some measures were not fully implemented for lack of financial resources even during economic growth. The scope of the measures proved insufficient, as poverty and inequality remain high, early school leaving needs to be tackled and access to care services needs to be improved.

The 2007 Joint Report included the following key challenges:

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

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

Although the efforts made — such as introducing ambitious targets and continuing to support first employment — should be acknowledged, on the whole, the key challenges identified remain valid.

3.3. Key challenges and priorities

The 2006-08 NSR took a lifecycle approach and identified as priorities: the need to ensure access to education and the labour market for children and disadvantaged young people; and access to resources and services for families with children and for pensioners. Latvia's current attempt to reach all important target groups has resulted in setting very broad priorities (participation in the labour market; income support systems; access to quality services). The need to focus on pensioners and families with children is still important and deserves to be highlighted, as their poverty risk remains high. Tackling the adverse consequences of inflation would seem most topical. As a reversal in employment trends is expected, it is important that employment opportunities for the disadvantaged continue to be improved. Priority tasks could

have better reflected the evolving needs of vulnerable groups, and the situation in the regions, or mentioned the need for improvements in the interplay between taxes and benefits. As the new tasks are very broad, they can also be seen as addressing the key challenges identified in 2007. They are broadly in line with the 'social inclusion strand' objectives. However, in the face of a recession and due to rather weak targeting and consistency, it is unlikely that the current poverty risk will decline significantly, in-work poverty included. Latvia intends to use Structural Fund support and the ESF in particular, to carry out many of the measures, but implementation for the period 2007-13 is falling behind schedule. It also remains to be seen whether full implementation will be achieved in the light of the tighter budgetary outlook.

3.4. Policy measures

Policy measures are grouped according to three priorities, based on actions in the line ministries.

The priority *'Efficient participation and inclusion in the labour market'* will be addressed by improving accessibility and the quality of vocational education and vocational rehabilitation. Opportunities to find jobs will be increased for families with children, the unemployed, and specific disadvantaged groups. Quantified targets set for measuring progress include reaching the Lisbon employment target (70%) by 2010, increasing the share of students in vocational education to 28.85% (currently 26%), and, interestingly, reaching the long-term unemployment rate of 2.3% (which may reflect the unfavourable prospects for the economy).

'Improving income support systems' will be achieved by increasing the monthly guaranteed minimum income benefit (from LVL 27 to 37 in 2009); improving the legislation governing housing benefits; and increasing benefits for those disabled from childhood. Families with children will be supported, for example, by providing free school lunches during the first school year. Benefits for children who lack parental support will increase. Pension benefits will be further supplemented and adjusted. Continuing to increase the minimum wage from 48% of the previous year's average in 2008 to 50% in 2010 is included in this priority. The tax-free threshold will increase slightly. The authorities expected that the at-risk-of-poverty rate would decrease to 21%.

'Access to quality services' will be ensured by improving vocational education and lifelong learning systems, providing better access for the disabled and Roma to education, and improving social workers' skills to help disadvantaged young people. Foster care will be supported, as will centres for family support and youth initiatives. Access to municipal housing will improve. Support will improve for groups like ex-offenders, the disabled and elderly. The lifelong learning indicator will increase to 12.5% in 2010 (from 7.1%), youth educational attainment will reach 85%, the share of successful graduates in basic education will increase to 89%, and the availability of municipal and social housing will grow (by 0.4% and 3%).

Latvia's budget for 2009 is undergoing further amendments. Information on the scale of resources allocated is lacking in the NSR. Considering the adverse effects of recession and a tighter budgetary outlook, reaching or maintaining most of the targets for 2010 is challenging.

3.5. Governance

A formal mechanism involving all stakeholders has been created. As previously, consultation and coordination on the NSR took place within the framework of Committee for Coordination

of Social Inclusion Policy. The NSR does not provide information on the outcomes of the discussions. The involvement of partners other than line ministries seems limited to clarifying issues. Compared to 2006-08, discussions held in the media and with stakeholders lost in visibility. Better involvement of the poor in improving their own situation is still a challenge. The Coordination Committee referred to above will have a role in monitoring the progress of the NSR.

4. PENSIONS

4.1. Key trends

Latvia conducted a fundamental reform of the PAYG scheme in 1996 to ensure the long-term sustainability of pensions. Risks were diversified by putting in place:

– A public statutory scheme, comprising a state compulsory NDC PAYG tier and a funded statutory tier;

– A private, voluntary scheme allowing additional savings.

The reform strengthened the link between contributions made and benefits received. People with low pension entitlements can benefit from a minimum pension. The statutory minimum pensionable age has gradually increased, and stood at 62 years for both men and women on 1 July 2008. Provision for early retirement has been prolonged again and will be available until the end of 2011. So it is still possible to retire two years earlier and receive 80% of pension, calculated according to a general formula. The effective labour market exit age increased in 2007 (63.3) and was above the EU average, although, according to the NSR, a further decrease in retirement age for certain categories was introduced (like those working in hazardous conditions). In a tight labour market, employers appreciated the skills, experience and attitudes of older workers, which raised their employment rates to 57.7% (52.4% for women and 64.6% for men in 2007).

The issue of pension adequacy has gained importance, as even during a period of high economic growth the risk of poverty for older people increased (from 21% in 2005 to 30% in 2006 and further to 33% in 2007), especially for women (39%). Single elderly people are affected more (75%). Increasing the low pensions has been the key policy response. Given the high inflation rate, supplements to old-age pensions were introduced in 2006 to alleviate poverty among the oldest cohorts. From 1 January 2009 old age pensioners, will receive an increased monthly supplement of LVL 0.70 for each ‘contribution’ year accumulated before 1996. The new NSR also recognises the need to index all pensions, irrespective of amount. This was expected to happen in October 2009 (according to the price index for higher amounts). For the time being, the redistributive functions within the system have gained importance: raising minimum pensions, and indexing the lowest pensions (according to the price index and 50% of the real increase in contribution wages) twice a year. The higher pensions (five times the state social security benefit) are currently not indexed. Pension expenditure as a share of GDP in 2006 was among the lowest in the EU at 6.1%, and falling. This needs to be monitored, in the light of the inadequacy of pension benefits. Expenditure on public pensions, including funded statutory pensions, is projected to rise from 6.8% of GDP in 2004 to 8.3% in 2050.

Undeclared work and underreported wages are issues for the social security system. The social insurance contribution rate is 33.09% of the gross wage; pensions account for 20% of this. The pension contributions of those who have joined the funded statutory tier are divided as follows: 12% to the NDC PAYG tier and 8% to the funded tier. This was expected to change in 2010, when the share going to the funded statutory tier increases to 9%, to be followed by a further increase to 10% in 2011. Coverage is provided for all employees, the self-employed and part-timers included. The aggregate replacement ratio is 0.38%.

4.2. Key challenges and priorities

The 2006-08 NSR identified the resources to ensure adequate pensions as a challenge. Pension adequacy remains important, as costs increase for items such as food, heating, electricity, clothing and medical services. Compared to those of the general population, pension incomes have decreased. Pension adequacy issues have risen very high on the political agenda. A referendum on minimum pension amounts was held in August 2008, but the turnout was too low to have an effect. However, this put pressure on the Government and plans were drafted to increase the lower pensions, among them plans to increase state social security benefits, which did not come to fruition. Plans for indexation of pensions in 2009 are also not clear.

Pension reform seems (based partly on performance in 2007) to have succeeded in ensuring a sustainable pension system. The current demographic situation is favourable to the state pension system, as pensions are being drawn by small cohorts born during the Second World War, while those born in 1980s (when the birth rate was twice as high as it is now) are expanding the workforce. This will change when the small group of people born in the 1990s reaches working age while, simultaneously, people born during the high-birth-rate years start retiring. Although (since 2002) there has been a surplus in the special state social insurance budget, the introduction of a pension reserve fund has been postponed due to general budgetary constraints. The prospects for this fund do not look bright, as the current NSR only refers to the need for timely accumulation of social insurance budget revenue. A temporary arrangement for administrating the surplus has been reached with the State Treasury, allowing the budget to profit from savings at an interest rate of 6%.

The design of the funded statutory pension tier does not guarantee future levels of benefits. Issues of sharing and regulation of risk might become topical as the funded scheme, removing the risks of longevity and return from the state, matures. Concerns are already being voiced about the inadequate return currently granted by active and dynamic pension plans.

4.3. More people in work and working longer

The pension system strives to focus on incentives for people to remain in the labour market for as long as possible and go on working beyond the statutory retirement age. The pension formula was initially designed to encourage people to continue working after the statutory pensionable age without drawing a pension, thus accumulating additional notional pension capital resulting in a higher pension. Parliament took a decision to pay a reduced old-age pension along with a salary, but the Constitutional Court ruled against the measure. This has contributed to fewer incentives to postpone drawing a pension. Upon reaching the statutory pensionable age, workers prefer to combine pensions with wages if they remain employed. However, the option of combining a full pension with a salary encourages people to work longer and improves their income.

4.4. Privately managed pension provision

Latvia is among the countries that have reshaped their statutory scheme by providing a funded statutory tier to complement the unfunded NCD PAYG tier. This was also expected to prevent poverty among pensioners when the scheme (introduced in 2001) matured. With the deteriorating outlook for the economy, it remains to be seen whether there is still scope for financing transition costs through higher employment, declared work and salaries.

The administration of the second tier still largely falls to the State Social Insurance Agency (SSIA). The SSIA has contracted the Central Depository to administer the accounts of the second-tier participants. Decisions on the investment of assets are taken by the asset manager. The capital is kept in a custodian bank. The institutions involved in the scheme are supervised by the Finance and Capital Market Commission. The return rate from assets in 2007 was lower than in previous years and fluctuated between -0.82% and 5.09%. None of the pension plans managed to exceed the inflation rate (10.1% in 2007) and thus achieve pension capital growth.

The private voluntary scheme was introduced in 1998, offering to the option of improving pension income by making contributions to private pension funds, but coverage is low: by the end of 2007 only 9.6% of the economically active contributed.

4.5. Minimum income provision for older people

People with small pension entitlements can benefit from a minimum pension (introduced in 1996). This is linked to the amount of the state social security benefit (LVL 45) and length of career. In 2006, the state social security benefit increased, raising the minimum pension. Indexation system also improved. Now a monthly supplement is also granted for old age pensions. The national debate often revolves around another indicator: the minimum subsistence level, the monthly average value of a minimum basket of consumer goods and services. The average old-age pension remains below this minimum, but the gap is narrowing. In 2005, only 8.5% of all old-age pensions were above the subsistence minimum; this rose to 16.4% by the end of 2007. As a result of indexation in April 2008, and of the increase in the pension supplement in June, the average old-age pension has increased and in July 2008 it stood at LVL 144.20 (89% of the current subsistence minimum of LVL 161.91). However, pensioners, especially women, face poverty too often. The relative median income ratio (65+) in 2007 is 0.65%, while the relative median poverty gap is 19. The effect of social transfers, already weak, declined further to 5 in 2006. 2007 saw an increase by one percentage point. Social transfers (before pensions) reduce poverty from 27% to 21% (the fifth lowest effectiveness in the EU).

4.6. Information and transparency

After pensions were reformed, the public was informed about the new system. A series of programmes were shown on television, and banks are now advertising second- and third-tier pension scheme products. The mass media are the main source of information on the changes in pension law. An interactive web page is gaining importance. Nevertheless, a survey conducted in August by GE Money Bank revealed how little people know about pensions: 60% of the respondents did not see any difference between the tiers of the pension system. Most of them think that this has to do with poverty and exclusion. The lack of understanding is most striking among young respondents, low wage earners and people with primary education. 28% of respondents are sceptical about saving money in the third tier, and 68% do

not trust private financial institutions. Interestingly, a high number of people are joining the statutory funded pension scheme. People aged 30 to 49 at the time of the reform can opt to join the scheme, but, evidently, the likely prospects of earning a higher old-age pension if sticking with the first tier alone have not been explained. The number of voluntary participants rose to 374 523 in 2006 (including 215 310 women) compared with some 28 000 in 2002.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Latvian healthcare system aims to provide universal coverage, although the services available free of charge are limited and the proportion may shrink in the near future: cost-sharing is widely applied and will likely increase. The Health Compulsory Insurance State Agency (HCISA) and its five territorial departments administer the resources allocated to health care from the national budget. Care is purchased on the basis of contracts with providers in accordance with set criteria. Primary care, provided by general practitioners (GPs) and nurses, sometimes in joint practices, is the cornerstone of the system. GPs are independent contractors and act as gatekeepers for specialist and hospital care. Most specialist and hospital care provision is public. Dental practices and pharmacies have been privatised.

The 2006-08 NSR identified the following challenges: access to health care; continuing the reforms; improving human resources; and improving financing. The NSR states that 'the overall situation in public health sector is improving — long-term objectives have been interposed, tasks defined and policy planning documents developed for the implementation of different measures.' Indeed, many policy documents have been drafted. Some are under way, including a policy paper on financing models for out-patient and in-patient services and a development programme for out-patient and in-patient service providers for the new planning period. It is estimated that public funding for health will represent 3.37% of GDP in 2009 (compared with 3.65% in 2008). In fact, a decrease in resources is expected, impairing the system's ability to operate even at current levels. Patient fees and contributions will rise and some services will possibly no longer be provided free of charge. This will increase the burden on households, while local governments might not be able to fully cope with the new challenges of helping large numbers of residents also to access care. Life expectancy at birth is low (especially for men) and infant mortality is high by the EU standards. The gap between healthy life years and life expectancy is high. The major causes of death are diseases of the circulatory system, followed by tumours. This situation will be improved through health promotion and disease prevention, e.g. screening programmes; for example, from 2009 a centralized cancer screening will be organized and monitored by HCSIA. The targets set include increasing life expectancy at birth to 95% of the EU average by 2010, and the authorities expect that health inequalities will decline, especially for the most disadvantaged.

5.1.2. Accessibility

As stated, the number of services available free of charge is limited. Public expenditure on health care is low and private expenditure, mostly out-of-pocket payments, is very high and growing (accounting for 38.6% of total expenditure in 2006) despite exemptions for certain categories of patients and vulnerable groups or upper limits introduced on payments. Some

state support is available to obtain cheaper or free medication for certain diseases. Latvia has set quotas for planned services. Usually by the end of year (and as early as October in 2008) hospitals stop or limit planned operations. Patients can either pay, or wait until the next year. Depending on the doctor, waiting times to get an appointment continue to be lengthy. On the positive side, GPs have addressed the situation by setting aside one hour a day for urgent cases. The Health Ministry intends to allow people to visit the doctor during weekends (once every two to three months).

The generally limited public resources allocated to health sector can impair access. EU-SILC monitoring data reveal that 19.3% of respondents in 2005 and 15% in 2007 had needed medical treatment or a health examination over the last 12 months, but had not obtained it. The main reason for not visiting the doctor (or dentist) in 2005 and in 2006 (especially for women) was the high cost of medical services. However, 2006 saw some improvement. A 2006 opinion poll also showed a slight increase in the number of respondents judging their health to be relatively good or good.

5.1.3. Quality

On the positive side, the NSR reports that help to ensure adequate medical technology is provided in the regions and that efforts are made to improve cost effectiveness. The infrastructure and use of e-Health information technology will improve. Emergency medical service is being modernised and the structure of service providers optimised. Although wages have gradually improved and plans are in place to support medical studies, current staff shortages, overtime and dissatisfaction among medical staff affect quality. NSR data show rising mortality rates for new-born children and women after giving birth, which increased further in 2008. There is growing dissatisfaction with the management of the system. The Health Ministry and agencies and institutions under its supervision have been criticised for bureaucracy, overlapping functions, etc. Patient satisfaction, according to EU consumer surveys, is very low. The NGO representing patients' interests, the Patient Rights Protection Centre, folded in 2007 for lack of finance.

5.1.4. Sustainability

The sector has received more resources in recent years and expenditure is projected to increase from 5.1% of GDP in 2004 to 6.2% in 2050. Outpatient visits are rising, and the number of hospitals and days spent in them is falling, although the average length of stay in hospital was still high in 2005, at 9.6 days. Moreover, hospitals still spend the bulk of healthcare financing. Hospitalisation is still high, at 234 hospitalisations per 1000 residents in 2007.

Over the years, the number of primary care doctors (internists, family doctors or general practitioners and paediatricians) has been stabilising. The long-term programme 'Development of Human Resources in Health Care 2006-2015', drafted in 2006 and cited in the NSR for 2006-08, has tackling low pay as one of its priorities. The age profile of doctors and other personnel remains a serious concern: over 40% of doctors are in the pre-retirement age group, or have reached statutory pensionable age but continue to work. There are also serious problems in attracting and retaining nurses and emergency care staff. To this end, the ESF will support medical studies during the 2007-13 planning period.

Note, though, that due to the economic downturn some of the programmes might be suspended. The Minister of Health has said that the human resources programme could also

be suspended. Promised salary increases have been put on hold, and the burden of payments for patients could rise. The 2007 Joint Report states that health expenditure in Latvia is below the EU average and recommends allocating more public resources to the health sector. This remains valid. Since the Government has declared a cost-saving budget for 2009, and all line ministries have cut their expenditure, it is estimated that resources will remain at the same level as in 2008. The estimate was that, after inflation, this will translate into a LVL 44 million decrease. The funding for this sector is likely to remain at the same level for the next three years. As capacity in hospitals and primary health care is relatively high, there is still scope for improving health outcomes by continuing to tackle the issues of quality and efficiency.

5.2. Long-term care

5.2.1. Description of the system

Long-term care (LTC) is based on an assessment of the individual's needs and means carried out by social work specialists. The main decision to be taken is the choice between home care or a residential solution. The criteria are rather restrictive: services are provided only based on an appraisal of person's needs abilities, resources and support available. If a person is recognised as capable of taking care of himself or herself, LTC is refused. Clients have to pay for LTC. Local governments, responsible for the bulk of LTC, support the needy. Some groups are exempt from payment. At the same time, if a person has sufficient means (or someone covers the full cost), the services will be provided immediately. The share of alternatives to residential care is increasing. Work has started on providing integrated services by combining multidisciplinary services within one institution.

5.2.2. Accessibility

How long elderly and disabled people can stay in their homes depends to a large extent on the support available from local governments. The latter organise and prioritise the services according to the available budget. Alternative forms of LTC include day-care centres for retired people, social residential houses, social and group apartments. Unfortunately, the NSR provides only absolute numbers, making it difficult to estimate the extent to which needs are satisfied, whether all local governments can provide adequate services, and the share of clients on waiting lists.

5.2.3. Quality

Although Latvia has made efforts to set quality standards for LTC, regional disparities exist, as the quality of care depends on the resources allocated. There are difficulties in providing sufficient numbers of care staff and social workers. Although organising home care is more complicated in rural areas, there are local governments who find ways to provide services to their residents. Thus, the home care centre in the Sigulda district has organised mobile units with care workers and a driver visiting all customers three times a week, supplying them with basic goods and providing some services. An extra service is provided: changing and laundering of bed linen and clothing.

5.2.4. Long-term sustainability

The current, rather low LTC spending (representing 0.4% of GDP) is projected to increase to a modest 0.7% by 2050. Taking into account the growing number of old people, and the

number of severely disabled people, LTC options would need to be extended to cover all those who really need support. However, given the unfavourable economic prospects, the short term perspective is becoming more important. The coming winter is expected to be very hard for people. Local governments have expressed concern about their capacity to cover residents' needs. Support for the needy and services, like social housing and night shelters, is funded entirely by local governments.

6. CHALLENGES AHEAD

- To develop a coherent strategic approach to promoting social inclusion and effectively breaking the cycle of deprivation, especially for families with children.

- To promote targeted active inclusion measures for vulnerable groups, by addressing the adverse effects of price increases on low and medium income groups; increasing the effectiveness of social transfers; and enhancing associated services and employment opportunities.

- To ensure that resources for adequate pensions are available in both schemes and actively tackle the issue of pensioner poverty, while continuing to monitor the effects of the maturing funded scheme.

- To ensure that public sector spending cuts do not affect healthcare, given the low health status of the population and low overall expenditure; to reduce the individual financial burden of health care; to improve the quality of care services; and to address human resources issues while continuing to improve the efficiency of healthcare.

- To ensure that public sector spending cuts do not adversely affect the provision of long-term care; to address human resource issues and ensure continuity of services.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	6,9	36,7	**2000**	57,5	61,5	53,8	29,6	36,0	**2000**	13,7	14,4	12,9	21,4
2005	10,6	48,6	**2005**	63,3	67,6	59,3	32,6	50,0	**2005**	8,9	9,1	8,7	13,6
2008*f*	-2,3	52,6	**2007**	68,3	72,5	64,4	38,4	57,7	**2007**	6,0	6,4	5,6	10,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**1995**	n.a.	n.a.	n.a.		-
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2000**	6,0	54,7	43,9	**2005**	19,3
2006	65,4	76,3	12,7	17,3	50,5	52,1	8,7	**2006****	6,4	60,5	38,6	**2006**	15,0

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	25,0	n.a.	6,8	5,1	0,4
2000	15,3	60,1	16,7	3,8	10,2	1,4	7,9	**2010**	25,2	-2,9	-1,9	0,4	0,0
2006	12,2	48,3	29,1	3,7	10,2	1,4	7,3	**2030**	34,6	-1,5	-1,2	0,8	0,1
								2050	51,2	-1,3	-1,2	1,1	0,3

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	21	21	18	33	25	28	30	19	6.3	**2005**	19
male	19	-	18	21	27	-	32	12	-	**2006**	18
femal	23	-	19	39	24	-	28	19	-	**2007**	10

	People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	10,7	12,8	12,3	13,2	**2000**	7,9	8,3	7,5	**2000**			
2004	7,2	7,8	7,1	8,4	**2004**	4,6	4,8	4,3	**2004**	15,6	20,5	10,7
2007	8,3	6,6	6,7	6,6	**2007**	1,6	1,9	1,2	**2007**	16	19,7	12,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,65	*0,7*	0,63	***Aggregate replacement ratio***	0,38	0,33	0,44

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

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
-12	-11	-11	NDC/DC	/	-	100	/	20	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Lithuania

1. SITUATION AND KEY TRENDS

The Lithuanian economy experienced a period of impressive growth in 2001-2007. In 2007 GDP grew by 8.9% and GDP per capita in PPS reached 61% of the EU average (a 20% catch-up in 7 years). The labour market situation also benefited from the favourable macroeconomic trends. In 2007 the employment rate reached 64.9% (EU: 65.4%) compared to 57.5% in 2001 and the unemployment rate fell to a record low of 4.3%. The relatively high employment rate of women and older workers further increased to 62.2% and 53.4% respectively and youth unemployment decreased to 8.2% (against EU: 15.3%).

The strong economic performance did not, however, result in a substantial improvement in the relative poverty level, which stood at 20% in 2006 (the second highest after Latvia in the EU). Looking at the different age groups, the at-risk-of-poverty rate is higher for children (25%) and elderly women (28%). The demographic situation is challenging in Lithuania. Life expectancy for men is low (65.3 years at birth but 13 years at 65 in 2006). There were minor increases in the fertility rate but it remains low (1.31). The old-age dependency ratio projection is relatively favourable in the medium term (23.2 against 25.9 in the EU in 2010) but is projected to skyrocket to 51.13 in 2050. In addition, the demographic and labour market situations have been heavily affected by very high economic emigration in the last decade.

Although the amount allocated to social protection has increased in absolute terms, the share of total expenditure for social protection remains one of the lowest in the EU (13.2% in 2005, half of which goes on pensions) and yet shows a declining trend. It is also important to stress that the economic situation started to deteriorate in 2008, with inflation reaching double digits and the projected slowdown of GDP growth to -4% in 2009[65]. That will adversely affect public finances, the labour market situation and the situation of the poorest groups in society. What is more, the deteriorating economic situation in the EU might cause the return to their country of Lithuanian citizens who left for economic reasons, something that would pose an additional challenge to the labour market and public finances.

2. OVERALL STRATEGIC APPROACH

The Lithuanian NSR structures its overall strategic objectives in line with the overarching objectives of the OMC for social protection and social inclusion. However, the overall approach is presented in conceptual terms and lacks clear strategic directions which would allow those overarching objectives to be achieved. The NSR states that the key challenges remain broadly unchanged, such as unfavourable demographic trends, a declining labour force activity rate, substantial regional differences, an increasing need for health and social services and the financial sustainability and adequacy of the pension system, which to a degree puts a question mark on the effectiveness of the measures applied in 2006-2008. It also identifies a new set of challenges related to the economic slowdown in Lithuania, but does not reflect on how the social inclusion and social protection policies should be redesigned in 2008-2010 to cope with the effects of this downturn. The NSR claims mutual interaction with the National

[65] European Commission Interim Forecast January 2009

Lisbon Strategy in particular in terms of activation and employability of vulnerable groups and the incentives provided by the pension and healthcare system to stay longer and in better health in employment. Gender equality is presented as a horizontal principle to be mainstreamed in all policies. Support from the Structural Funds is mentioned as one of the key tools to moderate regional differences.

3. SOCIAL INCLUSION

3.1. Key trends

Good economic performance in recent years has helped to improve the situation of the poorest groups in society in absolute numbers. Nonetheless, although the at-risk-of-poverty threshold rose to 2811 in PPS in 2006 it remains among the lowest in the EU. Further, relative poverty stayed high (20% and EU: 16% in 2006) and deep (29% poverty gap). The same population groups as in 2004 faced the highest risk of relative poverty in 2006: the unemployed (down from 63% to 61%), single parents with dependent children (48% to 44%), families with three or more children (44% to 42%), tenants (33% to 30%) and single adult households (up from 32% to 38%). National statistics reveal a persistently high at-risk-of-poverty level in rural areas (34%). Social transfers reduced the at-risk-of poverty rate for the total population by 7% (from 27%) but were less efficient than in the EU-25 on average (10% reduction), one of the reasons being the limited public resources allocated to social expenditure.

The growth of the employment rate in recent years (64.9% in 2007) significantly reduced unemployment (4.3%), youth unemployment (8.2%) and long-term unemployment rates (1.4%), with the share of people living in jobless households falling from 7% in 2006 to 6.3% in 2007. Conversely, it is a matter of concern that the share of children in jobless households increased from 5.3% to 6.9% in the same years. Furthermore, the National Strategy Report reveals an increase in unemployment and youth unemployment in 2008. And although the population as a whole got richer and there was some decrease in the inequality of income distribution between the highest and the lowest quintile, the gains in wealth remain highly uneven (6.3 against 4.8 in the EU in 2006). Furthermore, while the situation in the labour market improved, in-work poverty remained relatively high (9% in full-time and 25% in part-time against 7% and 11% in the EU-25 in 2006).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Four priorities were established in the 2006-2008 National Strategy Report: (1) increasing labour market participation, (2) improving access to quality services, (3) eliminating child poverty and enhancing assistance to families, and (4) tackling disadvantages in education and training. Three challenges on social inclusion for Lithuania were identified in the 2007 Joint Report: these concerned child poverty, rural poverty and governance.

In the area of the labour market, the overall improvement of the situation was significant, the employment rate of different groups increased and unemployment went down. The decisive factors for this progress were the expanding economy and the shrinking labour supply because of high out-migration of the labour force from Lithuania. Some progress has been reported as regards the improvement of the most vulnerable groups on the labour market, such as the increased number of social enterprises employing disabled people and subsidised employment. However, the effect and adequacy of those measures for the whole vulnerable

population is not assessed in the NSR. Concerning the priority of improving access to quality social services, the progressive trend of shifting from stationary to non-stationary social services (provision of services at home or at day centres) is intensifying. However, the NSR still reports a substantial lack of social services, in particular for elderly and disabled people and significant regional inequalities in the access to services. As for the quality of social services, no progress was reported in relation to the plans in the 2006-2008 strategy to set quality standards and introduce control mechanisms. Some progress has been achieved in tackling child poverty. The NSR reports moderate decreases in the poverty risk for children, mainly due to the improved situation on the labour market and increased social benefits for children and families. However, the at-risk-of-poverty rate in single parent households and for families with many children remains very high and the share of children in jobless households increased in 2006. The 2006-2008 strategy revealed the highest risk of poverty among 3-5 year olds. The new strategy does not, however, report on the progress made in this respect. Regarding the priority of tackling disadvantages in education and training, Lithuania performs well as regards the rate of early school leavers or the share of young people with at least secondary education. Some progress has also been reported in relation to the integration of children with special needs and the disabled into the educational system. However, the coverage of those measures and their adequacy is not assessed.

Combating rural poverty, identified as a challenge for Lithuania in the 2007 Joint Report, has not yielded encouraging results despite a number of measures reported. The rural population lived at high and deep poverty risk and the rural/urban divide widened. Progress on the better governance challenge is analysed in section 3.5.

3.3. Key challenges and priorities

The social inclusion strand of the National Strategy Report has an overall objective of reducing the risk of poverty by 2.5% to 17.5% in 2010. However, this target seems to be declarative as it is not split by target group and does not have a clear-cut operational strategy behind it. The strategy focuses on three important priorities: (1) *Eliminating child poverty and enhancing assistance to families.* The stress is on the high poverty risk of single-parent households and households with many children, children in 'social risk' families, children of economic migrants living in Lithuania and children's rights. (2) *Increasing labour market participation.* The focus of this priority is on the high relative poverty of the unemployed and the economic activation of disadvantaged people using their potential as a countermeasure against the shrinking labour force and better integrating them in society. (3) *Improving access to quality services.* The emphasis is on the underdeveloped social services in general and the rural/urban and smaller towns/biggest cities differences in access to services. The new NSR thus keeps its focus on the same priorities as the 2006-2008 strategy with the exception of the 2006-2008 priority of tackling disadvantages in education and training. In addition, gender equality, balanced regional development and active ageing have to be integrated in the implementation of the NSR as horizontal principles. The highlight on regional differences under the third priority reflects to some extent the challenge identified in the 2007 Joint Report on combating rural poverty. The 2007 Joint Report challenge of better governance by developing, in partnership with all the relevant stakeholders, monitoring, evaluation and mainstreaming systems is not prioritised.

3.4. Policy measures

The measures under the first priority, *eliminating child poverty and enhancing assistance to families*, are split into two groups: (1) eliminating child poverty and social exclusion and

guaranteeing children's rights and (2) preventing social risks to families and supporting families at social risk. 'Families at social risk' is a concept for dysfunctional families. There is therefore a risk that not all poor families will be addressed as due account is not taken of the high at-risk-of-poverty rate in single-parent households and families with many children. Despite the fact that every fourth child is at risk of poverty in Lithuania, the NSR does not set a quantified target in this respect. The quantified targets set in the NSR are taken from different national programmes. Although they are important, their choice for the purpose of reducing child poverty is not backed by argument. Most of the measures under this priority merely refer to the recently adopted national strategies and programmes such as the Child Wellbeing Strategy, the Programme on Social Inclusion of Orphans and Children without Parental Care, the Anti-Violence against Children Programme, the National Demographic Strategy and the Social Housing Programme. Some other measures are formulated as broad statements without operational background, such as making sure that benefits for children in families at social risk are used for their needs or assisting economic emigrants' children living in Lithuania.

The second priority, *increasing labour market participation*, covers two objectives: (1) increasing employment and participation in the labour market and (2) enhancing social inclusion. The quantified targets for this objective are taken from the National Lisbon Programme. The most relevant of these are the targets for activity and employment rates by different age groups. However, there are no specific targets set for disabled and other vulnerable groups, with one exception: activation of the long-term unemployed. Furthermore, the link between the targets set and the policy measures is not demonstrated. Again, the measures either refer to the national programmes (mostly mainstream programmes such as on vocational training, higher education, labour force mobility, economic migration) or are of a declarative nature (such as encouraging social partnership, developing entrepreneurship among the population, enhancing ALMP to make sure the potential of disabled people is used on the labour market.). Specific well-planned measures for the vulnerable groups are lacking. Neither is due account taken of financial and other work incentives/burdens and relatively high in-work poverty.

The third priority, *improving access to quality services*, covers three objectives: (1) improving the quality of social services, prioritising the progressive forms of social services and increasing their accessibility; reducing regional imbalances in accessibility, (2) enhancing social integration of the disabled, elderly, victims of human trafficking, ex-prisoners and refugees, and (3) increasing the participation of all groups in cultural, sports, community and self-education activities. Three out of five quantified targets for this priority are related to greater accessibility and efficiency of professional rehabilitation services for the disabled. The other two targets relate to the increase in the number of social workers and the recipients of social services. There are no targets set for the first and third objectives of this priority, and the targets are not split by vulnerable groups with the exception of the disabled. Important measures are planned on the setting of quality standards for social services, improving the infrastructure for social services and working conditions of social workers, developing non-stationary infrastructure, social inclusion of the disabled and refugees, better access to cultural and sports activities. However, as in the previous priorities, the measures are often not specific enough to be operational and lack analytical background.

3.5. Governance

Like the previous NSR, the 2008-2010 strategy was developed by the Ministry of Social Security and Labour, assisted by a working group representing government institutions, social

partners, NGOs and municipal authorities. This group will also monitor implementation of the new strategy. However, the new strategy does not reveal how the quality of stakeholder involvement was assured in the drafting and how it will be assured in the monitoring of the NSR; neither are the governance lessons from the 2006-2008 period specified.

Being a framework document, the 2008-2010 strategy consolidates national social inclusion policies and accommodates relevant national programmes and other initiatives as its measures. However, the formulation of these measures in the NSR often lacks the clarity, baselines and specific targets necessary for assessing their achievement in future. Nor does the NSR specify what mechanisms will be put in place for mainstreaming the social inclusion policies in the relevant public policies and the Structural Funds. Therefore, the issue of effective monitoring, evaluation and mainstreaming, identified as a challenge already in the 2006 and 2007 Joint Reports, still has to be addressed.

4. PENSIONS

4.1. Key trends

Lithuania has a statutory social insurance pension system financed by contributions (23.5% of gross wage paid by the employer and 2.5% by the employee in 2008). Pensions consist of a PAYG, flat-rate basic pension and a supplementary pension depending on years of service, individual wage and insurable income in the country. In 2005-2007 coverage by the statutory system rose from 85% to 92% of the labour force. The second tier of the statutory system, the mandatory funded privately managed pension scheme, was introduced in 2004. It is funded by a fraction of the social insurance contribution (5.5% of gross wage, between 2009-2010 3%). This scheme attracted 69% of those covered by full social insurance (including 92% of eligible >30 year olds) by 2008 — substantially more than projected. Supplementary voluntary pension provision also exists but its take-up remains marginal at 0.1% of the labour force. Tax breaks are available for this provision as well as for life insurance products. In addition, the provision of a social assistance pension (90% of the basic pension) was extended in 2006 to cover all elderly and disabled persons without entitlements in the social insurance system. The rapid economic growth of the last few years has allowed the government to increase pensions, though at a lower pace than the real growth of salaries. The aggregate replacement ratio remained below the EU average (0.44 compared to 0.51 in the EU in 2006). The poverty risk for the elderly (65+) was substantially higher for women in 2006 (28%, compared to 10% for men).

4.2. Key challenges and priorities

There were several improvements in terms of wider coverage of the population by statutory pensions (identified as a challenge in the 2007 Joint Report). Coverage of the labour force increased to 92% and the unemployment level fell to a record low of 4.3% in 2007 although starting to pick up in 2008. Nevertheless, some population groups such as farmers and performers remain excluded from the statutory system. In addition, the effects of the grey economy (which appears to be shrinking in recent years) on the pension system, in particular in the light of the economic downturn, would merit further analysis. As from 2008, persons taking care of children under three or other dependent family members are insured for the full social insurance pension (they used to be covered only for a basic pension). However, despite the increased share of the population entitled to full pension rights, the level of pension remains low. In 2007 the aggregate replacement ratio was 40%. According to projections of

the theoretical replacement rates, a drop in net retirement income as a ratio of work income at the point of retirement is expected to drop by three percentage points between 2006 and 2046 for a worker retiring at age 65. Pension expenditure compared to the EU average is rather low, at 6.7% of GDP in 2004. Statutory pension expenditure over the period 2004-2050 is projected to grow by 1.9% for the statutory pension and 3.7% including the privately managed funded scheme. The old-age dependency ratio projection of 65+ is relatively favourable in the medium term (23.2 against 25.9 in the EU in 2010) but a sharp increase to 51.13% is projected in 2050 (this projection in 2004 was 44.9%).

The transfer of contributions to the mandatory funded privately managed scheme reduces the resources of the statutory pension system. This loss was partly compensated by the state budget. However, there are no long-term funding commitments in this respect. This poses a risk for the financial sustainability of the statutory pension system and may possibly hold down the increase in statutory pensions. The NSR target to increase the average pension from 42% at present to 50% of the net average wage by 2015 is not backed by adequate financial measures.

4.3. More people in work and working longer

The employment rate of elderly people has grown steadily and is above the Lisbon target of at least a 50% employment rate among older workers (55-64) by 2010. It reached 53.4% in 2007 (60.8% for men and 47.9% for women). The overall employment rate came close to the EU average in 2007 (64.9% and EU: 65.4%). The legal retirement age was 62.5 years for men and 60 years for women in 2008. The NSR refers to a preliminary plan to start increasing the retirement age gradually from 2012 until it reaches 65 years for both men and women in 2026.

This increase would bring the level of women's pensions closer to those of men and would have positive effects on the sustainability of the statutory pension system. The average labour market exit age in 2007 was 59.9 years (61 in the EU). In 2007, the pension supplement was introduced for the years in service exceeding the 30-year qualifying period. Staying longer in work is rewarded by a pension benefit increase of 8% per annum compared to the average pension. On the other hand, the early retirement scheme for long-term unemployed persons has been in existence since 2004, reducing the pension by 0.4% for every full month remaining until the retirement age. From 2008 full pension rights were ensured for those taking care breaks to look after a child or dependent person as described above.

4.4. Privately managed pension provision

The high participation rate can be described as a success of the new system yet forebodes the risk of inadequate pension benefits for some population groups (in particular older and low-paid workers) and threatens the financial sustainability of the statutory pension system. In the early years most private pension funds were not sufficiently profitable for their participants to cover the loss due to their partial opt-out from the statutory system. This shortfall seems to be deepening in the face of the current financial turmoil. The effectiveness of this new system needs to be monitored as it matures.

The administrative costs of some private funds have also attracted criticism both in the recent report of the National Audit Office and from some independent experts. In this respect, the NSR indicates the Government's intention to introduce ceilings for administrative charges. In addition, as already stated above, the lack of long-term planning to cover the loss to the statutory system due to the private provision constitutes a risk to the financial sustainability of

that system. Furthermore, some research on the effects of the private provision on income (in)equality of future pensioners would be beneficial, either compared with those who did not opt for the system or those that have chosen different risk profiles, or based on the differences in the current wages from which the pension contributions are paid.

4.5. Minimum income provision for older people

The poverty risk for the elderly (65+) is close to the total rate in Lithuania (22% and 20% total). The risk increased by 5 percentage points from 2005 to 2006 because benefit levels were not uprated in line with rapid wage growth. Similar falls were recorded in the 65+ share of income of the 15-64 age group and in replacement rates. To correct this erosion of relative benefit levels the government increased the main flat-rate part of the pension benefit by 10% from 1 January 2008, resulting in increases in all pensions with relatively higher increases for lower pensions.

For minimum income provision for older people the ambition is further that the social assistance pension (SAP: 90% of basic pension) should be higher than the level of social assistance for adults (state-supported income or SSI). This was achieved in 2006 when the SAP amounted to 125% of the SSI. But in 2007 ad hoc increases in the SSI reduced the SAP to 101%. The SSI benefit amounted to €101 in 2008, which is insufficient in terms of alleviating the poverty risk. Thus on a relative scale commitments to reinforce minimum pension guarantees have only partly been met.

The at-risk-of-poverty rate is considerably higher for women (28% compared to 10% for men), in particular in the 75+ age group (still 10% for men and as much as 35% for women). One of the reasons for this gender gap is the different statutory retirement age, giving women less time to build up pension rights. Women are also more affected by career breaks, but that issue is being resolved from 2008 as described above. As the private pension provision is based on the separate mortality tables for women and men, private pension payouts will be lower for women owing to women's higher life expectancy. The reformed survivors' pensions and planned increases for single older persons should improve the situation of women.

4.6. Information and transparency

The websites of the State Social Insurance Board[66] and the new privately managed pension provision[67] provide exhaustive information on pensions (some of which is also available in Russian and in English). From 1 July 2007 private pension funds are required to provide enhanced information to all participants in the system. However, the pension funds' managers publish only the nominal results of the funds, which do not reflect the impact of inflation. There is also a lack of transparency on future pension benefits under both the statutory and privately managed pensions. So far these have been largely dependent on economic performance and ad hoc adjustments.

66 http://www.sodra.lt.

67 http://www.pensijusistema.lt.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Lithuanian Health System is organised by public authorities at municipal, county and national level. Compulsory health insurance paid as part of social insurance taxes at 3% of gross wage and 30% of personal income tax provides 99% coverage of the population. Health services are predominantly public but the government indicates its intention to promote private provision, in particular in primary care. Concerning health outcomes, healthy life expectancy was low in 2006 (51.2 for men and 54.3 for women) and the NSR reveals disquieting trends for the population's health status in many areas. Life expectancy at birth in Lithuania was 71.1 years (78.4 in the EU in 2004), low for men (65.3 compared to 77 for women). This gender gap was smaller at the age of 65 (13 for men and 17.6 for women). The percentage of people reporting bad or very bad health was considerably higher in the two lowest income quintiles (about 16%) compared to the two highest quintiles (6.2% and 3.4%) in 2006.

5.1.2. Accessibility

Healthcare facilities are concentrated in major cities and regional inequalities in the access to healthcare services are recognised. However, the NSR does not provide information on actual access to health care. The system is still under-resourced and historically oriented towards stationary services and hospital care, with one of the highest inpatient care ratios and number of doctors per 1 000 inhabitants in the EU. Ambulatory care, preventative care and the promotion of healthy lifestyles are insufficiently developed and certain specialities are lacking in the periphery. Although the healthcare budget has increased, the NSR does not provide evidence on improvements in accessibility.

The total self-reported unmet need for medical care (due to waiting time, costs or distance) stood at 8.2% in 2006 compared to 3.1% in the EU on average and was up on 2005 (7.2%). The level of self-reported unmet need was dependent on income level, with a substantially higher level of unmet need in the low income quintiles. The self-reported unmet need for dental care was 11.1% in 2006 (5% in the EU). Transparent and comprehensive monitoring of accessibility should be developed, in particular taking into account the large number of self-reported unmet needs. In this respect, the NSR reports that public monitoring of waiting lists for healthcare services was introduced in 2007 and claims that waiting times have been reduced, although the claim is not backed by data. Support from the Structural Funds is intended to reduce regional differences in the provision of and access to primary care.

5.1.3. Quality

Lithuania is implementing a Health Care Quality Assurance Programme 2005-2010. However, many of the measures are still at the conceptual level and, according to a recent WHO publication, have not been implemented yet for lack of funds. This publication also refers to the 2007 report of the National Audit Office of Lithuania which claims that no comprehensive quality assurance system exists in the healthcare system and that quality indicators and evaluation by the municipalities are lacking. Quality management systems, in particular in the larger hospitals, nevertheless seem to be in place. The NSR does not,

however, provide information on the functioning, efficiency and development of quality assurance systems.

5.1.4. Sustainability

Despite a welcome increase in resources allocated to the sector, the health system in Lithuania is still under-resourced as compared with other EU Member States, with low health expenditure as a % of GDP and per capita. Total health expenditure accounts for 5.9% of GDP and is among the lowest in the EU (9% on average in 2005). GDP per capita expenditure was 862 in US$ PPP compared to the EU average of 2 454. In addition, the NSR admits that the use of resources is not efficient enough and sets increased funding and greater efficiency as key priorities. However, no comprehensive commitments are made in this respect. The projected increase in public health expenditure 2004-2050 of 0.9% of GDP due to population ageing is relatively modest compared to other MS (partly due to the underdevelopment of the current system).

The NSR identifies planning of human resources as one of the key priorities. However, no data on the HR situation, high staff migration, and skills shortages is provided. A 2002 survey revealed that 60.7% of specialist trainees and 26.8% of physicians expressed the intention to emigrate. The methodology for planning of healthcare specialists and pharmacists was approved in 2007. The NSR fails, however, to provide a comprehensive strategy to overcome the risk of staff shortages. Part of the solution to this challenge will be provided by ESF-supported training for medical staff.

Given the low health status of the population the strong focus on health promotion is welcome.

5.2. Long-term care

5.2.1. Description of the system

While at present the bulk of long-term care is delivered in the home by informal carers, formal long-term care services are provided at municipal and county (state) level by public, private and non-governmental institutions. Both public and to some extent private funding is involved. LTC is provided in inpatient institutions and nursing services are provided in both inpatient and outpatient institutions. In 2006-2007 several legal acts were adopted to coordinate health care, nursing and social care services. It is also planned to integrate inpatient nursing care into the regular hospitals. The target is to have at least 80% of those services in regular hospitals and at least 50% of nursing services combined with social care services by the end of 2008.

5.2.2. Accessibility

The NSR points out regional differences in access to LTC and high demand for it. In this respect it announces that the number of inpatient nursing beds can be increased from 3 832 to 6 480 in 2008-2010. The strategy is not clear, however, about the likelihood of this increase to happen, neither does it provide data on the need for this type of care. It is also admitted that the need for nursing and social services at home has not yet been surveyed and established. Nor does the NSR cover the issue of the remuneration/compensation/support mechanisms for informal carers. Concerning services for the disabled, the state-funded rehabilitation process,

with a predominantly medical rehabilitation approach and underdeveloped professional and social rehabilitation services, is not efficient enough and does not provide adequate coverage.

5.2.3. Quality

The social care standards were established in 2007. According to the NSR, they will help in eliminating the differences in the quality of services between regions and different providers. Yet the strategy does not explain how and when it will be done. The NSR also mentions that surveys of satisfaction with care services were carried out in 2007, although their outcome is not revealed.

5.2.4. Long-term sustainability

Public long-term care expenditure constituted 0.43% of GDP in 2005. It is projected to increase by 0.4% of GDP by 2050 due to ageing according to the EPC. The NSR recognises the challenge of ageing and shrinking of the population but does not provide a clear-cut strategy to handle it. Given the increasing old-age dependency ratio, long-term care will be less and less able to rely on the currently predominant informal care.

6. CHALLENGES AHEAD

- To combat child poverty, in particular providing support to single parents and families with many children and increasing access to social and community-based services, to the labour market, and to high quality education for all.

- To review the efficiency of social transfers and to combat rural poverty by promoting active inclusion and moderating substantial regional inequalities in the access to social services.

- To reinforce governance, in particular by developing proper monitoring and evaluation systems and the mechanisms to mainstream social policies.

- To continue efforts to ensure that adequate pensions are available in both tiers of the mandatory pension scheme and actively tackle the issue of pensioner poverty, particularly for elderly women facing a high risk of poverty, while continuing to carefully monitor the financial situation and consequent effects on benefit adequacy in both the PAYG and funded schemes.

- To ensure that the current economic context and possible public sector expenditure cuts do not affect healthcare access, in view of the low health status of the population and the low overall expenditure; to use the current situation as an opportunity to improve the value for money in the system notably through stronger use of primary care, better coordination of services and promotion and prevention strategies to improving health status. In the medium run, to continue to address the geographical and socio-economic disparities in access, improve the quality of services and address human resources issues.

- To develop a comprehensive quality assurance system in the healthcare sector based on indicators.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4,2	39,3	**2000**	59,1	60,5	57,7	25,9	40,4	**2000**	16,4	18,6	14,1	30,6
2005	7,8	52,9	**2005**	62,6	66,1	59,4	21,2	49,2	**2005**	8,3	8,2	8,3	15,7
2008*f*	3,4	59,9	**2007**	64,9	67,9	62,2	25,2	53,4	**2007**	4,3	4,3	4,3	8,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	63,3	75,1	12,9	16,9	n.a.	n.a.	12,5	**1995**	n.a.	n.a.	n.a.		-
2000	66,8	77,5	13,7	17,9	n.a.	n.a.	8,6	**2000**	6,5	69,7	26,1	**2005**	7,2
2006	65,3	77,0	13,0	17,6	52,4	56,1	5,9	**2006****	5,9	67,3	32,2	**2006**	8,2

s: Eurostat estimate; p: provisional

**THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	15,8	47,8	29,8	1,8	8,8	3,4	8,4
2006	13,2	44.8p	32.1p	1.9p	9.0p	1.6p	10.7p

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004			
		Total social expend.	Public pensions	Health care	Long-term care
2004	23,0	16,0	6,7	3,7	0,5
2010	23,2	-0,7	-0,2	0,3	0,1
2030	34,7	0,3	1,2	0,7	0,1
2050	51,1	1,4	1,8	0,9	0,4

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	19	22	16	30	26	30	29	15	5,9	**2005**	21.0b
male	17	-	15	15	28	-	30	12	-	**2006**	13
female	21	-	16	37	23	-	28	16	-	**2007**	8

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	:	10	10,1	10	**2000**	8	9,4	6,5	**2000**	n.a. n.a.	n.a.	n.a.
2004	6,5	8,1	8,3	8	**2004**	5,8	5,5	6,2	**2004**	15,6	20,5	10,7
2007	8,3	7	7,3	6,8	**2007**	1,4	1,4	1,3	**2007**	16.0p	19.7p	12.3p

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,69	0,74	0,65	***Aggregate replacement ratio***	0,4	0,38	0,44

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
-3	1	1	DB/DC	/	-	89	/	26	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)* *p - provisional data*

Luxembourg

1. SITUATION AND KEY TRENDS

GDP growth remained strong in 2007 (5.2%) but is projected to slow down this year as the financial crisis and the slowdown in the international economy take their toll. These trends will continue in 2009: real GDP growth is likely to be the slowest recorded in 25 years. Job creation, still buoyant in the first half of 2008, is expected to slow down while unemployment, which had begun to decline in 2007, stopped decreasing this summer and has already started to rise.

The employment rate of the resident population remains below the EU average (marginal improvement since 2000 to 64.2% in 2007 —– with a significant gender gap of 16.2%), with that of older workers being particularly low (2006: 33.2%; 2007: 32% — way below the EU target of 50%) and that of females (2007: 56.1% — below the EU target of 60%) still unsatisfactory despite a positive trend since 2000. Youth unemployment still represents an important issue (its level has increased twofold since 2000, from 7.1% to 15.5% in 2007, reaching the EU average).

The old-age dependency ratio (21.1% in 2010 and 37.8% in 2050) is expected by 2050 to become one of the lowest in the EU (37.8% against 50.4% as expected for the EU as a whole). In 2006 the level of social protection expenditures reached a total of 20% of GDP. Sickness/health care and pensions constituted the two main groups of functions, accounting respectively for 25.4% and 36.7% of total public expenditures. By 2050 Luxembourg is expected to record one of the highest increases in total public social expenditures, corresponding to 8.3% of GDP.

Non-nationals currently account for 42.6% of the total population. Portuguese are the most significant group (37.2%). Non-nationals are more subject to unemployment (59% of total unemployment) and are more at risk of poverty (19.5%, compared with 7.2% for nationals)

2. OVERALL STRATEGIC APPROACH

The overall strategic approach builds on and follows the 2006-2008 strategy while reinforcing specific fields of action in line with the challenges identified in order to respond even more adequately to the common objectives of the Social OMC. Recognising the interlink between economic and social aspects, the approach supports the reinforcement of the welfare state — which promotes equal opportunities for all and investment in human capital as a preamble to economic development — by encouraging a competitive and stable economic environment, sound public finances and a sustainable social security system. A major aim of promoting social cohesion is described as ‘to prevent the emergence of parallel groups within Luxembourg society’. The main priorities are illustrated in connection with the three common overarching objectives of the Social OMC. In terms of promoting equal opportunities for all, the emphasis is placed on: (1) immigrants’ social inclusion into Luxembourg society; (2) combating poverty by promoting equal access to equitable incomes, goods and services and through specific actions targeted at vulnerable groups; and (3) taking up the challenge of gender mainstreaming. Considering mutual interaction with the Lisbon Strategy, links are made visible in a coherent and realistic way, although the priority objective addressing school failure has been removed from the current NSR (early school leaving is currently defined as a

'point to watch'). Policy integration is particularly noticeable in the case of child poverty. Seen as highly correlated with the low level of parents' participation in the labour market, reconciliation between work and private life is thus supported by quantitatively and qualitatively enhancing affordable childcare structures in full accordance with the promotion of a 'life cycle approach' (IG No 18) and the fight against poverty (Social OMC). Finally, regarding governance, Luxembourg features an effective institutionalised social dialogue and well-established 'tripartite' structures that have a consultative role and seek systematically to find consensual solutions to social and economic problems. The preparation of the NSR is based on wide-ranging talks involving all relevant stakeholders, from public authorities and social partners to NGOs. Coordination of the NSR with the Lisbon Strategy and the Sustainable Development Strategy is partly carried out by two inter-ministerial committees in charge of those strategies (the link with the Sustainable Development Strategy and the ESF is not developed except in a purely formal way).

3. SOCIAL INCLUSION

3.1. Key trends

Overall, the level of poverty in Luxembourg remains relatively stable. In 2007 the poverty threshold was twice as high as the EU average (the highest in the EU) and stood at €17 929 (one-person household) and €37 650 (two adults and two children under 14 years old). Standing below the EU average (16% in 2007), the risk of poverty continued to affect 14% of the total population in 2007 (against 13% in 2005 and 12.3% in 2004). People aged 65+ are less exposed to poverty (7% in 2007 against 19% for the EU-25). Children aged 0-17 years remain a group critically exposed to the risk of poverty (20% in 2007). Households with dependent children account for 70% of the population facing poverty in 2007 (particularly concerned are: jobless households (mainly lone-parent households); single parents; and large families). Other groups severely exposed are non-nationals (19.5%, compared with 7.2% for nationals) and tenants (30%, compared with 9% for home owners).

In 2007, in-work poverty affected 9% of the population working full-time and 10% of those working part-time (compared to 7% and 12% in the EU-25). Although the level of total unemployment is low (4.1% in 2007, mainly affecting non-nationals and low-skilled), the increasing risk (46%) for this group of facing poverty should be kept in mind. In general, social transfers satisfactorily alleviate the risk of poverty, from 23% to 14% for the total population, from 33% to 20% for children (0-17 years) and from 23% to 13% for people aged 18-64 years. In 2006, net social assistance income is among the highest, corresponding to 80% of the poverty threshold for single persons, 80% for lone parents with 2 children and 70% for couples with 2 children.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Luxembourg achieved some progress in addressing 2006-2008 priorities as well as 2007 Joint Report challenges. Considering that since 2000 Luxembourg's overall employment rate only showed limited progress, the employment rate of older workers remained low, youth unemployment increased, there is still room for improvement concerning the priority objectives of restoring full employment. As regards preventing early school leaving, Luxembourg remained well below the 2010 target (Eurostat, 2007: 15.1%; EU-25 2007: 14.5%); although progress in this field is supported by figures based on national indicators. In

line with the 2007 JR challenges, current objectives are explicitly targeted at promoting labour market participation of young people and older workers. With an increase since 2005 of 3 751 available places in public childcare facilities ('Maisons-Relais', total available places in 2007: 11 751) and of 347 places in 'parental assistance' arrangements since 2003 (total available places in 2007: 437), the progress achieved in the field of reconciliation between work and private life with regard to the ambitious intermediate target set for 2009 (an increase of 10 000 places in childcare structures) is more than reasonable. Finally, some advancement can be reported in the field of promoting access to housing. The 'housing pact' was adopted on 11 June 2008 and measures will now enter into force, given the second constitutional vote by Parliament (on 22 October 2008). In accordance with the 2007 JR challenges, this priority has been focused on vulnerable groups.

To enable progress to be monitored effectively, specific attention has to be paid to adequately quantifying outcome targets. This is particularly the case when looking at priorities focused on restoring full employment and preventing school failure. These have not been sufficiently specified as to timeline, including intermediate steps, which could be measurable (the quantified objectives are much too global). More precision is needed here on the inclusive aspects of the employment and education policies/measures in order to define reasonable, specific and measurable intermediate outcome targets and show how the different policy instruments are to interact

3.3. Key challenges and priorities

The 2008-2010 report pursues four priority objectives: ensuring the well-being of children; encouraging the labour market participation of young people and older workers; modernising social assistance; and facilitating access to housing. These objectives build on and follow the objectives set in the previous report (except for preventing school failure and raising the overall level of education) and consistently reflect the current key trends. In line with some challenges identified in the 2007 Joint Report, the new objectives explicitly reinforce the former strategy on almost all priorities, with a stronger focus given to the social inclusion dimension (poverty reduction) and to actions targeted at specific vulnerable groups. Nevertheless, considering Eurostat figures, the issue of school failure should be dealt with alongside the main priorities (young men, children with an immigrant background and from families with a low socio-economic status are more affected). It is also noticeable that arrangements for mainstreaming social inclusion in all relevant public policies (economic, employment, education, etc.) have not been sufficiently prepared, while mainstreaming in the ESF has only been officially established. Finally, the four priority objectives for 2008-2010 take gender equality issues into account; although sometimes in a very general way (more information and evidence are from time to time needed to support statements).

3.4. Policy measures

Concerning the priority objective addressing the *well-being of children*, existing measures are continuing, such as the extension and individualisation of care services (for children with specific needs). New actions are also introduced, such as a 'child bonus' (being simultaneously a family allowance and a tax measure benefiting mostly families with low incomes) or 'cheque-services' ('services vouchers', to be provided when using childcare facilities). This policy combines, in an integrated way, a preventive and a remedial approach aimed at improving the situation of all households with children (by increasing the level of disposable income and the opportunities to (re)enter the labour market through easier access to structures and services). This priority objective thus globally reinforces actions taken in the

field of reconciliation of work and private life. Actions also reinforce measures targeting children with an immigrant background, at risk of social exclusion or material poverty, etc. (draft Law No 5764 on assistance to children). Ambitious in terms of scope, actions need some reinforcement to attain the main objective (clear targets are only fixed in the field of increasing childcare facilities). Even if the gender dimension has been taken into account, efforts should continue in the field of mainstreaming of disability issues. The report does not mention the scale of resources allocated, nor does it describe in sufficient detail how the ESF is contributing in concrete terms to achieving this priority objective (i.e. through OP priority axis No 1).

Concerning the priority objective of *encouraging the labour market participation of young people and older workers*, no new measures have been identified (the approach is basically a carryover of the former objective) and specific quantified targets have not been set. With regard to young people, the approach is sufficiently multi-dimensional and integrated (activation measures, orientation services, and mechanisms supporting skills and competences recognition which are coupled with the reform of the primary and secondary education system, including vocational education). But when assessing the situation of older workers, the scope of the approach as well as its instruments (mainly a 'plan for maintaining workers in employment' and an individualised right to vocational training) appear to be quite unsatisfactory. The gender dimension is said to be taken into account, but without giving sufficient evidence in relation to the measures undertaken. There is no information on whether adequate attention is paid to the mainstreaming of disability issues. Sufficient resources are being allocated to achieve the objective and the ESF is making an effective contribution (through OP priority axis No 1).

Concerning the priority objective of *modernising social assistance*, the reform was already announced in the first NAP/Inclusion in 2001 (the need to reform 'paternalistic/arbitrary social assistance' with extensive and complicated administrative procedures). This reform (draft Law No 5830) is structured around a few key features: merging local welfare offices into regional services, harmonising operating methods around a 'one-stop-shop approach', and enhanced professionalisation, efficacy and transparency. The reform also redefines the concept of 'assistance' (an enforceable right; subsidiary and supplementary; multi-purpose; and individualised). The idea of follow-up and partnership is underlined through a 'solidarity contract'. The new system is not expected to be completely in place before January 2010. The approach is sufficiently multi-dimensional and integrated, although it would have been useful to show some measurable intermediate steps. The reform develops a gender perspective (by supporting single parents, often women) and the mainstreaming of disability issues (by supporting 'mobility' as a 'basic need'). It takes into account the situation of non-nationals and third-country nationals, including those staying illegally in the country (Article 28 provides for short-term discretionary humanitarian aid). The allocated resources are sufficient and clear monitoring arrangements are planned (annual reports, structured social surveys, solidarity contracts, etc.).

Concerning the priority objective of *facilitating access to housing*, it has been decided — on the basis of an in-depth analysis of the housing structure and the social situation of households — to supplement the overall policy on access to housing with a specific initiative supported by NGOs — i.e. the creation of a 'social estate agency' targeted at households with low effective income and people facing multiple problems. The main missions of this structure are: real-estate prospecting, rental management (intermediate role in rental contracts and control of payments) and technical assistance (repairing dwellings). Clear targets are set: 50 dwellings for 2009, an increase of 50 dwellings per year, and in the medium term, around 500

dwellings to be administered in the whole territory. The reform is sufficiently multi-dimensional, integrated and takes into account a gender perspective (by supporting single parents with children — often women — with a supplementary rental allowance), the multi-dimensionality of child poverty (as material deprivation), and the situation of immigrants. The allocated resources are sufficient and clear monitoring arrangements are planned (annual reports based on the quantitative targets).

3.5. Governance

Governance issues are considered to be well addressed in Luxembourg. In comparison with former reports, the present NSR can be seen as the result of a strategic planning process, which has improved even further. Preparation arrangements promoting administrative coordination in the field of social inclusion can be considered quite effective and sufficiently inclusive. Nevertheless, some minor weaknesses (in terms of procedural outcomes) can be observed at the level of coordination with the Lisbon Strategy and the Sustainable Development Strategy. Concerning mobilisation and involvement of actors, the social inclusion process is based on broad consultations with all relevant stakeholders. The government — in cooperation with local authorities — also supports NGO initiatives (e.g. an annual conference on poverty and inclusion) and takes into consideration conclusions and demands emerging from these activities. In this respect, the role of non-governmental actors seems to have been strengthened while their views have, to some extent, been taken on board (e.g. the 'social estate agency'). At this point, it might perhaps be regretted that little overall visibility was given to the social inclusion process (e.g. in official political discussions, in the media). Appropriate arrangements are generally made to monitor and assess the reforms and measures undertaken (although expected outcomes could sometimes be specified more and/or quantified at an intermediate level).

4. PENSIONS

4.1. Key trends

The pensions system in Luxembourg is dominated by a public scheme that covers employees and self-employed persons. It is financed in equal parts by employer, employee and general budget contributions, is based on a strong political consensus and ensures a high level of adequacy (a system with very high aggregates replacement ratios compared to international standards — 0.61 compared to an estimated 0.49 for the EU-25). It is organised as a pay-as-you-go defined-benefit system based on a financial model with a contribution rate fixed for a period of 7 years and a reserve fund for compensation (up to 2008 the fund accumulated assets worth 25% of GDP). Pension benefits are calculated on both the length of contribution periods and the accumulated lifetime amount.

A major feature is that the rise in age-related government expenditure is projected to be among the highest in the EU, reaching 8.3% of GDP (3.4% in 2050 for the EU-25). Despite this, very little has been done to reform the pensions system and no progress was recorded in 2008. With the prospect of the upcoming parliamentary elections in June 2009 and the relative complexity of this subject, which covers various policy areas in the fields of social security and labour, a ground-breaking outcome is not to be expected.

A Working Group on Pensions was created in November 2007 to evaluate the system's performance and to develop strategies to adapt the system to demographic and structural

changes in order to guarantee future pensions commitments with stable, adequate revenues and also to safeguard the achievements of a minimum pension based on inter-generational and inter-economy solidarity. The first results are expected for 2009.

4.2. Key challenges and priorities

Luxembourg has, over the last 25 years, pursued a strategy to adapt its social security system. Currently, the challenges identified in the 2007 Joint Report are reflected in the activities of the above-mentioned Working Group. The system's financial sustainability should be reinforced by an increase in employment rates among the resident population and in particular women and over-55 year olds. The financial sustainability of the pension system depends on relatively high rates of economic growth in the future, and mainly on a very large contribution by non-resident workers to the Luxembourg economy and pension schemes. Despite the existence of a substantial reserve fund, the fact remains that in the event of a decline in the employment of non-residents, an ageing population would then have to finance not only resident pensioners' pensions, but also a large number of pensioners outside Luxembourg. It is furthermore likely that the current predominantly young (cross-border) professionals will, when they reach retirement age, have a strong impact on today's very advantageous dependency ratio, while many of them will tend to have acquired full pension rights. The long-term sustainability of public finances and the viability of the pension system thus remains a challenge of vital importance. Luxembourg should therefore concentrate its efforts on reforming the pension system, mainly to encourage the labour market participation of older workers.

As regards the first priority, discussions focus on how to increase the effective retirement age, which has not changed over the years (men: 59.2 and women: 60.3 according to OECD data) and falls below the EU average (especially for men), while Luxembourg's life expectancy remains higher. Meanwhile — according to the European Commission's Macro Fiscal Assessment (to which the OECD also refers) — an increase of 7.4% of GDP (from 10% to 17.4%) in Luxembourg public spending for pensions between 2004 and 2050 is projected, which is one of the strongest growth rates in the EU (2.2%).

The second priority concentrates on how to overcome drawbacks related to work incapacity. According to Statec data, 15% of the active population aged 50+ leave their job because of health difficulties or work incapacity. A total of 5% become unemployed. This shows the importance of prioritising prevention of work incapacity and measures for job retention for older workers, as well as supporting measures such as rehabilitation and redeployment programmes.

Luxembourg is also striving to improve the individualisation of pension rights (the question of divorcees' acquisition of pension rights).

4.3. More people in work and working longer

Several incentives aimed at the voluntary extension of professional careers, which were introduced by the 2002 pension reform, have not yielded the expected results. In fact, the employment rate of the elderly has decreased slightly (from 33.2% in 2006 to 32% in 2007), although the rate for females has shown a positive trend since 1997. The NSR illustrates that an increase of 0.02% in the accrual rate of 1.85% for every year between the age of 55 and the effective retirement age for people with a minimum of 38 contribution years is not much of an economic incentive to defer retirement. Nor do *part time* early retirement options constitute

an attractive alternative, as income above one third of the minimum wage will directly lead to a reduction of the early retirement pension. It is expected that better incentives for health prevention at work combined with stricter supervision of medically justified work absenteeism could bring positive results.

4.4. Privately managed pension provision

Private pension plans are offered as financial products to individuals (neither very popular nor financially substantial). They are governed by income tax law and the Grand Ducal Regulation of 25 July 2002. They enable individual supplementary pension benefits to be paid in addition to the state pension, and allow tax deduction on an income amount of between €1 500 and €3 200 per year, depending on the age of the policy holder. Benefits are paid starting from the age of 60 at the earliest. Property ownership is another form of private saving for old age.

4.5. Minimum income provision for older people

The guaranteed minimum income (€1 146.50 per month in 2008) applies to the elderly in the same manner as to the rest of the population. In the 60+ age-group, about 1.2% receive supplements to make up the shortfall, compared to 3% for the population as a whole. In 2009, a new measure will replace the former tax deductions allowable for pensions with a tax credit paid to every taxable person, which will enable pensioners with little income who are exempted from tax to enjoy the same advantages as taxpayers.

As minimum income provisions for those who have not worked a full pension career are nearly as generous as minimum pension provisions, the adequacy of pensions does not pose a great challenge for Luxembourg. Nevertheless, it should be kept in mind that this parameter might constitute a disincentive to work for a full pension career

4.6. Information and transparency

A tripartite coordination committee, composed of representatives of government, employers' organisations and trade unions, is the most important political advisory group in the field of pensions. Information on public pensions is available for the public on the Ministry's website. The pension funds inform their members via mail on a yearly basis on the years of pension rights acquired. A preliminary determination of the pension amount to be expected is only provided on request.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Life expectancy at birth (men: 76.8 and women: 81.9 in 2006) is slightly higher than the EU-25 average (men: 75.8 and women: 81.9 in 2005) while healthy life years at birth reached 61.0 for men and 61.8 for women in 2006 (latest estimates for the EU-15, men: 64.5 and women: 66 in 2003). Luxembourg has the lowest infant mortality rate in the EU (1.8% in 2007).

Compulsory health insurance provides coverage to 99.7% (2005) of the population. Total health expenditure was 7.8% of GDP (2005), below the EU average in spite of a steady

increase between 1998 and 2004. The healthcare system is mainly publicly financed through social health insurance. Health care is provided by public services, private practitioners and not-for-profit associations paid from the Ministry's budget. Preventive services are the responsibility of the Ministry of Health. Luxembourg imports all pharmaceutical products and bases most retail prices on those set in the country of origin.

The national strategy is focused as a priority on the financial sustainability of the system and is aimed towards cost containment and better use of resources. Common drug and technology purchasing is also envisaged (single hospital procurement centre) with a view to achieving efficiency gains and moving towards greater use of generic medicines.

Since 2004 a Joint National Action Programme has been implemented to improve the quality of the system through increased spending efficiency. A better communication and information system has also helped to increase the transparency of the healthcare system.

In the short run, there is no need for new measures. It would be desirable for the strategies adopted to follow the policy cycle through to their strict implementation and monitoring (this is also true for long-term care).

5.1.2. Accessibility

The health insurance system is mandatory for all economically active persons. In 2006, the national data showed that it covered 98% of the resident population (including family members as 'dependants'). Another 174 200 non-resident people are affiliated as cross-border workers (or family members thereof).

Self-reported unmet needs for medical care (0.4 in 2006; EU: 3.1) and dental care (0.8 in 2006; EU: 5) are very low compared to the EU average.

Although a few new measures have slightly increased the level of co-payments (i.e. from 5% to 10% for the first GP consultation within a month in 2005) and reimbursement rates for dentistry services, out-of-pocket payments as a share of total health expenditure have remained stable (6.7% of total health spending in 2005 — the lowest among OECD countries; OECD 2008).

5.1.3. Quality

Since 2004 a Joint National Action Programme (updated on an annual basis with new priorities) has been pursued to improve the quality of health care through increased spending efficiency. In terms of quality assurance, the Ministries of Health and Social Security are encouraging hospitals and healthcare units to establish synergies and collaboration with other healthcare providers at the wider regional level. The aim is to increase the quality of care through the creation of specialised care centres.

Since 2005, the scientific council has been developing, in selected areas, treatment guidelines based on international scientific standards of evidence-based medicine. Impact evaluation is not yet formalised. However, impact analyses of the guidelines for prescription of antibiotics have shown positive results regarding the prescription patterns of paediatricians and internists (not the case for most GPs). Quality assurance was implemented in 2003 for some specific areas: the rate of hospital infections, mammography quality (EFQM framework generalised but not yet evaluated), etc.

With regard to e-health, research and other work has been undertaken: an inventory of the different software systems used in hospitals and specialised national health centres aimed at identifying potential interoperability of the various systems in place; establishment in 2005 of a secure computerised data communication network for health professionals and healthcare institutions; and a project aiming at establishing electronic prescriptions.

5.1.4. Sustainability

In 2005, per capita expenditure in PPP reached USD 4 153 (€3 341 — OECD 2008) while total healthcare expenditure (7.8% of GDP) was below the EU average (9%).

Healthcare expenditure has to be considered in conjunction with the specific characteristics of Luxembourg's labour market (largely based on cross-border workers). If non-residents (25% of the total population insured by Luxembourg's health insurance system) currently place the country in a favourable demographic situation (they are 9 years younger on average, only 0.2% percent of 65+), their use of healthcare services is expected to rise with increasing age. Another source of concern are figures showing 3.37% higher healthcare spending growth against real GDP growth between 1995 and 2005, a figure among the highest in Europe (due to the increase in the covered population and the modernisation of the healthcare infrastructure and technology; OECD 2008. The introduction of the System of Health Accounts can also partly explain this figure). The financial situation of the system being challenged in the medium term, cost-controlling measures have been introduced which concern: doctors' prescription behaviour, new management practices and centralised procurement of medicines, the use of generic medicines (identified in the 2007 Joint Report as a core challenge), strong health promotion and prevention policies.

Promotion and prevention policies as well as disease management schemes are being developed. In recent years, the system has strengthened its internal and external communication. Since 2007, social security statistics have been made available online. The health portal aiming to support healthy lifestyles, preventive actions, and better orientation in the health sector should be in place in 2009. The number of prevention programmes has also increased (cancer detection programmes have been run and show positive results). By developing a proactive attitude, some budgetary effects are expected (the system of preventive medicine will be analysed and cost-benefit studies are planned).

5.2. Long-term care

5.2.1. Description of the system

LTC services are provided in a social security framework, with a compulsory social contribution allowing access to services on the basis of need, independently of the ability to pay. Concerning home care, recipients of care can obtain a cash payment allowing them to receive care from an informal carer (limited to 10.5 hours a week in order to guarantee follow-up by the formal care services). Palliative care is under the responsibility of hospitals, although the authorities intend to promote it outside hospitals and ensure its financing through the social security system.

Long-term care expenditure amounts to 1.54% of GDP (2005), which exceeds the EU average, and is projected to grow by 0.6% (EU-25: 0.6%) by 2050. As such it has been identified by the authorities as a risk to the social security system.

5.2.2. Accessibility

Public long-term care insurance guarantees equal access for the whole working population, including cross-border workers, irrespective of age and health status (only people covered for long-term benefits by international organisations are excluded). The crucial criterion to qualify for benefits is proven dependence on another person for daily life activities for a minimum of 3.5 hours per week.

Access to long-term care cannot be mentioned without considering the problem of the price of accommodation in both nursing homes and integrated centres for the elderly. This accommodation price is significant and is borne by the resident himself/herself. Here, the National Solidarity Fund provides means-tested support (‘accueil gérontologique’).

Overall, accessibility problems are well addressed, through the compulsory dependency insurance and co-payments for vulnerable groups requiring additional care which are not covered by long-term care insurance. Specific measures allowing the payment of informal carers and simultaneous follow-up by formal institutions are already in place. A cost-effectiveness evaluation of these schemes would be interesting, particularly to examine the incidence of co-payments for additional expenses not covered by the comprehensive scheme on vulnerable groups’ accessibility patterns.

5.2.3. Quality

Market entry to the care sector is subject to the approval of the Ministry of Family Affairs (endorsement of quality standards and the conclusion of a framework contract with the health insurance organisation). The new Long-Term Care Act (23 December 2005) established a quality commission and a so-called ‘Cellule d’évaluation et d’orientation (CEO)’, evaluating long-term care needs, including monitoring of quality standards for long-term care and measuring mismatches between the care provided and the needs of the dependent person. Following a survey of patients’ satisfaction in the area of home care conducted in 2006 (by the CEPS/INSTEAD institute), a series of measures have been implemented: streamlined administrative procedures, minimum requirements for keeping patient records, and information on application procedures provided in four languages (Luxembourgish, French, German and Portuguese). Concerning long-term prevention and rehabilitation, the NSR already provides examples of good practices: for medium-term geriatric rehabilitation, more than 100 beds have been made available. During the last five years the area of psychiatric care has undergone major reforms: new psychosocial day centres, sheltered workshops, and therapeutically accompanied housing facilities have been built. An ambulatory multidisciplinary psychiatric care service for adolescents facing difficulties has been launched. Better coordination with social services and the coverage of more remote areas in the north of the country remain key issues.

5.2.4. Long-term sustainability

Overall, long-term care insurance is facing a steep rise in expenditures. These reached 1.54% of GDP in 2005 and increased by 25% between 2004 and 2006, in particular benefits in kind (roughly 70% of the total expenditure). According to the EPC/EC projections, public long-term care expenditure is set to increase by 0.6 pp of GDP by 2050 due to population ageing. The Law of 23 December 2005 (implemented in 2007) changed various parameters in order to ensure the financial equilibrium of the system.

6. CHALLENGES AHEAD

- To strengthen the control and coordination of the inclusion strategy and to reinforce the mechanism for monitoring and evaluation.

- To promote active inclusion by strengthening multi-faceted efforts towards specific vulnerable groups, namely young people, older workers, and non-nationals.

- To address the long-term sustainability of the pension system to ensure that it is sustainable also in circumstances of low economic growth.

- To address the financial sustainability of LTC and improve the quality of LTC services through the integration of the various LTC services with healthcare services in order to ensure continuation of care at home and in the institutional setting.

- To assess and evaluate improvements in reducing the overuse of antibiotics and in the use of generic medicines (with regard to quality and financial sustainability).

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	8,4	243,7	**2000**	62,7	75,0	50,1	31,9	26,7	**2000**	2,3	1,8	3,1	7,1
2005	5,2	254,1	**2005**	63,6	73,3	53,7	24,9	31,7	**2005**	4,5	3,5	5,8	13,7
2008*f*	1,0	261,1	**2007**	64,2	72,3	56,1	22,0	32,0	**2007**	4,1	3,4	5,1	15,5

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	73,0	80,6	14,7	19,7	n.a.	n.a.	5,5	**1995**	5,6	92,4	6,2		-
2000	74,6	81,3	15,5	20,1	n.a.	n.a.	5,1	**2000**	5,8	89,3	7,0	**2005**	0,4
2006	76,8	81,9	17,0	20,3	61,0	61,8	1,8	**2006**	7,3	90.9*s*	6.5*s*	**2006**	0,4

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

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits — ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old age dependency ratio (2060) Eurostat	Expenditure (% of GDP) Level in 2004 and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	20,7	45,1	24,9	3,1	13,1	1,2	12,7	**2004**	20,9	19,5	10,0	5,1	0,9
2000	19,6	39,9	25,4	3,2	16,6	1,5	13,4	**2010**	21,1	-0,1	-0,2	0,2	0,1
2006	20,4	36,7	25,4	4,9	16,9	2,9	13,2	**2030**	30,8	5,5	5,0	0,8	0,2
								2050	37,82	8,3	7,4	1,2	0,6

**including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	14	20	13	7	19	20	20	9	4	**2005**	13
male	13	-	12	7	19	-	20	8	-	**2006**	13
femal	14	-	13	8	19	-	19	12	-	**2007**	14

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	3,4	6,7	5,3	8,1	**2000**	0,6	0,5	0,6	**2000**	16,8	15,9	17,6
2004	3,4	7,1	5,7	8,5	**2004**	1,1	0,8	1,4	**2004**	12,7	12,6	12,7
2007	3,4	7	6	7,9	**2007**	1,2	1,2	1,1	**2007**	15,1	19,2	11.1u

**: excluding students; i: change in methodology; b: break in series; u: data lack reliability due to low sample size*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,96	0,95	0,97	***Aggregate replacement ratio***	0,61	0,59	0,58

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
			Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**				Occupational & voluntary	
Total	Total	Statutory pensions				Statutory pensions	Occupational and voluntary pensions	Statutory pensions	Estimate of current (2002)	Assumption
0	-1	-1	DB	/	-	92	/	24 (d)	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions);*
*** (DB/DC); (d) For Luxembourg, one third (8%) also comes from the general State budget.*

Hungary

1. SITUATION AND KEY TRENDS

The government's fiscal consolidation measures to reduce the very high budget deficit caused a significant slowdown of GDP growth in 2007 (1.1%), which is likely to further decrease substantially in 2009 according to the EC forecast (-1.6%) that takes the rapidly deteriorating economic outlook into account. The labour market situation has remained unchanged in the last few years, and after a modest improvement it is still characterised by one of the lowest employment rates (2002: 56.2%; 2007: 57.3%) in the EU. It is coupled with an unemployment rate (7.4%) close to the EU average but slightly rising and expected to increase further to 8.8% by 2009. The activity rate (61.9%), still well below the EU average, remains the most significant labour market challenge. The poor employment situation can partly be explained by the low youth employment level that has continued to fall since 2004 from 23.6% to 21.0% in 2007. The employment rate of older people, after increasing for years and attaining 33.6% in 2006, also dropped somewhat (to 33.1%) and is still very low in comparison with the EU average (44.7%). The employment level of low-skilled people has also continued to decrease (27.3% in 2007) and is more than 20 percentage points lower than the EU-27 average (48.6%) and only one third of the employment rate of people with tertiary level education. Inactivity is mainly concentrated among the young and older cohorts as well as the unskilled and other disadvantaged groups, including the Roma population and people with disabilities. In line with EU trends, the employment rate of men (64%) is higher than that of women (50.9%); however, the difference is somewhat lower than the EU average. Regional labour market differences have also remained the second highest in the EU and micro-regional disparities are even more marked.

The old-age dependency ratio was 23.5 in 2008, below the EU average (25.4), but the projected figure for 2010 (24.2) may even double by 2050 in line with EU trends. Life expectancy at birth was 69.2 years for men and 77.8 years for women in 2006, one of the lowest among MSs, though steadily increasing. The poor health status of the population lessens life expectancy and also has negative implications for the overall labour market situation. Social protection expenditure was 22.3% of GDP in 2006, which remains well below the EU average (26.9%).

2. OVERALL STRATEGIC APPROACH

The 2008-2010 NSR does not bring any new approach in terms of strategic orientation compared to the previous report. Although the main objectives of the strategy are not explicitly listed in a transparent manner, major challenges can be identified on the basis of the assessment, including the policy responses to these challenges. The chapter on the overall strategic approach does not refer directly to the three overarching objectives but the separate strands address all their important aspects. Priority objectives of the strands build to a large extent on the strategic approach of the previous report and interventions also show continuity with former measures. This can be regarded as reasonable, since the main indicators show limited progress.

The document tends to build considerably on the overall reform agenda of the government across the three strands. Nevertheless, links to former reform concepts, as well as the coherence of planned strategies, are not always evident. The government confirms its commitment to the Lisbon process; accordingly, the NSR is in line with the aims of growth and jobs and is consistent with the country's National Reform Programme (NRP). As properly presented by the chapter on the overall strategic approach, all strands make significant contributions to the Lisbon targets, foremost to improving the employment situation. However, the presentation of positive 'feeding-out' effects of the growth and jobs agenda to the social protection and social inclusion (SPSI) objectives remains at a general level. Coordination could be strengthened even further in order to optimise the mutual interaction between the SPSI strategy and the policy priorities in the NRP.

Despite efforts made in the field of promoting good governance, the report remains weak in terms of tangible measures to improve the effective monitoring and evaluation of the implementation of former actions and the channelling of the lessons into the planning process. The effectiveness of the extensive funding (including EU resources) in delivering the measures announced in the 2006-2008 Report is still not clearly visible because of the lack of a comprehensive system of monitoring and impact assessment. Structural Funds and especially the European Social Fund (ESF) remain a major resource for implementing the strategy. Gender equality and the disability perspective are partially reflected in the strategic approach.

3. SOCIAL INCLUSION

3.1. Key trends

Poverty has continued to affect broad segments of society. The at-risk-of-poverty rate for children (19% in 2007) is much higher than for the general population: 12%, which is below the EU average. The favourable rate for elderly people masks a substantial gender gap. The poverty threshold for families (2 adults and 2 dependent children) was €4 959 in 2007, less than a third of the EU average. The main risk factors of poverty are still joblessness, parents with low education attainment, 3 or more children or lone-parent families and small-size settlements. The share of people living in jobless households (11.9% in 2007) is the second highest in the EU and the 13.9% rate for children is even farther from the EU average (9.4%). The 3.4% long-term unemployment rate is somewhat above the European figure. Poverty factors continue to characterise the Roma disproportionately to the majority society. According to estimates, half of the Roma are considered to be living below the poverty threshold. Prevention of intergenerational transmission of poverty, as well as some new societal phenomena (e.g. the rising number of ethnic-based insults and increasingly hostile climate in society; the growing risk of multitudinous indebtedness because of personal loans), require more attention. Moreover, the risk of poverty may increase in the near future for certain groups due to the effects of the financial crisis and further austerity measures to cut the budget deficit. Although unemployment and inactivity traps are not particularly high, work incentive elements of the benefit system need further improvement.

The performance of the social benefit system in terms of fighting poverty can be regarded as satisfactory. The poverty rate before social transfers for the total population (29%) is 17 percentage points higher than with transfers (the difference is 25 percentage points for children). A general minimum income scheme is not in place, but a minimum income is guaranteed for everybody in need through different entitlements. Overall participation in

education has grown steadily over the last few years but the composition of the student body by attainment levels and forms of education shows considerable deviation from international patterns. Participation at secondary and tertiary level has increased steadily but the share of those in secondary level or higher vocational training is extremely low. Although the drop-out rate was 3.9 percentage points lower (10.9%) than the EU average in 2007, over-representation of disadvantaged groups, e.g. Roma, is striking. While the performance of Hungarian students in the PISA survey is in most fields around the OECD average, between-school variance arising from economic, social and cultural status is one of the highest. Access to other quality public services, as well as the labour market situation and risk of poverty, remains very much influenced by size and location of settlement.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Although priority setting in the previous report is adequate, the effectiveness of the intervention mix, as well as instruments to monitor it, remains debatable since only very few indicators have reached their target values. Some of them have even deteriorated. Negative labour market trends can partly be explained by the adverse impact of the restrictive measures to improve the state budget (even measures such as the raising of labour costs or the cutback of public administration staff). At the same time, expenditure on social inclusion has not decreased in the years of budgetary restraint. Respecting the challenge identified by the 2007 Joint Report, efforts have been successful so far to protect the most vulnerable groups and to counterbalance the negative effects of austerity measures, since the relative income position of the poor has not deteriorated.

In spite o the government's commitment to fighting child poverty, the main indicators in this field have not shown significant improvement. Nevertheless, the approval of a long-term national strategy by Parliament represents a positive development. Cash allowances granted to families with children have preserved their value in relative terms since 2006. Support for day-care institutions for facilitating parents' return to the labour market has increased significantly. The document reports on numerous measures targeted at the group most affected by economic, social and territorial disadvantages, namely the Roma. While the multidimensional nature of their disadvantaged situation can only be addressed by complex solutions, programmes have remained on a general level in terms of integrated approach. In spite of the efforts of the government to monitor more closely and evaluate the efficiency of social inclusion measures, tangible results have been limited in this field. EU funds have been predominant in financing social inclusion developments.

3.3. Key challenges and priorities

As indicators show limited progress since the last cycle, priorities justifiably remain unchanged in the National Action Plan for 2008-2010, namely: promoting labour market inclusion and decreasing inactivity; fight against child poverty; reducing territorial and housing disadvantages, with special regard to the social inclusion of the Roma.

Challenges identified by the 2007 Joint Report are addressed within the three priorities. Accordingly, *promoting active inclusion by implementing the reform of the social benefit system* remains a concern for Hungary. This includes mainly elements aimed at improving interaction between employment and social services. Further incentives to encourage workers to remain in the labour market tie up also with the pension strand. In the light of the emerging difficult economic situation, the government should reiterate its commitment to *maintaining*

the level of resources dedicated to combating poverty and exclusion, which has been successful so far. Efforts to *strengthen the governance of social inclusion policies by improving monitoring* should be more tangible since sufficient feedback of evaluations to the planning process is not given due attention throughout the implementation stage.

The aspects of social cohesion are largely included in the New Hungary Development Plan, the National Strategic Reference Framework (NSRF) of Hungary for the implementation of the Structural Funds, which are the major sources for social inclusion developments in 2007-2013. Besides being a horizontal objective of the NSRF, social inclusion has targeted measures with earmarked resources, primarily as a separate priority axis (€444 million) in the Social Renewal Operational Programme co-financed by the ESF and also in the Social Infrastructure OP (co-financed by the European Regional Development Fund).

3.4. Policy measures

Promoting labour market inclusion and decreasing inactivity is based on active labour market policies in line with the NRP and built largely on the measures launched previously. Policy actions will primarily focus on disadvantaged groups, opportunities for alternative employment, work incentive aspects of the social benefit system and training of people with low qualifications. Employment schemes for a widened range of disadvantaged groups will continue to provide mainly reduced contributions for employers. The target group of the Public Employment Service (PES) will be extended to inactive people capable of work. A joint effort of the PES, the social benefit system and the disability pension scheme will continue to help people with reduced working abilities to remain in or return to employment through active participation in a rehabilitation process financed partly by the ESF. Entitlement to some social benefits will be linked to labour market services. In spite of their doubtful effectiveness, public work schemes can expect further support. The practical implications of the proposal whereby EU-funded investment projects employ registered job-seekers for up to 10% of their workforce remain to be seen. The focus on addressing the special problems of the Roma population could be emphasised further. Training schemes for low-skilled people will continue to be a dominant feature of the support system. After the success of the former programmes, additional regional integrated vocational training centres ('TISZK') will be established with the help of the Structural Funds in order to rationalise institutional operation and tailor the training supply better to labour market needs. Target values for 2010 appear to be feasible. Nevertheless, the 2010 targets for the most important indicators are less ambitious compared to the previous NSR. The gender dimension is not adequately addressed.

Although no significant changes in policy measures are noted since the last report in the field of *fighting child poverty*, the adoption of a comprehensive long-term strategy, 'Let it be better for children!' (2007-2032) and its Action Plan for 2007-2010, is an important step towards mainstreaming the issue as well as in coordinating efforts in this field. In line with the strategy and with the previous NSR, the government is committed to strengthening the income position of parents, including their employment situation, supporting daytime care services, ensuring equal opportunities in education and training as well as protecting the health of children. Although target values of current indicators appear realistic, the number of indicators is not sufficient to monitor overall progress. Among a number of supportive changes in the benefit system, a differentiated increase in the family allowance in 2008 favours disadvantaged families to a greater extent. Child welfare and protection services continue to play an important role in breaking the cycle of poverty. A further expansion of day-care facilities financed mainly by the ERDF will contribute to fulfilling the target of the indicator set for the priority. In order to strengthen the role of the education system in

eliminating social inequities, reinforcement of the regulatory framework for local governments to ensure kindergarten attendance of children is welcome. The revision of the school district system to prevent school segregation is still ongoing. Transparency in this field should remain the primary objective.

The policy mix of the priority *'reducing territorial and housing disadvantages'* represents a collection of discrete measures rather than a coherent strategy to address this highly complex problem. Access time for micro-regional centres, as the only indicator, is not enough to assess progress realistically across the diverse set of policy measures. Financial resources earmarked for the priority (domestic regional development funds, ERDF, EARDF) appear sufficient. Real coherence within complex programmes aimed at resolving multidimensional problems of territorial disadvantages (mostly with assistance from the Structural Funds) remains to be determined. The development of multipurpose micro-regional cooperation schemes to improve access to public services, as well as various initiatives to combat housing disadvantages, is welcome. The aspects of the Roma as a particular target group for this priority are addressed only in general terms.

3.5. Governance

Considerable efforts have been made to involve not only all government departments concerned, but also the most important social partners such as consultative bodies representing civil organisations as well as special target groups (also the Council for Gender Equality) in the preparation of the NSR. The engagement of the regional and local level seemed insufficient, however. The first draft was available to the general public for consultation via the internet. Plans aimed at involving stakeholders in implementation over the full policy cycle are not included. Although the government's commitment to setting up a comprehensive monitoring and evaluation system for social inclusion measures was expressed already in the previous report, details on the operation of such a system and its actual outcomes are only partly visible.

4. PENSIONS

4.1. Key trends

The Hungarian mixed pension system is characterised by the dominance of a statutory pay-as-you-go financed public scheme (3/4 share) supplemented by a mandatory fully funded tier (1/4 share). A voluntary funded pillar was established in 1993. The coverage of occupational pensions that started in 2008 is not significant. The relative living standard of elderly people is nearly equal to that of the 0-64 cohort (the relative income ratio was 0.97 in 2007; EU average: 0.84). The poverty risk of the elderly is lower than for the population as a whole, even though the level of pensions is only 52% of the EU average in purchasing power parity.

The statutory retirement age is 62 for men and has been gradually increased to the same level (from the former 55) for women by 2009. However, a great majority of people (94% in 2004) retired earlier, so that the effective retirement age is 3-5 years lower (58.6 in 2007) than the statutory age, though rising. The recent raise (from 18% to 24%) of the pension contribution rate to be paid by employers was partly due to a regrouping of health care contributions. An increase was carried out between 2006 and 2008 also on the individual pension contribution side, from 8.5% to 9.5%. In 2001, the former wage indexation was replaced by a 50/50 mix of

price and wage indexation resulting in a lower rate of pension increase which, however, is still more generous than the pure price indexation used in most MSs.

Reform of the pension system has been ongoing since the early 1990s, gathered pace in 1997 and is constantly on the agenda of the government as part of the comprehensive structural reform package. Nevertheless, counter-effective measures have often curtailed its positive resultants. Reform steps taken in 2006-2007 aimed at ensuring long-term sustainability of the system, mainly by lowering incentives for taking early retirement or claiming disability pensions. Even after these steps are taken into account, Hungary remains at high risk regarding the long-term sustainability of the system as a whole.

4.2. Key challenges and priorities

The main challenge facing the system continues to be sustainability. The old-age dependency ratio will more than double from 23.5 (2008) to 50.8% in 2050 while total pension expenditure is likely to rise from 10.4% (2004) to 16.8% of GDP by the same date. The system dependency rate may also increase significantly. While currently 76 pensions should be financed from 100 contributions, this number is expected to rise to 103 by 2050. The general ageing of the population, low employment rates, the very low retirement age, and contribution evasion will together have a significant detrimental effect on sustainability. As a result, Hungary is assessed as a high-risk country regarding public finance sustainability, particularly taking the most recent economic forecasts into account. Measures taken in order to address this issue identified already under the 2007 Joint Report do not appear to be sufficient.

The current performance of the pension system can be considered adequate. Theoretical replacement rates are relatively high for an average worker retiring at age 65 and they are projected to remain at this high level even in the future. This partly reflects the lower legislated retirement age than used in the calculations. The at-risk-of-poverty rate for the 65+ age cohort (6%) is significantly more favourable than both the EU-25 average (19%) and the figure for the rest of the population (13%), but there is a considerable gender gap (3% for men against 8% for women). While the relatively good position of current pensioners is due to the high coverage of the current public tier, income from pensions may become extremely low for populous groups that were most severely hit by the employment crisis after the transition in the early 1990s and who will soon reach retirement age with inadequate accruals and incomplete work records. The growth of the informal economy and the extension of other forms of contribution evasion also endangers adequacy for wide cohorts of people.

The challenge of ensuring long-term sustainability and adequacy calls for an immediate and comprehensive reform of the pension system coupled with further efforts to increase the employment rate of elderly people.

4.3. More people in work and working longer

Increasing the number of contributors by raising the employment level and preventing early exits from the labour market are crucial tasks for Hungary to ensure sustainability. As one of the most noteworthy labour market changes in recent years, the employment rate in the 55-64 age bracket improved notably, especially for women (13 percentage points from 2000 to 2007) primarily due to the increasing retirement age. Several measures were taken in 2005-2007 regarding the conditions of early retirement in order to encourage people to remain longer in the labour market by e.g. providing contribution allowance for employers hiring

workers over 50. The government's intention to block early exits by administrative measures, e.g. sharpening the age criteria and minimum service period requirements, is welcome. As of 2007, work during retirement became liable to pension contributions; as of 2008, accumulated earnings higher than the annual amount of the minimum wage will result in the suspension of early pension payments. Arrangements to lower the level of initial pensions have a direct positive effect on the sustainability of the system and also make retirement less attractive.

4.4. Privately managed pension provision

In 1997, the public pension scheme was extended by a privately managed mandatory fully funded tier. Since new entrants to the labour market have been required to join private pension funds, the number of participants in the new mixed system is steadily increasing and is currently approximately 70% of the insured. The private pillar is in an accumulative phase with payouts starting in 2013. Some components of the pillar are considered unpredictable due frequently changing contribution rules. In themselves, the regulations do not provide guarantees for benefits i.e. payments depend on returns obtained and contributions. After formerly pursuing conservative investment policies, from 2007 onwards portfolios became more diverse. Under a recent amendment, private pension funds are required to offer different investment options whereby members can choose between 'secure' or more 'risky' portfolios. Recent escalation of the turmoil on financial markets has drawn attention to the potential risks of these funds, since pension funds lost on average 20% of their value within a period of a few months. Achieving a balanced portfolio management will remain a real concern for private pension funds, particularly in the unstable market environment anticipated.

4.5. Minimum income provision for older people

Subsistence guarantees provided to the elderly include pension and supplementary statutory social benefits linked to their income and life situation. The minimum pension is due after 20 years of service and can be obtained by social security contributions paid at least on the basis of the minimum wage. Its relative level has fallen significantly over the last decade, amounting to HUF 28 500 (€114) per month in 2008, which is 35% of the average old-age pension and 40% of the minimum wage. Contrary to an earlier decision, the minimum pension will not be withdrawn as of 2009. For those unable to qualify for a pension or qualifying only for a low amount of pension, old age allowance provides support as a social transfer to those over 62, supplemented by targeted financial in-kind benefits and grants.

4.6. Information and transparency

Conscious behaviour with regard to pensions remains at a rather low level, particularly among the younger generation. In the last decade, the government has made various efforts to increase the transparency of the system e.g. by providing sufficient information to contributors and beneficiaries. These were more successful in the funded private scheme. The pension authorities sent reports to the insured on contributions to the PAYG scheme only once, in 2001. Since then contributors have been unable to check the accumulation of their accruals. In the private tier, annual reports are sent to fund members about their accumulations. Regulations and supervision have forced the funds to make comparable statements in particular about the structure of their costs and rates of return. However, the NSR remains vague with respect to concrete measures to be taken in order to increase transparency. The role of social partners and other stakeholders regarding communications on pensions, as well as their involvement in the decision-making process, has been limited.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The general health of the population is poor. Life expectancy at birth was 73.5 years in 2006, the sixth worst figure in the EU, and the gender gap is also significant (69.2 vs 77.8 years). Indicators on self-perceived health show substantial inequalities in the health status of groups with different income positions. A mandatory health insurance scheme administered by the National Health Insurance Fund (NHIF) gives universal access to comprehensive care. Municipalities and local governments are responsible for providing primary and specialist health care. General practitioners (GP) are independent contractors. A GP referral is needed to access specialist and hospital care but this gate-keeping function is often bypassed. Despite the dominance of public institutions within specialist care, there is a significant share of private ownership in a few areas. The system is financed through an earmarked payroll tax on employers and employees and through contributions from national and local governments. Informal payments are common.

A comprehensive healthcare reform was one of the main priorities of the government elected in 2006. Key components of the reform plans included partially privatising the health insurance scheme, reducing the excessive use of services through patient co-payments, and rationalising capacities through restructuring. After the rejection of some key components by a referendum in March 2008, the government also withdrew the law on health insurance reform. As a consequence, mandatory health insurance remained public and co-payments for doctor visits and daily hospital fees were abolished. Other reform measures, such as controlled patient routes and capping of public expenditure on pharmaceuticals, were more successful and helped to keep expenses under control. Further reform steps seem to have gained more consensus but plans presented in the report appear to be too ambitious for the next two years.

5.1.2. Accessibility

The basic package of healthcare services is universally available to every person staying in Hungary. The self-reported unmet need for medical care indicator was 2.4 in 2006 (EU average: 3.1). At the same time, the number of doctor consultations was the second highest in the EU. Regional inequalities in the geographic accessibility of healthcare services exist despite the high coverage. Facilities are concentrated in the major cities, while there is a lack of GPs and specialists in some disadvantaged rural areas. Major EU-funded programmes aim to restructure the capacities and catchment areas of inpatient and outpatient care institutions. Under these programmes, a rationalised network of regional and micro-regional outpatient care centres will be established. To improve the accessibility of emergency care, ambulance capacity is being restructured with the help of the ERDF. To reduce health inequalities, access to preventive and curative care needs to be improved for disadvantaged groups. Out-of-pocket payments are high (22.6% of total health expenditure), and extensive informal payments affect mainly the poor. Poor people also pay proportionally more for public health care than the rich.

5.1.3. Quality

Minimum standards for quality of care are in place and surveys have been conducted to identify the demand for care and to develop a needs-based approach. Further measures to improve quality will include implementing a monitoring and evaluation system based on defined indicators. Major IT development plans include establishing a database for the insurance system, developing a personal identification system, improving remote diagnostics and telemedicine. More attention will also be devoted in the future to standardisation, the use of protocols and measuring patient satisfaction. The average salary in the healthcare sector is still lower than in most other sectors. Several measures have been taken to improve administrative capacity. Medical equipment and infrastructure are poor in many institutions. Quality is considered by the NSR as an issue linked mainly to the institutional structure of the healthcare system.

5.1.4. Sustainability

Healthcare expenditure (8.3% of GDP in 2006) is slightly below the EU average, but growing steadily (1.4 percentage points since 2000). Health problems of the population induce a high financial burden, which is amplified by high contribution evasion. After years of constant deficit, the budget of the NHIF closed with a 0.1% surplus in 2007, whereas the government failed to introduce some measures (see above) to further reduce expenditures. Inpatient care was formerly notable for one of the highest numbers of acute hospital beds in the EU, indicating inappropriate and excessive use of hospital care. A recent restructuring of capacities created the basis for replacing inpatient acute care by one-day hospital care and outpatient specialist care. Plans include strengthening primary care, developing outpatient care and concentrating specialised care. Further arrangements to improve rehabilitation, chronic care, home nursing and strengthen GPs' gate-keeping function are welcome. Converting inappropriate allocation of human resources and combating the shortage of professionals in rural areas are main goals of the human resources strategy in recent reform plans. Various preventive actions, such as comprehensive screening programmes and healthy lifestyle campaigns, are under way with the assistance of the ESF, but should be further stepped up.

5.2. Long-term care

5.2.1. Description of the system

Long-term care services are provided by both health and social care institutions. Ongoing harmonisation of the responsibilities of the two systems aims to avoid overlaps and parallel activities. Local governments play a vital role in providing residential and home care. Funding for services is ensured by earmarked central budget support. The institutional framework includes chronic and nursing wards and residential institutions maintained mainly by municipalities. Acute care sectors of hospitals, as well as NGOs and religious organisations, also provide long-term care services. Family carers can apply to local authorities for a nursing fee. A fair number of measures have been taken to address the improvement of home care.

5.2.2. Accessibility

Long-term care capacities are at full stretch. The effective waiting list is estimated to be about 5-7% of the places available. Insufficient capacity, long waiting times for nursing care and geographic disparities in day and residential care lead to overuse of acute hospital beds by

chronic patients. To tackle this, the government will continue to support home care with the aim of providing country-wide coverage. Modernisation programmes of residential institutions, financed by the Structural Funds, will contribute to ensuring proper living circumstances for those who cannot be treated in their homes. Planned arrangements concerning supplementary support for micro-regional cooperation schemes providing social services may help to eliminate geographic disparities in access. Aspects of long-term care services should be taken into account in the ongoing process of restructuring healthcare capacities.

5.2.3. Quality

The report remains silent on the assessment of quality aspects of long-term care. Comprehensive quality assurance and accreditation mechanisms are lacking. A component of an EU-funded programme will provide for residential care protocols for the elderly, together with the establishment of a uniform electronic administration system. A pilot scheme is being launched to establish a new service management model in order to make services more adaptable to changing demands through better coordination. An inventory of social facilities and a national capacity monitoring system is also planned. The aim is to allow the elderly to stay in their homes for as long as possible. A patient follow-up system is also needed. Further measures are still called for to establish an improved comprehensive training system and to restore the prestige of professions in this field.

5.2.4. Long-term sustainability

The lack of a separate institutional system means that long-term care is financially over-reliant on hospitals. Measures for better coordination between health and social sectors, backed up by a separate financing system, are still lacking. Closer regional coordination through the development of care networks, urged by the former NSR, has partly been achieved by the restructuring of hospital capacity. The implementation of arrangements promoting home care will contribute to the sustainability of the system.

6. CHALLENGES AHEAD

- To promote active inclusion by implementing the reform of the social benefit system, including improving links to labour market services, ensuring the conditions for comprehensive rehabilitation and introducing further incentives to remain on the labour market;.

- In the context of budgetary restraints and economic downturn, to maintain the level of resources dedicated to combating poverty and exclusion among vulnerable groups, in particular the Roma;

- To strengthen the governance of social inclusion policies, primarily by improving monitoring and evaluation and by supporting the involvement of civil society;

- To address the long-term sustainability of the pension system and ensure the adequacy of pensions, in particular by further limiting early retirement and reducing the inflow into disability pensions, and reducing contribution evasion;

- To reach political and public consensus on implementing a coherent healthcare reform across government cycles, and to improve the health status of the population through the promotion of healthy life styles and prevention;

- To enforce GPs' gate-keeping role, to tackle the financial burden of health care for disadvantaged groups, to reduce inequalities in access to care through further restructuring of capacities and to develop a quality assurance system;

- To improve long-term care provision, especially home care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5,2	56,1	**2000**	56,3	63,1	49,7	33,5	22,2	**2000**	6,4	7	5,6	12,4
2005	4,0	63,2	**2005**	56,9	63,1	51,0	21,8	33,0	**2005**	7,2	7	7,4	19,4
2008*f*	0,9	61,5	**2007**	57,3	64,0	50,9	21,0	33,1	**2007**	7,4	7,1	7,7	18

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	65,3	74,5	12,1	15,8	n.a.	n.a.	10,7	**1995**	7,3	84,0	16,0		-
2000	67,4	75,9	12,7	16,5	n.a.	n.a.	9,2	**2000**	6,9	70,7	26,3	**2005**	3,9
2006	69,2	77,8	13,6	17,7	54,2	57,0	5,9	**2006**	8,3	70,9	22,6	**2006**	2,4

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

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	23,5	n.a.	10,4	5,5	n.a.
2000	19,3	41,4	27,9	4,0	13,2	3,8	9,6	**2010**	24,2	0,3	0,7	0,2	n.a.
2006	22,3	42,2	29,0	3,1	13,0	3,1	9,6	**2030**	34,1	2,8	2,7	0,8	n.a.
								2050	50,8	7,0	6,4	1,0	n.a.

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk-of-poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	12	19	12	6	20	19	21	13	3,7	**2005**	-
male	12	-	11	3	21	-	21	10	-	**2006**	14
femal	12	-	12	8	19	-	21	15	-	**2007**	10

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	13,5	13,2	12	14,3	**2000**	3,1	3,5	2,5	**2000**	13,8	14,3	13,2
2004	13,2	11,9	11,1	12,7	**2004**	2,7	2,8	2,6	**2004**	12,6	13,7	11,4
2007	13,9	11,9	10,8	12,9	**2007**	3,4	3,3	3,6	**2007**	10,9	12,5	9,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,97	1,04	0,93	***Aggregate replacement ratio***	0,58	0,6	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
5	13	13	DB/DC	/	-	100	/	26,5	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Malta

1. SITUATION AND KEY TRENDS

In 2007 the Maltese economy recorded a growth rate of 3.9%. And for the 2008 the GDP is estimated to a positive 2.1% also in front of emerged crises of the last months. In the context of the present challenging international economic conditions, and taking into account the specific domestic situation, in its Budget for 2009, the Government adopted a number of measures which aim to stimulate economic activity whilst at the same time addressing the challenges facing the Maltese economy, within the context of the renewed Lisbon Strategy. In fact the total employment rate has gradually increased (54.6% in 2007 compared to 53.9% of 2005), though below the EU average (65.8%). The female employment rate has shown only a modest increase (35.7% in 2007 compared to 34.9% in 2006) and to the employment rate of older people which has decreased from 30.8% in 2006 to 28.5% in 2007. More positive is the youth employment rate, which increased to 46% in 2007 from 44.7% in 2006, staying above the EU average. The unemployment rate remains relatively low compared to the EU average; after rising steadily it has fallen in the last two years, dropping to 6.4% in 2007. By contrast, the long-term unemployment rate (2.7% in 2007) remains below the EU average (3.1% in 2007).

Malta is expected to experience similar demographic trends as most other Member States, due to a currently falling fertility rate. Life expectancy at birth is 79.5 (2006) with 77 and 81.9 for men and women respectively. Healthy life expectancy was 69.1 for women and 68.1 for men in 2006. Infant mortality rate (6.5 for 1000 live births in 2007). The old-age dependency ratio for people 65+ years old (19.8% in 2008) is somewhat lower than the EU average of 25.4% and is projected to increase at the same pace as the EU as a whole (49.8% and 50.4% respectively by 2050), even if the data is quite stable with respect to 2006. Demographic trends indicate a slow gradual ageing of the population (in 2007 the population aged 80 years and over was about 3% of the total population and those aged 65-79 years old made up 10.8% of it) with life expectancy at 77 for men and 81.9 for women. The demographic ratio is also affected by the immigration increase (13877 in 2007 against 12000 in 2006, an increase of 13.6%). Irregular migration represents a major challenge for Malta, and has a strong bearing on the social situation. The early school-leavers rate remains by far the highest in the EU (37.3% in 2007), but is showing a remarkable downward trend (from 54.2% in 2000).

2. OVERALL STRATEGIC APPROACH

With the National Strategy Report (2008-2010) the Maltese Government has confirmed its commitment from the previous round to ensure adequate social protection and to consolidate social cohesion. As a result of the current crisis, Malta expects to have a negative impact on the most vulnerable groups of society. Therefore the short term strategy aims to maintain the rate of those experiencing risk of poverty stable at 14.2%, complemented by a medium-term goal to reduce the rate of people at risk of poverty and social exclusion below the present rate of 14.2%.

The report highlights that the main social policy challenge for Malta is to ensure more appropriate and sustainable approaches that sufficiently correct or compensate against social

imbalances and inequalities within an overall sustainable public budgeting process. The overarching objectives for socio-economic development and social protection/social inclusion are listed taking an approach based notably on the following pillars:

– Ensuring continuous investment in human capital, education and training.

– Providing social protection and support especially to those who are more vulnerable and in need of help.

The Report highlights employment as a key issue bridging economic and social development. In general, the strategy is focused on the key priorities and well explains that Malta is going through a comprehensive reform, marked by a shift from government provision to a growing emphasis on the responsibilities of the individual. Malta's employment strategy addresses in particular the need to increase access to employment through the introduction of more flexible forms of work, through the provision of services aimed at reconciling family and work and support of Education and Learning system. Beside active measures, the Maltese government intends to overhaul the interaction of taxes and benefits, to ensure a positive impact on the labour market.

However, the strategy report displays some general weaknesses. While the overarching objectives are listed, an adequate analysis is not provided. Synergies and linkages between the three strands (social inclusion, pensions and health care) are not sufficiently explained. The continuity with the previous plan could have been more adequately highlighted through providing more in-depth analysis of the shift in priorities and policy responses.

In the preparation of the Report an extensive involvement of other stakeholders has been ensured. As to gender, the strategy makes an important contribution to the promotion of women's participation in employment with comprehensive measures. Nevertheless, gender mainstreaming is missing from a number of measures related to access to services and to avoiding the risk of exclusion. The Report highlights the use of ESF to support labour market reintegration and social inclusion of vulnerable groups, as well as promoting youth and female employment. ESF also supports reform and capacity building in the public sector.

3. SOCIAL INCLUSION

3.1. Key trends

The at risk poverty rate in 2006 was standing around at 14%, just below the EU average (16%). The groups most exposed to poverty risk are children and people over 65, with a rate of around 19% and 21% respectively, around EU average for both rates. Moreover, single parents, the unemployed and persons in rented housing are also faced with higher risk of poverty.

The percentage of people living in jobless households was reduced to 7.7% in 2007, from 8.6% in 2004, whereas the EU average is around 9.3%. For children living in jobless households, the trend is quite negative (9.2% in 2007 respect to 8.2% of 2006), although the rate is closer to the EU-27 average (9.4% in 2007). The number of early school leavers strongly decreased in 2007(37.3%) from 41.7% in 2006, but it is still by far the highest in the EU.

In-work poverty risk for families with children is also high, which can be explained by a low number of two-earner families (two-adult households with 1, 2 and 3+ dependent children: 11%, 15% and 24%, respectively; EU-25: 12%, 14% and 24%, respectively). This problem is closely linked in particular to high female unemployment.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The 2006-2008 National Action Plan on Social Inclusion placed children and young people at the centre of policy formulation and implementation. In this context, important efforts to combat illiteracy and raise the general level of education have been made and significant progress has been achieved, which is also underpinned by the favourable trends in early school leaving. Similarly, youth and female employment rates have increased. The effectiveness of the welfare system has been improved. During the period between 2006 and 2008 various measures were adopted in the area of social inclusion and protection, such as:

– Amendments to the social security legislation,

– Initiatives aimed at consolidating family friendly measures,

– Reform in the children's allowance system,

– Measures to increase solidarity,

– Measures to enhance the well-being and social inclusion of persons with disability,

– Measures that spur people to work and improve their employability,

– Reform in the income taxation system, and

– Pension reform.

Notwithstanding the above, making work pay to bolster labour market activity, strengthening the fight against benefit fraud and aligning the social benefit and social security system more effectively with emerging needs remain important challenges for Malta.

3.3. Key challenges and priorities

The Maltese National Strategy identifies as main challenges for the programming next period:

– Tackling school absenteeism and pursuing the commitment to reduce educational underachievement;

– Increasing the overall employment rate, particularly through the inclusion of older workers, women and vulnerable groups within the labour market;

– Promoting greater availability of adequate and affordable housing;

– Combating the intergenerational transmission of poverty and social exclusion, especially for children and elderly people;

– Addressing the social aspects of migration and promoting equality and diversity; and

– Reforming the social protection system to ensure its sustainability, adequacy and comprehensiveness.

On the basis of the challenges, the following three priority policy objectives are established in the Report:

– Improving the social inclusion prospects of children and young persons;

– Promoting active inclusion; and

– Promoting equality of opportunities.

These three priority policy objectives are a fair choice because they reflect the main preoccupations of the Maltese population at present and build on those selected for the 2006-2008 NSRSPSI.

The strategy document is exhaustive in setting out the range of short and medium term solutions (especially for the subjects indicated above) to Malta's immediate problems, and take a multi-dimensional approach for tackling poverty and social exclusion. The document explains the procedures for implementation and the way in which the objectives are to be achieved. A number of quantified are targets are identified for the various policy objectives, most of which are rather ambitious.

3.4. Policy measures

The Plan reports some measures linked to the overall objectives.

Under the policy objective "*Improving the social inclusion prospects of children and young persons*" measures aim at combating the intergenerational transmission of poverty and social exclusion, particularly by promoting children and young persons' personal development, well-being, rights, interests and responsibilities. By way of example, interventions in the field personal development include continued reforms in the educational system, modernisation of schools and colleges, investment in education and ICT training, enhancing informal learning and active citizenship, consolidation of youth employment services offered by the Public Employment Services. The well-being of children will be improved through measures which increase the availability of adequate housing and improve child-care services and other services to families. Moreover, community mobilisation programmes regarding children's rights, and a review of the Juvenile justice system and youth policy are envisaged to safeguard the rights of children. Through the implementation of the above measures in this field Malta aims to reduce the risk of child poverty below 19% and increase the percentage of 20-24 year olds with upper-secondary qualifications and above to 70% by 2013.

Under policy objective "*Promoting active inclusion*" measures will be supported under all the three pillars of active inclusion: adequate income support, access to inclusive labour markets, access to quality services. For example at the moment, the unemployment subsidy can correspond to 72% of net minimum wage, but can reach 85% or even more in particular cases (married people with children). The impact of the benefit system on the access to the labour market is substantially connected with the phenomenon of undeclared work; some workers can be discouraged to enter into work by the opportunity to combine unemployment benefit with a non declared salary. However, the action plan does not relate a detailed indication by how adequate income support will be ensured. The Report lists a broad range of measures to promote equal access to training and employment for all. In relation to access to quality

services, great emphasis is placed on improving accessibility, affordability and quality of child-care services with a view to increasing work-life balance. Moreover measures aim ate reducing burdensome procedures to access social welfare services for all citizens. A series of rather ambitious targets are also identified. Malta aims to raise by the overall employment rate to 57%, female employment rate to 41% to 2013 and the employment rate of older workers to 35% by 2010. Other targets include reducing the long-term unemployed on active measures at any one time to 20%, increasing the number of adults in lifelong learning by 8% by 2013. The target of increasing the provision of formal childcare for children under 3 years to 15% by 2010, would imply significant progress, however, would still remain well below the Lisbon target of 33%. More specific targets are also set for training of public sector employees, percentage of households connected to broadband, and ICT literacy of the population.

Under policy objective "*Promoting equality of opportunity*" Malta aims to ensure full social participation irrespective of religion or belief, disability, age, gender or sexual orientation by combating discrimination, promoting the integration of third-country nationals, and the mainstreaming of social inclusion and anti-discrimination issues. Specific measures are aimed at increasing the employment rate and enhancing the well-being of disabled people, however, no concrete target is defined in this respect. Other measures include enacting legislation, promoting diversity by awareness raising campaigns and combating stereotypes. Another important target group for which specific measures are mentioned in the Report are third-country nationals, including asylum-seekers and refugees.

3.5. Governance

Following the Plan there was an extensive involvement of all the various actors and stakeholders in the preparation of the document from the earliest stage. The report provides a detailed overview of existing monitoring and evaluation arrangements, and briefly describes planned arrangements. Globally, the consultation process can be considered satisfactory although no detailed indications are provided on the involvement of social partners. It is positive that linkages with the use of Structural Funds are put in evidence.

4. PENSIONS

4.1. Key trends

As regards the challenge on the participation of older workers in the labour market, no progress can be registered. In fact, the employment rate of older workers has decreased. This entails an increased risk for exclusion of elderly citizens and an important impact on Pension system.

In Malta the Pension system is an earning-related mandatory system. It is called *two third pensions* because the initial benefits at the moment of retirement are calculated as two thirds of the average income of the best three years during the 10 last years prior to the retirement, after a contribution period of 30 years. For self- employed people the income averaging period is extended to the last 10 years. The contribution base is such that all income higher than 133 % of average annual earnings is not taken into account when calculating the pension entitlement. The full rent of a pension is payable to a person who has paid contributions over a 30 years period. Private pensions still do not form part of the obligatory pension framework. The measures adopted in 2007 and 2008 are focused to improve minimum incomes and to improve sustainability with measures to enhance flexibility and to change the retirement age

from the present 60 years for women and 61 years for men to 65 years for both men and women from 2015 to 2027.

The relative median income ratio for people aged 65 years and over is 0.79% in 2007 compared to EU average 0.84%; while the aggregate replacement ratio was 0.5 % in 2007, respect to EU -25 0.49%.

4.2. Key challenges and priorities

The main challenges of Maltese's system affordability and substitutability of the so called "two third pension" system in an environment where the share of ageing population is expected to rise; and where worrying examples as the decreased employment rate of older workers may be risk of exclusion for elderly citizens and an important impact on Pension system.

This will result a gradual increase in the share of expenditure on current pensions system in the Gross Domestic Product (GDP) from 7.3 in 1995 to 7.4% in 2004 and to 8.7% in 2010 and its projected that to peak at 9.1% in 2030 and will reduce to 7% in 2050.

Therefore Maltese Government Priorities to tackle these key issues are:

– To support and encourage extend working life;

– For increasing pension system awareness of the importance of personal savings that should be enhanced further. In particular the Pension Reform of March 2006 recognised the need of strengthening, in especially for public sector, the link between contributions and benefits;

– .To create the condition for a sustainable financial system of Pensions expenditures.

There is a need to boost the employment among women since their higher exposure to poverty and lower theoretical future replacement rates compared with men.

The Gross replacement rate for Malta in 2006 was 65 (79 for Net replacement rate). Change in Gross theoretical replacement rate is expected to take place as -17% between 2006 and 2046 (-21 for Net replacement rate).

In anyway it is not clear if 2007-2008 reforms are enough to guarantee adequacy and sustainability of the current pension system.

4.3. More people in work and working longer

To prevent early exit from the labour force, as Malta has the lowest effective labour market exists age, 58.5 years compared to 61.2 years average of EU, the operations of the Benefit Fraud and Investigation Directorate contributed indirectly in limiting the number of persons seeking to exit the labour market through fraudulent claims for social benefits

Also to enhance the flexibility of the labour market the government has adopted some measures as introducing a register of persons seeking part-time employment, granting the crediting of Social Security contribution to parents who temporally opt out of the labour market to care children and other measures to ease the burden of job to job transition on workers. In addition, in 2008, the capping of the National Minimum Wage on earnings from

pensioners under 65 years was removed, and such pensioners will no longer forfeit their right to a social security pension if their earnings from employment exceed the National Minimum Income capping. This initiative should encourage elderly persons to remain active in the labour market and help them maintain an adequate relative standard of living. A substantial number of persons have already benefited from this measure and the positive effects of this Budget 2008 measure will be evident in future measurements of the ARPRs. The change of the invalidity pension system will also remain a key target to ensure that people spend more time at work by reducing the number of invalidity Pension awards. The employment rate was 55.7% in 2007 compared to 54.8 % in 2006. The gender gap was around 37 % in 2007 as for men reached 74.2 % and for women 36.9 % and in 2006 this gender gap was around 40 % as for men was 74.5 % and for men 34.9 %.

Malta has implemented different measures to attract women into the labour market (also through the implementation of the new ESF programme), for example with fiscal measures such as tax credits returning to work and fiscal support for part-time workers. It will be crucial to step up these efforts: the employment rate for women with at least one child below 6 is the lowest in the EU while the rate for younger women, mainly before maternity, is above the EU average.. The government has also taken some initiatives to encourage older workers to re-integrate in the labour market, such as paying social security contributions in specific cases or pensioners to work without having their pension reduced.

4.4. Privately managed pension provision

The Government is considering introducing a mandatory second pillar scheme. The consultation document contained a large section on this issue. In fact with the green paper 2006 the Maltese government has proceed to consult the stakeholders and the social partners to introduce a second pillar scheme; but now it is not clear if it will be made in the future and in which conditions. However so far this has not been implemented, also because of the unfavourable economic conditions. During 2007 two provisions relating to out-of-court dispute resolution in the Markets in Financial Instruments Directive (2004/39/EC) were transposed in article 20, effectively extending the role of the Consumers complaints Manager beyond products and services falling under this directive. This will help engender positive perceptions towards private pensions.

4.5. Minimum income provision for older people

The issue of poverty of elderly people is about adequate pension provision, but it is also an issue of diversified income in old age. The at-risk-of- poverty rate of older people has raised because it was 21 % in 2006 and 16 % in 2005.The gender gap in 2006 was very low, 2 points, as for men reached 22 % and for women 20 %.

The national minimum pension was pegged against a minimum of 60 % of the median national equivalence income; and the retirees can now work and earn an unlimited amount without any reduction in their pensions. Further measures were introduced in the 2007 and 2008 budgets to improve adequacy of incomes as persons receiving severe disability pensions are now entitled to receive this pension up to five years after marriage to persons without any disability regardless of the income earned by the spouse,; the same period for widows and widowers who remarried, some tax has been removed in the inheritance of the residential home, the service pension (466 €) will be ignored in the calculation of the social Security pension, the 2008 budget adjusted the income tax bands in order that the lowest earners don’t

pay taxes, pension credits for children care and deduction for elderly care in private residential services.

Again the pension's reform launched in 2006 reform set a new maximum pensionable income up to 2013 when the MPI will be capped at a weighted average of wage growth and inflation rate

One of other measures in the 2008 budget led to the introduction of pensioners' entitlement to a cost of living increase (COLA) comparable to that of employed persons. In other words, previous two-third pension beneficiaries will be getting a full COLA, fixed at Lm1.50 (€3.49) in this budget year.

4.6. Information and transparency

Discussions on the subject of second Pillar pension scheme (SPPS) or Third Pillar Pension Scheme TPPS have been ongoing throughout the period 2006-2008 with the intention of roping in the major players in the are a of pension provision. The department of Social security has a well established network of district offices from which people can obtain information on the various pensions and benefits that they may be entitled too. This information process is also backed up by regular TV and radio call in programs where the audience can ask questions or participate in live discussions.

Given that The SPPS and the TPPS are still not formally introduced there is scope for more awareness and information campaigns.

The Consumer Complaint Unit (CCU) of the Malta Financial Services Authority (MFSA) is responsible for protecting consumer rights by providing, advice and information on financial services or related products. It performs this public duty very well by using various tools eg media campaign, chat shows on television and radio programmes.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

A National Health Service (NHS) provides free comprehensive public healthcare to all residents. Primary healthcare - PHC is provided in health centres by general practitioners (GPs), nurses and some specialised services. Following a referral, patients' access specialist and hospital care in public hospitals. The NHS is funded out of general taxation and cost-sharing applies to pharmaceuticals and some dental and optical care, all means-tested. 25% of the population purchases voluntary private health insurance to access private PHC and basic outpatient specialist care which co-exist with public services.

The Maltese Government, together with the country's main stakeholders, have recognised the need to enhance equity in access to care, promote quality and excellence and safeguard sustainability as the main priorities. Health inequalities are seen not only as a humanitarian cause but also leading to economic losses both in terms of lost productivity and higher health care expenses. Hence, the Directorate for Health Information and Research will be seeking to identify and map out existing epidemiological health inequalities in Malta.

Considerable progress has been registered since Malta's first involvement with the NSR process two years ago. One particularly important aspect of this progress is the effort made by Government to consult with a wide range of stakeholders on a variety of health issues, not merely those pertaining to the NSR. The next major challenge is translating policy into action.

The self perceived health rate is above the EU average, with an interesting spread between men (Very Good or Good together 72.7%) and women (66.2%).

5.1.2. Accessibility

Free comprehensive public healthcare (including preventive care) contributes to ensure access to all. This is coupled with means-tested entitlement (for low income household) to pharmaceuticals, dental and optical care, i.e. benefits that are excluded from the public healthcare basket. The additional long-term capacity will bring waiting times down by reducing the number of bed blockers. Extra capacity is to be coupled with an analysis of waiting lists and a new waiting list management system including waiting time targets, new agreements with doctors and longer ward hours. The Maltese Authorities have to ensure that their engagement to bring waiting time for interventions down to an acceptable level materialises. The Government wants to ensure fairer and more transparent prices for medicines, which includes a greater monitoring of prices and, an increase the use of generics. A pilot "pharmacy of your choice" scheme has been launched to enhance access to medicines. Several proposed e-health solutions (health portal, electronic patient record, phone counselling) should improve information to patients and patient flows through the system.

5.1.3. Quality

As promised in last year's report the new Mater Dei hospital now offer modern/latest medical equipment and ICT. The new cancer facility that is being planned will also incorporate these new developments. The 2008-2010 report also indicates that a number of quality services charters have been implemented. The Maltese Government stresses that the future Health Care and Mental Health bills, to be presented to Parliament, provide for far-reaching changes in the legislative framework of patients' rights and will ensure that uniform standards are applied throughout the system (public and private providers). Providers will be encouraged to set up systematic patient care protocols to enhance patient safety and clinical outcomes. Comparable indicators are seen as relevant to allow informed decision making. According to the authorities there is a large degree of patient choice and the above mentioned bill will further consolidate patient rights, responsibilities and representation within the system. It is hoped that this will also lead to a more sensible use of the system. The plan is to use population surveys to monitor satisfaction on the nature and quality of health services, and providers will be required to conduct an in-depth survey of the views of service users. The Maltese Government further expects that ICT and e-health solutions can improve coordination between PHC and secondary care and supply providers with better information. The Maltese Authorities are satisfied that the increasing immunisation rates will help to improve influenza and hepatitis B vaccination coverage.

A task force to be set up in 2009 will oversee the implementation of reforms in primary and community care. In the meantime the following measures will be undertaken:

– Health centres will be refurbished and equipped with the capability to treat minor emergencies. This will allow patients with minor injuries and ailments to be treated more

rapidly and will allow the emergency service at MDH to focus its resources on the more serious emergency and acute cases;

A central emergency call triage centre will be established. This will ensure better response times to emergency domiciliary care and streamlining of human resources required for home visiting.

5.1.4. Sustainability

– Total health care expenditure (8.4% of GDP in 2005) is under the EU average in GDP terms (9% in 2005). Ageing is seen as a challenge, resulting in an increasing demand for services, together with increased costs of medical devices and pharmaceuticals (also related to stricter quality requirements). Other issues (changing patterns of morbidity, increasing expectation of patients to be treated on the island and not referred abroad, cancer treatment, the costs for giving health treatment for immigrants, etc) add pressure on the Maltese National Health System which might impact on sustainability for an effective sustainable financial system. A central unit of financial management to monitor and control the financial management of the system has been set up within the public health sector.

The Government is not intending to take over the provision of primary health care from the private sector since the private community family doctor plays a vital role in the health system. Rather, the objective is to find a way of strengthening and supporting these doctors to develop into primary practices and teams with formal patient registration.

5.2. Long-term care

5.2.1. Description of the system

Services are provided by the State, the church and private/voluntary organisations. Complementing PHC and rehabilitation, the Department for the Care of the Elderly runs residential homes for the elderly (who pay a part of their annual income), a geriatric hospital, a home help service (e.g. household activities and shopping, meals-on-wheels, household maintenance) for a nominal charge but free for low income individuals, and the telecare/telephone system. The system is funded through taxation and income-linked co-payments. The church provides free residential care for the disabled. The private sector also provides home care and support. Government policy focuses on keeping people at home and in the community for as long as possible and on ensuring a healthier and more active elderly population.

5.2.2. Accessibility

The report recognises that an increasing demand for services and limited availability of institutional care in the public and church sectors have resulted in long waiting lists, whilst the private sector is only affordable to a segment of the population. Initiatives to enhance provision include increasing the numbers of public sector beds and contracting private beds. Authorities are focusing on enhancing the provision of community services such as day centres and adult learning centres. A legal framework for voluntary organisations has been enacted, supporting the role of NGOs in this field. A needs assessment for elderly people, especially those living in the community, is planned.

5.2.3. Quality

Legislation on quality standards is deemed rudimentary and is to be updated, and licensing and monitoring will be strengthened. Better coordination between levels of government and the church, the private sector and NGOs is being sought. A step-down facility was created to facilitate transition from acute to long-term care.

5.2.4. Long-term sustainability

The 2008 health and long term care expenditure projections foresee an increase of 1.8 percentage points of GDP to 2050 Authorities expect that a number of initiatives such as privately managed, state funded homes and support to family carers that maintain people at home will help to control costs and ensure an efficient use of resources. Training of human resources ranges from basic care skills to specialised professional training and is considered fundamental by the authorities. Thus, a manpower plan will focus on requirements of staff and their skill mix, as well as training and retraining for staff and carers. Specific promotion and prevention campaigns for the elderly are planned. The plan of Government is to increase the bed capacity accompanying by a concomitant expansion in skilled human resources, particularly carers.

6. CHALLENGES AHEAD

- To combat poverty among children and the elderly and break the intergenerational transmission of poverty and social exclusion and to tackle early school leaving and educational underachievement.

- To promote the inclusion of women, young people and vulnerable groups within the labour market and to address the social aspects of migration.

- To improve the sustainability and adequacy of pension system though higher female employment and longer working lives;

- To promote greater availability of adequate and affordable housing.

- To reduce waiting times for health and long-term care services, ensuring better reimbursement of medicines and enhancing the provision of long-term care services are priorities in the health and long-term care field, as the gap between life expectancy and healthy life years may indicate that more effective health promotion and disease prevention is needed.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	n.a.	83,6	**2000**	54,2	75,0	33,1	52,4	28,5	**2000**	6,7	6,4	7,4	13,7
2005	3,5	78,2	**2005**	53,9	73,8	33,7	45,3	30,8	**2005**	7,3	6,5	9,0	16,4
2008*f*	2,1	76,4	**2007**	54,6	72,9	35,7	46,0	28,5	**2007**	6,4	5,9	7,6	13,8

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,9	79,5	15,3	17,5	n.a.	n.a.	8,9	**1995**	n.a.	n.a.	n.a.		-
2000	76,2	80,3	15,2	18,5	n.a.	n.a.	5,9	**2000**	6,8	72,5	26,7	**2005**	1,6
2006	77,0	81,9	16,1	19,5	68,1	69,2	3,6	**2006****	8,4	77,4	20,2	**2006**	1,8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	16,1	50,2	27,6	2,3	12,8	2,4	4,7	**2004**	19,8	18,2	7,4	4,2	0,9
2000	16,9	50,5	29,3	2,6	9,4	2,4	5,9	**2010**	21,2	n.a.	1,3	0,3	0,0
2006	18,1	52,8	28,4	3,4	6,3	2,8	6,3	**2030**	39,1	n.a.	1,7	1,3	0,1
								2050	49,8	n.a.	-0,4	1,9	0,2

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	14	19	12	21	14	19	12	21	3.8	**2005**	14br
male	14	-	10	24	14		10	24	-	**2006**	11r
femal	15	-	14	18	15		14	18	-	**2007**	11

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	7,9	7,8	5,7	9,9	**2000**	4,4	4,5	4,2	**2000**	54,2	56,1	52,5
2004	9,2	8,6	6,8	10,4	**2004**	3,4	3,7	3	**2004**	42b	39.5b	44.2b
2007	9,2	7,7	6,2	9,3	**2007**	2,7	2,8	2,4	**2007**	37,3	32,9	41,1

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0.79	0.77	0.78	***Aggregate replacement ratio***	0.5	0.52	0.48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	Estimate of current (2002)	Assumption
-21	-17	-17	DB	/	-	n.a.	/	30	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

The Netherlands

1. SITUATION AND KEY TRENDS

After a prolonged stagnation during the first half of the decade, the Dutch economy has performed well during the last three years. Real GDP growth strengthened and outperformed the EU average in 2007 (3.5%; EU 2.9%). As a consequence of the global economic crisis, growth is currently slowing down and estimated to have reached 1.9% in 2008. In 2009, GDP growth is projected to contract by 2%, while light recovery is expected in 2010.

The Lisbon employment targets have been met (2007: overall 76%, older workers 50.9% and women 69.6%)[68]. While the female employment rate is significantly higher than the Lisbon target of 60%, the high incidence of part-time female employment gives a significant reduction in full-time equivalents from 69.6% to 44.4%. The unemployment rate fell to 3.2% in 2007, which is low compared to the EU average (7.1%). Due to the slackening of economic activity, unemployment is expected to rise rapidly (4.1% in 2009 and 5.5% in 2010). The youth unemployment rate (5.9%) is the lowest in the EU. The national target has been met: youth unemployment is not more than double the overall unemployment rate. Ethnic minorities are overrepresented among the unemployed in all age categories. At 1.3%, long-term unemployment is below the EU average (3%).

The at-risk-of-poverty rate before social transfers except old age and survivors benefits is 21%, while the overall poverty risk after social transfers is 10% (one of the lowest in the EU). The at-risk-of-poverty rate for children aged 0-17 years is 14%. Those most affected by poverty are members of non-Western ethnic minorities[69], single-parent families and households living on benefits other than pensions.

Life expectancy at birth was 77.7 years for men and 82 years for women in 2006: an increase of three years for men and one and a half years for women over the last decade. Healthy life expectancy remained fairly constant for men (61.7 years in 2003), but decreased from 62.1 years in 1995 to 58.8 years in 2003 for women[70]. The Netherlands is one of the Member States with the lowest old-age dependency ratio (20.7% in 2005). This ratio is projected to rise to 45.6% in 2050, but remains below the EU average (50.4%). The total public social expenditure on pension, health care, education and unemployment transfers is currently 20.9% of GDP.

2. OVERALL STRATEGIC APPROACH

The choice of priorities for the social inclusion part of the NRS is in line with the 2006 – 2008 report. The guiding principle of the Dutch government is that work is the best remedy against

---

68 The Dutch government has set a national employment target of 80% by 2016. The *Labour Participation Committee (Bakker Committee)* was established to come up with proposals for increasing participation and average hours worked. Its report, entitled *Towards a future that works*, was presented in June 2008

69 Members of non-Western ethnic minorities are people who have at least one parent who was born in Turkey, Africa, Latin-America or Asia (except Indonesia and Japan)

70 The decrease in healthy life years is mainly caused by an increase in unhealthy lifestyle among women (e.g. increase in smoking and alcohol abuse and an unhealthier diet)

poverty. The key emphasis in preventing long-term poverty is therefore placed on increasing participation through work acceptance and training. This means equipping people with the necessary skills and giving them the opportunity to engage in paid work or, if this is not feasible, in volunteer work. To increase effectiveness, priority has been given to preventing poverty and exclusion in future generations, e.g. by combating child poverty. In addition, the NSR includes measures to address the non-use of provisions and over-indebtedness.

Since in-work poverty is very low in the Netherlands, there is a clear link between inclusion and employment policy. Policy initiatives mentioned in the NRP aimed at increasing the overall education level, reducing early school leaving and (re)activation of vulnerable groups increase both employability and opportunities for social inclusion.

As previously, the number of targets for the mentioned priorities is limited and targets are mainly formulated in general terms. In the report, specific gender-related issues and attention to different target groups are only mentioned under the objective of promoting (labour) participation. An omission in the report is the lack of analysis of the relationship between the three policy areas. Also, the NSR does not mention to what extent the Structural Funds will contribute to achieving the national priority policy objectives.

3. SOCIAL INCLUSION

3.1. Key trends

10% of the Dutch population lives on a disposable income below the at-risk-of-poverty line. The at-risk-of-poverty threshold is an annual income of €10.924 for a one-person household and €22.941 for a household consisting of two adults with two dependent children. In-work-poverty risk after social transfers is low (4%), while unemployed persons face a high risk of poverty (27%). Unemployment traps remain high. Especially lone parents are affected: in 2007 they faced an income loss of 8.75% when accepting a job at minimum income level. In 2008 the situation improved for families with children when the tax discount for children was converted into a child allowance.

Despite progress in recent years, ethnic minorities continue to lag behind with respect to educational attainment, labour market performance and housing conditions. Due to the large number of flexible contracts among ethnic minorities, their unemployment rate is more volatile over the economic cycle. Their labour market performance is therefore projected to deteriorate with the current economic slowdown.

The youth education attainment level is below the EU average (76.2%; EU: 78.1%) and the EU benchmark of 85% by 2010. The situation is worse for boys (71.9%) than for girls (80.5%). Despite falling from 15.5% in 2000 to 12% in 2007, early school leaving is still far above the national target of 8% set for 2012. Ethnic minorities are overly represented among early school leavers. Also, the educational attainment gap between natives and non-Western ethnic minorities is high (2005: 53% against 67%). Early school leaving and low educational attainment are considered to be main causes of the low employment rates of non-Western ethnic minorities.

Despite an intense policy focus, low levels of literacy remain a severe problem. Although the number of 15 year-olds who are low-achievers in reading literacy is one of the lowest in the EU, their number has grown rapidly from 9.5% in 2000 to 15.1% in 2006. Also, it is

estimated that approximately 1.5 million people lack the necessary reading and writing skills to participate fully in society. Another concern is the relatively low participation of poorly-qualified and unemployed people in lifelong learning.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

For the period 2006-2008, the government put forward four policy objectives:

– Promote participation through employment, training and/or unpaid social activities;

– Combat poverty and promote participation among children and young people;

– Promote the use of existing provisions;

– Address over-indebtedness.

The 2008-2010 NSR gives detailed information on the progress towards the targets for these four policy objectives. For instance: the growth in employment picked up from 1.8% in 2006 to 2.6% in 2007. However, the report does not mention to what extent this progress can be attributed to the favourable economic situation. Two particularly noteworthy and unfavourable trends are the steep increase in the number of disabled young people (+17pp since 2004) and the increase in the number of applications for support in debt settlement.

Due to the election period, 2007 has been relatively quiet in terms of actual implementation of new policies affecting income and social inclusion. On the other hand, several measures have been or will be implemented in 2008 and 2009 to enhance the participation of under-represented groups in the labour market. These measures should help to meet the challenge put forward in the 2007 JR to promote integration of ethnic minorities, single parents and older people into the labour market.

The 2007 JR mentioned that it was disappointing that the NRS did not put forward any new policies for tackling inactivity and low-wage traps. The NSR 2008-2010 makes reference to the (planned) adaptation of several measures that should point financial incentives in the right direction.

The challenge to continue developing an adequate evaluation and monitoring framework for assessing the employment and social measures has still to be met. Since the government is not playing a central role in implementing social inclusion policy as part of a decentralising and deregulation operation, it is important to closely monitor developments in this area. According to the NSR, efforts are being made to synchronise existing data systems and reports so as to monitor targets and indicators for risk groups in mainstream employment and social measures. This should reduce the number of policy monitors by 25%.

3.3. Key challenges and priorities

The government has maintained the same four policy priority objectives as for the period 2006- 2008. These objectives reflect the current key trends and the challenges presented in the 2007 JR. However, the issue of adequate evaluation and monitoring of employment and social measures, identified as a challenge in the 2007 JR, is not addressed in the 2008-2010 NSR.

The selected priorities are relevant, although the focus is broad and objectives and outcome expectations could be made more specific. Since poverty was a growing problem during the last economic downturn, there is a need for vigilance with regard to the effects of the current economic crisis on the situation of the most vulnerable. The Netherlands was not confronted with the effects of the financial crisis until after the NSR was written, therefore possible difficulties in meeting policy objectives in view of the current economic downturn are not addressed.

3.4. Policy measures

The first priority is well elaborated: tailored policies are being developed to increase participation of various target groups. Under the policy of decentralisation, local governments are now primarily responsible for the re-integration and participation of disadvantaged groups. Although the number of benefit recipients has fallen by 19% since the introduction of the Social Assistance Act in 2004[71], municipalities have mainly been successful in helping those who are relatively easy to place. Evaluation shows that municipalities are not successful in re-integrating the hard core of long term benefit recipients. To make it easier for municipalities to pursue a more coherent participation policy, the existing budgets for re-integration, civic integration and adult education will be combined from 1 January 2009.

Specific programmes have been launched to increase the participation of target groups. For example, the government aims to help 50.000 migrant women find their way to voluntary or paid work by 2010, to guide an additional 200.000 people at the lower end of the labour market into work by 2011 and to realise 30.000 extra work-study programmes for unqualified young people. This is relevant given the disadvantaged status of these groups, but it is difficult to forecast the effects of these programmes.

To encourage people (especially women) to work – and work longer hours – the government announced a review of the 2005 Child Care Act and introduced fiscal measures, such as the phasing out of the transferability of the general tax credit. Estimates indicate that the full phase-out would have a significant impact on female participation. However, since the transition will take 15 years and there are several exemptions, this measure is insufficient for tackling the high marginal effective tax burden on second earners in the short run. Given the importance of increasing the labour supply, it is disappointing that transferability is not being eliminated more rapidly and without exemptions.

In the field of social inclusion of immigrants and ethnic minorities, policy measures focus on acquaintance with the Dutch language and culture and combating discrimination. The NSR highlights the importance of the Dutch integration policy in improving the social inclusion of immigrants. To better prepare immigrants, thereby also helping to prevent exclusion, the integration system has been drastically overhauled with the 2007 Civic Integration Act and the Deltaplan Inburgering (a master plan for integration).

Changes will be made to the Sheltered Employment Act (WSW) and the scheme for those Disabled from an Early Age (Wajong) to better assist people with disabilities, who are

[71] An important aspect of the Social Assistance Act is the change in funding of municipalities. Instead of claiming all welfare expenses directly from the central government, local governments get a fixed budget to cover all welfare expenses. The idea is that this will lead to a more efficient implementation of the welfare case load

capable of working, in finding a suitable job that enables them to work independently as far as possible. This could lead to better opportunities for re-integrating these people.

As regards the second priority, arrangements have been made with municipalities to combat poverty among children from poor backgrounds. From 2009 municipalities will have more scope for giving extra financial support to families that have been on a low income for several years. In addition, families on low incomes with school-going children will receive more assistance in the form of provisions, such as computers and sport club memberships. Because of the direct impact education has on the risk of poverty, there is a strong focus on preventing early school leaving. To encourage sustainable labour participation and prevent benefit dependency, youngsters between 18 and 27 will no longer be entitled to social assistance benefits. Municipalities are obliged to give young people applying for benefits a personal offer consisting of work and/or training.

The remaining two priorities are concerned with reducing the number of households at the minimum income level. With regard to preventing the non-use of income support, the government is continuing its existing policy measures, in line with the principle of individual responsibility: trying to reach beneficiaries through advertising, merging the databases of different institutions and simplifying application forms. To halve the number of people with problem debts in 2011, stricter rules on advertising will come into force for credit providers, plus higher fines for violation of those rules. Also, the government wants to improve the quality of debt relief assistance and to cut waiting lists. Although these measures could have favourable effects, the individual responsibility approach may be too one-sided to reduce the number of minimum income households.

3.5. Governance

There has been an extensive process of consultation for the preparation of the NSR which has involved, among others, municipalities, social partners, organisations in daily contact with the high poverty risk group (e.g. the municipal credit bank and social housing corporations), as well as NGOs and people from the high poverty risk groups themselves. The results of the consultation are summarised in the appendix of the NSR. The results are also visible throughout the report e.g. in the themes 'child poverty' and 'encouraging the use of income support'.

The civil society dialogue has resulted in agreements between the government and other stakeholders on the scope of NRS-related topics, e.g. in the areas of promoting participation, fighting illiteracy and dealing with problematic debts.

4. PENSIONS

4.1. Key trends

In the Netherlands, all residents from the age of 65 are entitled to a universal flat-rate public pension (AOW)[72]. In addition, around 90% of the active population is covered by supplementary occupational pensions. The third pillar of the Dutch pension system is relatively small and comprises individual, voluntary pension plans. In 2006, the first pillar

[72] Precondition for a full first pillar pension is to be a resident in the Netherlands without interruption between the age of 15 and 65. Non-residents who pay income tax in the Netherlands are also insured

accounted for 50% of total net retirement income and the second pillar for almost 40%. Although the relative importance of the secondary pension income is increasing, the first pillar will remain an important source of income for older people. In 2030, the AOW will still account for 44% of total net retirement income.

The contribution rate to the public pension scheme was 6.8% of GDP in 2004. This share is projected to decrease slightly over the next couple of decades, while public spending on pensions is expected to increase from 7.7% to 11.2% of GDP in 2050. According to ISG projections, the net theoretical replacement rates will increase with 8 percentage points between 2006 and 2046, reflecting the defined benefit design of statutory and occupational pensions in the Netherlands.

4.2. Key challenges and priorities

The 2007 JR acknowledged that the Dutch system ensures adequacy. It also highlighted two challenges: strengthening incentives for older workers to remain in the labour force and increased participation of women and part-time workers in occupational pension schemes.

The first pillar is financed according to the PAYG system; the ageing of the population has put pressure on this system of financing. The Dutch strategy for the first pillar relies on an ambitious goal of achieving budgetary surpluses over a long period, supported by intensified employment policies and discouraging early exits from the labour market. Recent reforms of tax law and regulations affecting early retirement have successfully raised the average exit age from 61.6 years in 2005 to 63.9 years in 2007. Nevertheless, the employment rate gap of 37 pp between the 55-59 age group and the 60-64 age group (EU average: 28.2 pp) demonstrates that older workers still make up a large proportion of the unused labour supply in the Netherlands. Therefore, in order to deal with the financial pressure of ageing, efforts should be continued to expand participation of older workers and to further delay the average exit age until at least the State pension age of 65 years.

No specific measures are taken to increase the participation of women and part time workers within the occupational pensions sphere. The NSR states that, since the Netherlands has strict regulations for equal treatment between men and women and between full time and part time workers as concerned company pension systems, this challenge will be automatically met by focussing on increasing labour market participation and average hours worked.

4.3. More people in work and working longer

The employment rate of people aged 55-64 has increased significantly in the past decade. However, beyond the age of 60 the participation rate is still low (31.1% in 2007). There are large gender differences: 80.4% of men aged 55-59 and 39.8% of men aged 60-64 still have a job, while the corresponding figures for women are 55.7% and 22.2%.

To bring about the necessary increase in the effective exit age, disability and unemployment benefits have been reformed to prevent these schemes from being used as early retirement routes. Also, the fiscal treatment of early retirement and pre-pension schemes has been changed. To further raise the effective exit age, new measures are to be introduced in 2009: employees who stay employed after the age of 62 will receive a bonus for each year they continue working and people will have the opportunity to voluntarily delay claiming their state pension. Delaying retirement benefits after the age of 65 years will be rewarded with a

higher pension later on[73]. Unfortunately, national studies show that it is unlikely that the proposed new financial incentives will successfully influence older worker's behaviour[74].

Even though life expectancy has increased by more than six years, the age of eligibility for a state pension has remained unchanged since the scheme was established in 1957. Increasing the retirement age in line with life expectancy would have favourable effects on labour market participation and fiscal sustainability. However, the government wants to avoid an increase in the state pension age.

4.4. Privately managed pension provision

Around 90% of the active population is covered by supplementary occupational pensions. The number of households above 65 years that receive a supplementary pension will rise from 84% in 2006 to 95% in 2030.

In recent years, many pension funds have switched from final-pay schemes to average-wage plans[75]. Nowadays the typical occupational pension contract comprises an average earnings defined benefit pension in which only nominal benefits are guaranteed, but with the intention of providing wage indexation. As from 2005 a number of large companies introduced a new type of pension scheme, the 'collective defined-contribution scheme (CDC)', mainly with a view to limiting the company's financial risks. With the introduction of these CDC schemes, the risk of poor investment performance is shared between the employers and the members of the scheme. If buffers are too low, contributions are adjusted or indexation will be lower (or zero) for pensioners and putative pensioners, making them poorer in real terms in their retirement.

Supplementary pension funds are supervised by the Dutch central bank. Every fund has to fulfil obligations regarding financial reserves and sound financial policies. The financial position of the Dutch pension funds has been significantly affected by the problems on the international financial markets. The coverage ratios of the funds have decreased and several funds dropped below the minimum threshold of 105% or even below the 100% coverage rate. As a result, it is expected that most pension funds will not fully grant indexation for 2009 and that contributions will be adjusted. Pension funds with a coverage ratio below 105% have to submit a recovery plan to the Dutch central bank.

The third pillar is relatively small and only accounts for 10% of retirement income. The role of the government in the third pillar is confined to providing a fiscal and legal framework. There are two main forms of insurance in the third pillar, annuity insurance and capital insurance. Since the majority of self-employed persons can not participate in a second pillar scheme, the government offers them fiscal opportunities to save for a pension provision in the third pillar. Recently there have been doubts about the sustainability of third pillar pensions, as insurers have been calculating excessive costs, which lower the profitability of these

---

73 It should be noted that workers are often not able to keep working after the age of 65. In most cases labour contracts legally end at 65 by collective agreement. In addition, the demand for workers over 65 is weak since firms must pay employees' wages during sickness absence for a period of up to two years. For workers over 65 they cannot insure against this risk

74 E.g. Netherlands Bureau for Economic Policy Analyses, *Effecten doorwerkbonus*, 17 October 2008.

75 National figures show that between 2002 and 2007 the share of all active participants covered by an average-wage scheme jumped from approximately 25% to 84.5%

pension schemes. Although this state of affairs is not the direct responsibility of the government, it may adversely affect the income position of pensioners.

Differences in income position among older people are mainly situated in the second pillar pensions. Women (especially older women) are lagging behind men with regard to pension accrual in the second pillar. National figures show that women aged 55 and above have entitlements to second pillar pensions that are 80% lower than those of men in the same age group. Entitlements of women aged 40-50 are 50% lower. The upward trend in pension accrual of women can mainly be explained by increased participation rates and finding better paid jobs.

4.5. Minimum income provision for older people

In the Netherlands a statutory guaranteed minimum pension income in the form of the first pillar pension (AOW) applies. The amount of AOW depends on the minimum wage and the development of this amount can be linked to the development of wages in collective labour agreements. Such an indexation occurred in the period 2005 – 2008. People who are not entitled to the full AOW benefit and who have, together with other sources of income, a total income below the subsistence level (less than 70% of the legal minimum wage) are entitled to receiving social assistance.

The Dutch pension system is efficient at coping with old age poverty. People aged 65 and above enjoyed a living standard close to that of the general population (86%) in 2005: this represented a slight decrease compared to 2004 (88%). In 2007, the at-risk-of-poverty rate after social transfers for older people (65 years and over) was 10%, which equals the risk of the 0-64 population. It is noteworthy that the poverty risk for older people increased during the last couple of years (5% in 2005), while it decreased for the 0-64 population (12% in 2005).

4.6. Information and transparency

A new Pension Act was introduced with effect from 1 January 2007. It aims to modernise the pension system and adapt it to new developments in the pension area. An important element is improving transparency. Therefore, the Pension Act contains extensive instructions on providing information about the content of pension schemes and the way the pension scheme is administered (including indexation). The distribution of responsibility within the triangular relationship of employees, employers and pension providers has been clarified. The new Pension Act also introduced a new supervisory framework for pension funds - the Financial Assessment Framework (FTK). To make information on pensions more accessible, a pension register where people can access up-to-date information on their pension situation will be made operational by 2011.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

In 2006 the government implemented radical reforms in the health insurance system. The dual-funded and partly compulsory system was replaced with a mandatory universal system operated by private health insurers. A key idea of the reforms is to increase efficiency by

promoting competition on the health insurance and health care provider market. These markets are supervised by the Dutch Care Authority (NZa).

To maintain solidarity, a mandatory basic insurance package is laid down by law for all citizens whereby health insurers are obliged to accept all applicants and to charge each applicant the same nominal premium for this basic package. The basic health insurance is financed primarily through nominal and income related premiums. The latter are redistributed according to a risk adjustment scheme that compensates health insurers for predictable differences in their medical expenditures. Additional private insurance can be purchased, but in such cases insurance companies can reject applications and the ban on premium differentiation does not apply.

A major aspect of the reform is the creation of a direct relationship between payment and care provided by hospitals. The diagnosis treatment combination (DBC) forms the basis of this new payment system: insurers pay a single price per case for the total care provided to one patient. This allows a better comparison of the price of treatments and enables insurers to improve their contractual arrangements with care providers[76].

The competition on the health insurance market is leading to mergers among insurers. At present, the Dutch health insurance market consists of four large concerns having a combined market share of around 90%[77]. Although larger insurers might be able to negotiate better conditions with health care providers, there is a danger that this will lead to greater market power and, hence, higher mark-ups. More recently, a large health care provider started negotiations with health care insurers to bring about a vertical merger. This can mitigate several types of inefficiencies, but it may also reduce competition in the market, e.g. if the vertical merger enables insurance companies to foreclose access of other insurers to the health care provider. Another issue that may impair the functioning of the health care market is the limited role of consumers. Due to the large information asymmetries, technical complexity and uncertainty about future needs, consumers are not able to make properly considered choices and, as a result, may not take sufficient care when it comes to switching insurers[78]. This brings the risks of reduced competition in the future.

5.1.2. Accessibility

The Netherlands has an accessible health care system. The compulsory basic insurance package includes essential curative care, for which premium differentiation is forbidden. The government pays the nominal premium for children up to the age of 18.

Although everyone is required to have insurance, approximately 1.5% of the Dutch population is not insured. In 2006, half of the uninsured were people in their twenties and thirties. First-generation migrants are far more likely to be uninsured (6.6%) than natives (0.8%), while second-generation migrants are only twice as likely to be uninsured (1.6%)[79].

---

[76] Currently free pricing is possible for approximately 20% of all the medical actions in hospitals. The aim is to further implement performance costing to about 33% in 2009

[77] In 2007 the health insurance market consisted of six large concerns and seven smaller companies.

[78] In 2006 about 19% of the insured changed their healthcare insurer (due to the premium war started by insurers); in 2007 this percentage was only about 4.5%

[79] People are first generation migrants if they and at least one of their parents were born abroad. Second generation migrants are persons who were born in the Netherlands and of whom at least one parent was born abroad. These definitions are not necessarily based on the principle of nationality, since people can obtain Dutch citizenship when at least one of their parents holds this at the time of birth

Some people have insurance but fail to pay their premium. Benefits recipients and migrants are overrepresented in the group of defaulters. People on low incomes can apply for a health care allowance.

Out of pocket payments apply to certain services but are limited. Until 2008 insured individuals could obtain a refund of the basic rate premium up to a standard fixed amount in the absence of claims for care during the preceding year. Since the chronically ill were disproportionately disadvantaged by the no-claim system, this no-claim scheme was replaced in 2008 by a compulsory excess of € 150 a year.

The percentage of people who said they did not receive necessary medical care was low in 2006 (0.4%). The self reported unmet need for medical care is highest for people on the lowest incomes (0.9%). While there may be minor differences in the quality of health care due to specialised institutions, there are no significant regional disparities. Waiting lists, which were seen as an unsatisfactory feature of the previous system, continue to exist, albeit at reduced levels.

5.1.3. Quality

Quality is safeguarded through supervision by the Health Care Inspectorate. Furthermore, the government has established three priorities to promote quality in health care (improving transparency and measurability, enhancing the influence of patients and clients and improving safety of care itself).

Primary health care is delivered mainly by general practitioners. They perform a 'gate-keeping' role for specialist and hospital care. Patients can choose and change their general practitioners at any time.

Personnel availability is a prerequisite for providing good quality and access to health care. It is projected that by 2020 there will be a shortfall of half a million care personnel. To tackle this expected labour shortage, the government will focus on increasing the inflow of new personnel, keeping existing personnel and enhancing innovation.

5.1.4. Sustainability

Total health care expenditure was 9.2% of GDP in 2005, which is slightly above the EU average. Total expenditure per capita was also above the EU average (3192 $PPP against 2454 $PPP). National figures indicate that the total costs of care have increased on average by 4.4% a year during the 2001-2006 period. Two notable cost increases occurred in 2006: in the freely negotiable part of hospital care, costs rose by about 12% and a new funding system gave rise to an unexpected increase in expenditure on general practice care of about 17%. The NSR does not reflect on these increases and the contradiction with the aim of the reforms in the health care system (namely creating incentives for the efficient use of resources).

The national report does not mention long-term sustainability as a challenge as such, and little attention is paid to the effects of ageing on the health care system. However, liberalisation of the health care purchasing market was introduced in order to address future sustainability problems. In addition, policy is focusing increasingly on prevention and on innovation to contain future health care costs.

5.2. Long-term care

5.2.1. Description of the system

The Exceptional Medical Expenses Act (AWBZ) is the national insurance for long-term care and high-cost treatments. It arranges the organisation and financing of long-term care for the elderly, the disabled and chronic psychiatric patients. On 1 January 2007 the Social Support Act (WMO) came into force. It transferred several responsibilities (e.g. home services and transport for elderly and disabled) to municipalities with a view to create a stronger local social support.

5.2.2. Accessibility

In order to receive care under AWBZ a valid statement of need from the Care Needs Assessment Centre (CIZ) is required. Within the framework of the WMO, the municipality is responsible for determining who is eligible to receive care and for providing these services. In most cases, personal contributions are required. These contributions are income-dependent and may differ from one municipality to another.

5.2.3. Quality

According to the NSR there are problems regarding the quality of long-term care and the position of the client in the health care system. Therefore, adjustments in the current organisation of the AWBZ are required.

Arrangements have been made with all long-term care sectors on methods of measuring responsible care. The government has developed instruments to measure the standard of the care provided by nursing homes and homes for the elderly and how that care is perceived by patients. Quality data for nursing, medical care and home care will become available in accordance with the quality framework of sound care ('*kwaliteitskader verantwoorde zorg*'). This should provide clients with more insight into the quality of care and allow them to make informed choices between care providers.

The person-related budget is another important scheme to encourage the freedom of choice for people who are dependent on care. Also, measures have been announced to create more freedom of choice and diversity in living, such as a further extension of the scheme making it possible to receive heavy care at home which is usually provided in an institution *('full home package'*).

5.2.4. Long-term sustainability

According to the NSR the manageability of the volume and cost development of the AWBZ is a serious problem. The main causes of this are the fact that the scope of care provided by the AWBZ has expanded enormously over the years, and the growing need for care due to ageing. To maintain sustainability and solidarity, the government aims at considerably improve the current scheme. In this regard, there are plans for several measures to cut expenditure by € 800 million by 2010. This involves, for instance, a better definition of the provisions in order to combat unintended and undesirable use. In addition, compulsory personal payments will be introduced for all AWBZ treatments. At the same time, € 2.5 billion will be invested in addressing the challenges of the AWBZ's core business over the next few years.

6. CHALLENGES AHEAD

- To continue efforts to improve educational attainment of young people so as to ensure that everyone enters working life with at least a minimum level of qualifications (including an acceptable level of Dutch language skills);

- To promote active inclusion into society and the labour market for the most vulnerable groups, in particular by further stimulating the labour market integration of ethnic minorities, young disabled, long term unemployed and single parents, tackling inactivity, addressing low wage traps and increase take-up of minimum income benefits;

- To ensure the quality of monitoring within the national objective to reduce the number of policy monitors by continuing the development of an adequate evaluation and monitoring framework for assessing the participation of, and outcomes for, at risk groups in employment and social measures;

- To continue efforts to increase participation of older workers and raise the effective exit age, and to continue pragmatic regulation of occupational pension schemes allowing stabilising mechanisms to operate fully;

- To monitor the medical, social and financial effects of the reforms of the health care system, especially the functioning of the health care markets. It is particularly important to monitor the impact of consolidation on competition and to address the large asymmetries on information and lack of transparency in order to increase the influence of consumers;

- To safeguard the quality of and access to long term care in the future by addressing shortages in the supply of personnel and by dealing with the growing lack of manageability of the long-term care budget (AWBZ).

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,9	134,3	**2000**	72,9	82,1	63,5	68,4	38,2	**2000**	2,8	2,2	3,6	5,7
2005	2,0	130,8	**2005**	73,2	79,9	66,4	65,2	46,1	**2005**	4,7	4,4	5,1	8,2
2008*f*	1,9	129,0	**2007**	76,0	82,2	69,6	68,4	50,9	**2007**	3,2	2,8	3,6	5,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,6	80,4	14,7	19,0	61,1	62,1	5,5	**1995**	8,3	71,0	n.a.		-
2000	75,5	80,5	15,3	19,2	61,4	60,2	5,1	**2000**	8,0	63,1	9,0	**2005**	0,5
2006	77,7	82,0	16,8	20,3	65.0b	63.2b	4,4	**2006**	9,3	64,9**	7.7**	**2006**	0,4

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	30,6	38,0	28,5	9,9	4,6	6,5	12,6	**2004**	21,8	20,9	7,7	6,1	0,5
2000	26,4	42,4	29,3	5,1	4,6	6,8	11,8	**2010**	22,8	-0,3	-0,1	0,2	0,0
2006	29.3p	41.4p	31.8p	5.0p	5.8p	7.5p	8.5p	**2030**	40,0	3,8	2,9	1,0	0,3
								2050	45,6	4,9	3,5	1,3	0,6

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	10	14	9	10	17p	18p	18p	10p	4,0p	**2005**	11
male	10	-	8	9	18p	-	22p	9p	-	**2006**	10
female	11	-	10	11	17p	-	18p	11p	-	**2007**	9

p: provisional

	People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	6,0	6,9	5,4	8,5	**2000**	0,6	0,5	0,7	**2000**	15,5	16,2	14,8
2004	7,0	8,0	6,7	9,3	**2004**	1,6	1,5	1,6	**2004**	14,0	16,1	11,9
2007	5,9	6,5	5,3	7,6	**2007**	1,3	1,2	1,4	**2007**	12,0	14,4	9,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,83	0,84	0,84	***Aggregate replacement ratio***	0,42	0,49	0,54

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
8	5	2	DB	4	DB	100	91	7	9,8	11,5-12,5

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Austria

1. SITUATION AND KEY TRENDS

Austria's macro-economic performance has been strong, with real GDP growth at 3.4% in 2007 above EU average. The employment rate has risen above the Lisbon target in 2007 (71.4% - women: 64.4%, men: 78.4%). The employment rate of older workers, however, remains well below the Lisbon target of 50% in spite of a steep increase from 31.8% in 2005 to 38.6% in 2007. The strong employment growth has brought the unemployment rate down from 5.5% in 2005 to 4.4% in 2007 and a projected 4.1% for 2008, after a sharp increase recorded up to 2005. Youth unemployment has also decreased over the last two years, but at 8.7% still almost doubles the overall unemployment rate. The long-term unemployment has remained stable at a low level (1.3% in 2007).

However, as a result of the global financial crisis, growth has started to slow down in 2008 and is expected to fall to -1.2% in 2009. As job creation will not be sufficient to match the growing labour force due to increased inflow of migrants and rising participation rates of women and older workers, unemployment is expected to increase again in 2009 and 2010.

According to the latest available data, reflecting the income situation of households in 2006, the at-risk of poverty rate stood at 12%, with a higher risk for women than for men (14% vs. 11%). Without social protection transfers the at-risk-of-poverty rate would be twice as high. Social protection expenditure, as a percentage of GDP, amounted to 27.6 % in 2005, slightly higher than EU average. Out of total expenditure, pensions account for 48.6%, health for 25.5%, and social inclusion for 1.5%. Austria is projected to face similar demographic trends as most EU Member States in the coming decades: the old-age dependency ratio is projected to increase steadily from 23.6 in 2005 to 50.7 by 2060. Life expectancy at birth has risen substantially in the last decade, reaching 77.2 years for men and 82.8 years for women in 2006, which is above EU average.

Among migrants, employment is considerably lower than among Austrians, with a particularly pronounced gender gap: the employment rate of foreign women stood at 53.3% in 2007, compared to 74.5% for men. Unemployment, on the other hand, is more than twice as high for foreigners than for Austrian nationals (9.5% in 2007). This is closely linked to considerable gaps in education levels. The share of early school leavers among migrants is almost three times higher than the overall rate. Migrants are also affected by the risk of poverty to a much higher extent than Austrian nationals.

2. OVERALL STRATEGIC APPROACH

The key objectives of the Austrian strategy for the years 2008 to 2010 with view to social inclusion are to offer all children and young people optimal opportunities for development, to improve the employability and labour market integration of disadvantaged groups, and to reduce monetary poverty through a means-tested guaranteed minimum income. Regarding the pension systems, the strategy aims to provide social cushioning and to strengthen the incentives in the pension system for longer working lives. In the health sector, Austrian policies focus on the integration of health care services based on sustainable funding, the development of a binding quality framework, and further improvements regarding the

accessibility and affordability of health care services. It is also a priority to enhance health promotion and prevention, as well as to improve care and support services for older people. Austria's social inclusion and social protection policies are closely linked to the Lisbon strategy for growth and jobs. Measures to fight poverty and to support integration into the labour market are considered an investment in the people as well as the national economy, as they decrease the burden on the federal government budget and promote growth through a larger labour supply.

While there is overall continuity with the 2006-2008 Strategy Report, the new report adopts a more multidimensional approach towards social inclusion, and places more emphasis on social aspects in the pension system. The aims are defined in rather general terms, while quantified targets and concrete indications of financial means are largely missing. Good governance has been reinforced through a substantial and transparent consultation process of wide range of stakeholders. Although equal opportunities for women and men are addressed by some specific measures, a gender perspective throughout the strategy is missing. The European Social Fund in Austria contributes to a large extent to the social inclusion strategy. It supports the integration of disadvantaged groups into employment and helps to develop new approaches to support those furthest from the labour market.

3. SOCIAL INCLUSION

3.1. Key trends

Being poor in Austria means living on 911€ per month or less. The risk of poverty and inequality of income remained below the EU average in 2007. While the at-risk-of poverty rate - at 12% in 2006- has remained relatively stable over the last years, it is expected to increase due to rising unemployment. The situation of people living on low income is likely to get worse due to prices rising faster than available incomes since mid 2007. As a result of high food and fuel prices, non-profit organisations assisting the poor report that their clients are increasingly dependent on their assistance for covering basic needs. The groups affected most severely by the risk of poverty are unemployed (42%), mainly female pensioners in one-person households (24%), migrants from non-EU/EFTA countries (26%), lone parents (31%), as well as persons with disabilities (18%). Moreover, 6% of people in gainful employment have incomes below the poverty threshold, i.e. can be considered as 'working poor'. The at-risk of poverty rate for children and young people under 18 stood at 15% in 2007, and there is still some way to go to reach Austria's target of 10% by 2016. The intensity of poverty is less severe in Austria than on EU average, i.e. the gap between the median income of the poor and the poverty threshold is less pronounced (17% vs. EU average of 22% in 2007). Austria's performance regarding low educational attainment, which increases the risk of poverty substantially, has deteriorated over the last years. The percentage of low-achieving 15-year-olds in reading literacy went up steeply from 14.6% in 2000 to 21.5% in 2006, which is above EU average. The rate of early school leavers has also increased over the last years, to reach 10.9% in 2007, while the trend has been positive in the EU overall. The early school leaving rate is particularly high among migrants (28.9% in 2007), whose education outcomes do not significantly improve in the second generation.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Overall, Austria has succeeded in implementing the priorities in the field of social inclusion identified in the 2006-2008 National Strategy Report as planned, with the exception of the means-tested minimum income. Opportunities for disadvantaged children and youth have been improved, in particular through a new scheme to identify and address German language deficits of pre-school children, the reduction of class sizes and a guarantee for young people to get a vocational education. Furthermore, counselling and support for families in crisis situations as well as reintegration of young delinquents were part of the strategy. Progress was also made regarding the employment participation of individuals furthest from the labour market and social inclusion of individuals with disabilities, thanks to increased national funds for active labour market measures and some innovative projects.

The 2007 Joint Report on Social Protection and Social Inclusion identified the intergenerational transmission of poverty as a major challenge. While the above-mentioned measures in favour of children and youth are important steps in the right direction, continued and enhanced efforts are necessary to improve education outcomes of vulnerable youth.

Furthermore, the 2007 Joint Report also referred to the active inclusion of women, especially of single mothers, older female workers and pensioners. Considerable progress was achieved by the introduction of a minimum wage through collective agreements, the implementation of social security coverage for a-typical employment, the flexibilisation of the child care allowance facilitating a faster re-integration into the labour market, and the allocation of additional funds for child care facilities. However, further measures seem warranted to reduce the high poverty risk of single mothers and female pensioners. Minimum wages remain to be implemented in contracts not covered by collective agreements. The lack of child care facilities, as well as after school care facilities for the 6-14-year olds needs to be further addressed. Furthermore, it would be important to adopt a comprehensive approach aiming at improving career opportunities and incomes for women, including improved availability of qualified part-time jobs and counselling for young women with regard to career choices.

3.3. Key challenges and priorities

Austria's priorities for social inclusion policies are to enhance development opportunities for children and young people; to improve employability and labour market integration; to implement a means-tested guaranteed minimum income. These priorities are largely a continuation from the previous National Action Plan on Social Inclusion. The additional priority on integrated measures in other policy areas expresses a more comprehensive approach to address the multi-dimensionality of poverty and social exclusion. While the defined priorities are all very relevant, the strategy could further benefit from complementing the universal approach by additional targeted measures to combat poverty and social exclusion of vulnerable groups, most notably of lone parents and individuals with a migrant background. Also, against the background of high inflation, it might be relevant to consider not only income but also consumption poverty.

3.4. Policy measures

Policy measures targeting children and young people aim at reducing child poverty to 10% by 2016, from the current 15%. They are mainly a continuation of previously launched initiatives. A new measure is the launch of a pilot project for a common school for all 10-14-

year old. This is a relevant step to break the links between educational opportunities and socio-economic background; although concrete plans beyond the pilot phase 2008/09 are missing. Some new measures are foreseen to improve the quality of education for pupils with special needs. It would also be important to enhance non-formal education as a tool for social inclusion of young people.

With a view to fostering labour market integration, active labour market measures will be implemented for the long-term unemployed, recipients of social assistance, older workers (55+years), women, people with disabilities, persons with a migration background and the low qualified. The increased level of funding for measures of the Public Employment Service since 2006 will be continued beyond 2008. The effectiveness of the active labour market measures could benefit from a more integrated approach for particularly disadvantaged groups, involving cooperation with organisations specialised in providing targeted support for those groups.

Another priority of the Austrian strategy is to implement the recently launched means-tested minimum income, with the aim of making the current social assistance scheme more effective for the prevention of poverty. The currently relatively high non-take-up rate shall be reduced, and social assistance recipients shall benefit from active labour market measures implemented by the Public Employment Service. Although the minimum income has been fixed just below the poverty threshold, this new scheme has the potential to make a substantial contribution to reducing poverty, and it should therefore be a priority to implement it. Important challenges will be to provide the necessary additional resources for the Public Employment Service, including appropriately qualified staff, and to ensure a coherent approach for the labour market integration of unemployed persons and of social assistance recipients.

Integrative measures in other policy areas comprise social housing, assistance to homeless people, facilitation of cultural participation for low-income earners, as well as disability equality legislation and the support to victims of violence. Some measures in support of migrants, refugees and asylum seekers are also included, but a more comprehensive and far-reaching approach to foster their social inclusion is warranted. The strategy also addresses over indebtedness, which is a newly emerging problem in Austria, having increased steeply over the last years. In all these areas, it will be important to ensure adequate regional availability of social services.

3.5. Governance

Governance has been strengthened in the preparation of this year's Strategy Report through a substantial consultation process with a wide range of stakeholders. Transparency was ensured by the publication of all comments on the website of the Federal Ministry of Social Affairs and Consumer Protection. It would be important to continue with this approach also in the future. Moreover, there is a long-standing tradition of social partners' active involvement in the full policy cycle, in which NGOs are, however, less involved. Provisions for monitoring have been strengthened by the development of additional national indicators for social inclusion, but a comprehensive evaluation scheme is missing.

4. PENSIONS

4.1. Key trends

Pensions in Austria are based on a statutory pension system with defined benefits, which is organised on a pay-as-you-go basis. In 2007, older people (60+) enjoyed a living standard very close to that of the general population (93% relative median income ratio and aggregate replacement ratio of 0.61%, both well above the EU25 average). However, the poverty risk among older people (14%) is slightly higher than for the population below the age of 65, and most importantly, it shows significant gender differences (10% for men, 18% for women).

The pension system underwent important structural reforms in the years 2000, 2003 and 2004. These reforms have helped to improve long-term financial sustainability, although they have long transition periods. They foresee that the retirement age for women will gradually be increased to equal the retirement age for men, i.e. from the current 60 years to 65 years between 2024 and 2033, the annual accrual rate will be reduced stepwise from 2% in 2003 to 1.78% by 2009, and the assessment period will be increased to life-time earnings (from the best 15 years) by 2028. At the same time, a loss limit of 10% for pension entitlements gained from the unreformed system was introduced. The pension system was harmonised through the introduction of a uniform pension law for all professions, pension benefits were indexed to consumer prices and the link between contributions and benefits was strengthened. Early retirements due to reduced capacity to work and due to unemployment were abolished. A "bonus-malus" system for deferred and early retirement was introduced, which was however weakened by the reduction of the discount rate for early retirement from 4.2% to 2.1% in 2007, a very low rate by international comparison. For persons whose first pension contributions start after 1st January 2005, and for invalidity pensioners, the discount rate for each year of early retirement remains at 4.2%. Early retirement is still possible on the grounds of disability, of long-term insurance contributions (45 years for men, 40 years for women), and of physically hard work. Furthermore, a sustainability factor was in discussion, which was intended to function as a mechanism for adjustment of the system to longer life expectancy.

4.2. Key challenges and priorities

In its 2006 Sustainability Report, the European Commission assessed Austria as a low-risk Member State as regards the sustainability of public finances. According to the 2005 projections of the working group on ageing populations of the Economic Policy Committee, Austria is expected to face low pressure on its public finances from an ageing population. While Austria's spending on public pensions is currently among the highest in the EU, it is projected to decrease from 13.4% in 2004 to 12.2% in 2050. However, forecasts on pension expenditure are based on relatively optimistic assumptions and do not include expenditures for the so-called "equalisation supplement", a top-up payment for pensions below the minimum income level, nor expenditures on public subsidies to the voluntary, private funded pillar. This might entail unforeseen increases in future pension expenditure. The level of pensions is projected to remain on a relatively high level over the medium term, but will have to be closely monitored.

The main challenge for Austria, as identified in the 2007 Joint Report on Social Protection and Inclusion, is to ensure both the adequacy and sustainability of future pensions by significantly increasing the employment of older workers. While the employment of older workers has been a focus of active labour market policies, there has been limited progress in

further strengthening incentives to work longer in the pension system. Moreover, respective plans are missing in the Strategy Report 2008-2010. Recent measures, such as the reduction of discount rates for early retirement and the prolongation of early retirement due to long insurance contributions give the wrong signals. The mechanism for adjustment of the system to longer life expectancy has been subject to revision and it is not yet clear if and how it will be implemented.

The high poverty risk of female pensioners remains another important challenge. Significantly lower life-time earnings, combined with the fact that the 2004 reform foresees a very long transitory period for women's retirement age to be raised to the same as that of men (from 60 to 65 years), imply that pension outcomes for women will still lag behind in coming decades.

4.3. More people in work and working longer

The employment rate of older workers aged 55-64 years stands at 38.6% in 2007, well below the EU average of 44.7%, although it has been on a steep increase over the last years. Unemployment among older people is relatively low (3% for 50+ years in 2007). The effective retirement age has hardly increased since the start of the pension reforms in 2000. It was 59 years for men and 56.9 years for women in 2006, remaining well below the statutory retirement age (currently 65 years for men and 60 years for women). There has been a decrease in early exits from the labour market as consequence of the pension reforms, but 72% of all new pensions were still below the statutory retirement age in 2007. The abolition of early retirement due to reduced capacity to work in the year 2000 was to some degree de facto substituted by the instrument of invalidity pensions. These accounted for approximately 35% of yearly access to pensions in 2007. Invalidity pensions can not generally be considered an "easy going" early exit from the labour market, as life expectancy at the age of 60 of persons in invalidity pension is lower than life expectancy of people in normal direct old-age pension (4 years for men and 3 years for women). There is, however, scope for reforming the disability pension scheme, notably by enhancing health prevention at the work place. A working group has already developed proposals for a reform, and the Strategy Report announces plans to develop prevention and health care at all levels.

4.4. Privately managed pension provision

Private pensions are still much less important in quantitative terms in Austria than the public pay-as-you-go system, although their volumes have increased rapidly in recent years. The coverage of all dependent employees by occupational schemes has reached 15% in 2008, while the importance of the staff provision scheme introduced in 2003 (new severance pay scheme) seems to remain limited with view to old-age provision. This scheme is based on the legal obligation for employers to pay monthly contributions for each employee to a staff provision fund set up especially for this purpose. Employees have the option to withdraw their savings in case of termination of a work contract (if specific preconditions are fulfilled) or keep them until retirement age. The latter option, however, does not seem to be widely used at the moment. The number of individuals acquiring rights to draw pensions from private funds is increasing, however, mainly among those with higher incomes and education levels. An important incentive is the public subsidy available since early 2003 for the premium-aided pension savings scheme. In 2006, 15.3% of the population under 60 had a contract in the framework of this scheme.

4.5. Minimum income provision for older people

A means-tested minimum pension is available in Austria for individuals who are entitled to old-age pension. Although minimum pensions have been increased over-proportionally in the last years, they still remain below the poverty threshold. Persons without individual or derived pension entitlements can claim means-tested social assistance benefits administered by the federal states, which are also below the at-risk-of poverty threshold in most cases. The poverty risk of older people (65+) is higher than for the overall population, affecting women in particular (18% vs. 12% overall), although the gap between available income and the poverty threshold is relatively low (13% vs. 15% overall). Pensions for the disabled are also very low on average. The means-tested minimum income – if implemented as planned- will create a universal means-tested minimum pension, which would be an important improvement for older people without any pension entitlements. If raised slightly to the poverty threshold, it could substantially reduce the at-risk-of poverty rate for older people.

4.6. Information and transparency

Although information on the statutory pension system is generally available, transparency could be further enhanced. Gradual and stepwise implementation of reforms adopted in 2004 and 2005, exceptional rules, rules on capping of losses, long transition periods and "parallel accounts" in the old and the new system, contravene the aim of transparency, originally intended when introducing "personal accounts" in 2005. Regarding the second and third pillar, there is a considerable lack of information.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The overall architecture of the Austrian health care system is a rather complex and fragmented one, entailing a decentralisation of powers and multiple financing instruments. The federal government is responsible for the health care system, with the important exception of hospital care. As far as the latter is concerned, the federal government only has the competence for general legislation, whereas implementation and enforcement are under the responsibility of the provinces (*Länder*). 46% of health care expenditure is financed by compulsory social health insurance, 30% by tax revenue and 24% by private households, including financing by supplementary private health insurance. Health services are provided by regional government-owned, private non-profit and private organisations or self-employed health professionals. The Austrian system is characterised by a relatively high use of resources, regarding both medical doctors and technical equipment, and a large hospital sector in international comparison. Austria had 6.1 acute care hospital beds per 1.000 population in 2006 compared with an OECD average of 3.9. The hospital admission rate is also relatively high (27.3% vs. EU average of 18.3% in 2005). In 2005, a major reform of the Austrian health care system was launched. Given the substantial structural changes it involves, this reform is still in the state of gradual implementation. Its objectives, which are confirmed in the 2008-2010 Strategy Report, are integrated planning, management and financing of the entire health system; assuring and improving quality in the health system throughout Austria; ensuring the long-term financial sustainability of the health system through measures curbing costs and boosting efficiency.

Life expectancy of 79.9 years in Austria is above EU average, having increased substantially over the last decades. Infant mortality has been decreasing and is below EU average. There are, however, significant socio-economic differences in health status and life expectancy.

5.1.2. Accessibility

The Austrian health system is characterized by an easy and generally equal access to all medical and therapeutic services, although social and regional inequalities in health status exist. The social health insurance, which is organised as a compulsory insurance, is the core of the system. It covers around 98.5% of the Austrian population. Individuals without insurance may have access to health care services via means-tested social assistance. However, continued efforts are necessary to ensure equality between social assistance recipients and persons covered by compulsory insurance. Apart from patients' co-payments applicable in a few insurance funds, prescription charges for pharmaceuticals, and a relatively low daily co-payment to hospital care (up to a maximum of 28 days per year), the social health insurance provides free access to health services. In addition to existing exemptions, a new ceiling was introduced to prescription charges for patients suffering from chronic diseases or several diseases, notably 2% of the patients' income. Thanks to adequate staffing levels and equipment, there are no substantial waiting times or waiting lists for medical services in general. Waiting times do, however, exist for certain non-emergency surgeries. Supplementary private health insurance is mainly used to obtain better hospital accommodation and the doctor of one's choice, as well as to shorten the above-mentioned waiting times. The Austrian Strategy report identifies the need for additional measures to gradually remove the existing health inequalities of the Austrian population, in particular between eastern and western parts of the country. In some provinces, efforts are stepped up to improve the situation of individuals with a migrant background.

5.1.3. Quality

Several legal provisions adopted as a result of the 2005 health care reform have strengthened the framework for mandatory quality work in the Austrian health system. They aim at reducing the regional and sectoral disparities in the quality and availability of health care and at improving the overall quality of health care in Austria. The establishment of the Federal Institute for Quality in the Health System in 2007 has been a decisive structural improvement, although its real impact will only show in the years to come. The nation-wide implementation of quality guidelines developed at central level will remain a major challenge. It will also be important to ensure the best possible 'care path' from the patients' perspective (and not the institutions' perspective) involving smooth transitions between different types of care (hospital vs. outpatient care, health care vs. long-term care). The empowerment of patients is to be supported by setting clear standards. Initiatives to use evidence-based medicine and health technology assessment have been increasing in Austria over the last years. Furthermore, a number of initiatives were taken in the last years to strengthen health promotion and prevention in a system which has traditionally emphasised curative medicine. It will be important to implement the newly developed strategies and pilot projects on a wider scale.

5.1.4. Sustainability

Total expenditure on health care including long-term care rose from 8.4% of GDP in 1991 to 10.3% in 2004. Since then, it decreased slightly to 10.1% in 2006, which is still among the highest levels in the EU. Public health expenditure corresponded to 76.2% of total

expenditure in 2006. The public share increased during the 1990's, but has been largely stable since 2000. According to the 2006 forecasts by the Economic Policy Committee and the European Commission, the share of GDP dedicated to public spending on health and long-term care is projected to increase by 1.5 percentage points over the period 2005 to 2050, while the OECD forecasts an even higher rise (2007). Reasons for the long-term increase in expenditure on health are to be found, as in many other countries, in demographic factors, technical developments in the health sector and rising price of health care. Irrespective of these long-term projections, it is also a challenge to safeguard the short-term financial viability of the social health insurance funds, some of which already have substantial deficits. Progress in implementing the planned measures to improve efficiency, including the intended further shift from inpatient to outpatient care, has been slow, although some pilot projects of integrated care (e.g. for diabetes) were implemented and small outpatient centres were introduced. Measures to contain the cost of pharmaceuticals have not had any long-term effect, and no concrete new initiatives are announced in the Strategy report. The main challenge remains to ensure integrated and efficient planning, monitoring and financing within a complex system of financing mechanisms and competences split between federal and regional level.

5.2. Long-term care

5.2.1. Description of the system

The Austrian system for long-term care has two main components: the universal needs compliant long-term care benefit (introduced in 1993) and ambulatory, outpatient, semi-outpatient and inpatient care services organised by the *Länder*. Up to 80% of people in need of long-term care are cared for in their own homes by family members, specific outpatient services or by privately engaged carers. At present, around 5% of the Austrian population receive long-term care benefits. A working group has been established to tackle a number of issues which remain challenges for the future: long-term financing, adaptation of care benefits, and a further expansion and improvement of social services.

5.2.2. Accessibility

All individuals in need of long-term care, are legally entitled to a care benefit irrespective of income or wealth, which is calculated on the basis of the actual care need. In addition, they have access to social services, for which financial contributions have to be paid according to the financial situation of the beneficiary. Institutional care is predominantly provided by provinces and municipalities, or by religious and other non-profit organisations. Home-care services are provided by non-profit organisations or by private carers. A major step taken to safeguard access to long-term care has been the creation of a legal framework for 24-hour care at home and the introduction of an additional benefit to cover extra costs arising from social insurance coverage of the - now legally employed - care staff. These new provisions are an important improvement, although they only affect a relatively small number of persons with care needs. Care services in general have not yet been sufficiently expanded to eliminate the marked regional differences in availability, and the need for new flexible models for ambulant and semi-ambulant care has not yet been addressed.

5.2.3. Quality

In the last years, efforts to enhance quality in long-term care were continued. With the harmonisation of social care professions (implementation finalized in 2008) and the

introduction of a uniform job profile for "home helpers", a major challenge concerning the provision of qualified care staff has been addressed. Measures to support care-giving family members include the expansion of a scheme of home visits through qualified nursing staff to provide information and counselling, subsidies for substitute care, and improvements regarding social security coverage. It will, however, be important to further strengthen support to informal carers and to ensure the quality of informal care. Evaluations to monitor the impact of the measures and further research into regional and sectoral inequalities are likewise needed.

5.2.4. Long-term sustainability

According to the 2006 projections by the Economic Policy Committee and the European Commission, public long-term care expenditure is projected to increase by 0.9 percentage points of GDP by 2050 due to population ageing. Expenditures include those for benefits in kind in the social services sector, as well as cash benefits. Both are covered from the budgets of the Republic of Austria, the *Länder* and – to a minor extent- the local authorities, and not through social insurance. A major challenge for the financing of long-term care lies in demographic developments leading to an increased need for care services. New strategies are therefore needed to ensure long-term financial sustainability. A working group has been established to develop proposals as a basis for future political decisions.

6. CHALLENGES AHEAD

- To further reinforce efforts to break the intergenerational transmission of poverty; in this context enhance education opportunities and outcomes for vulnerable youth;

- To enhance efforts to reduce the above-average risk of poverty for women, in particular single mothers and pensioners, as well as for migrants. To this purpose, reinforce measures to improve life-time earnings of women, enhance the reconciliation of family and work, and raise the retirement age for women. Furthermore, a more forceful and comprehensive approach aiming at fostering the social inclusion of migrants is needed;

- To ensure both the adequacy and sustainability of future pensions by significantly increasing the employment of older workers;

- To quickly re-establish the financial viability of the health insurance funds and to also ensure the long-term financial sustainability of health care by improving efficiency, notably through a stronger integration of health care planning and financing, a shift of priority from hospital to outpatient care and enhanced health promotion and prevention. It will also be important to contain the increasing costs of pharmaceuticals;

- To continue to develop quality standards for health and long-term care and ensure nation-wide implementation;

- To further improve the access to information, guidance and training for informal (family) carers and develop strategies to address the increasing need for professional care staff.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,7	131,4	**2000**	68,5	77,3	59,6	52,4	18,8	**2000**	3,6	3,1	4,3	5,3
2005	2,9	124,8	**2005**	68,6	75,4	62,0	53,1	31,8	**2005**	5,2	4,9	5,5	10,3
2008*f*	1,7	121,5	**2007**	71,4	78,4	64,4	55,5	38,6	**2007**	4,4	3,9	5,0	8,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	73,3	79,9	14,9	18,6	60,0	n.a.	5,4	**1995**	9,7	72,6	17,0		-
2000	75,1	81,1	16,0	10,4	64,6	68,0	4,8	**2000**	9,9	75,8	16,8	**2005**	0,5
2006	77,2	82,8	17,3	20,7	58.4b	60.8b	3,7	**2006**	10,1	76,2	16,5	**2006**	0,5

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	28,8	46,3	25,6	5,8	11,3	1,4	9,7	**2004**	25,4	25,4	13,4	5,3	0,6
2000	28,4	48,0	25,6	4,9	10,8	1,1	9,7	**2010**	26,0	-1,0	-0,6	0,2	0,1
2006	28,5	48,6	25,5	5,8	10,4	1,5	8,2	**2030**	38,1	0,8	0,6	1,0	0,4
								2050	48,3	0,1	-1,2	1,5	0,9

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	12	15	11	14	17	19	21	12	**3,8**	**2005**	12
male	11	-	9	10	19	-	23	12	-	**2006**	13
femal	13	-	12	18	16	-	20	12		**2007**	13

	People living in jobless households					Long Term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	4,1	7,9	6,2	9,6	**2000**	1	0,9	1,2	**2000**	10,2	10,7	9,6
2004	5.6 i	8.8 i	7.6 i	10.0 i	**2004**	1.3 b	1.3 b	1.4 b	**2004**	8.7 i	9.5 i	7.9 i
2007	5,3	7,1	5,9	8,4	**2007**	1,2	1	1,4	**2007**	10,9	10,2	11,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,93	0,98	0,91	***Aggregate replacement ratio***	0,61	0,62	0,68

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
5	1	1	DB	/	-	100	/	22,8	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Poland

1. SITUATION AND KEY TRENDS

Economic growth reached 6.7% in 2007 but is projected to slow down to around 5% in 2008. High GDP growth positively influenced the labour market and has helped reduce poverty. Employment rate grew to 57% in 2007, but is still one of the lowest in EU, particularly for women aged 15-64 (50.6%). Employment growth is projected to slow down significantly over the next two years. The unemployment rate fell by over 4 percentage points since 2006, and reached 9.6% in 2007 (9% for men and 10.4% for women). The reduction of unemployment over the last few years refers particularly to women (19.1% in 2005 and 10.4% in 2007) and young people (36.9% in 2005 and 21.7% in 2007), but still remains high in relation to the EU averages. Although the unemployment in 2008 tends to decrease, it is expected that over 2009-2010 will increase and reach 9.6%.

At 17%, the at-risk-of-poverty rate fell from 21% in 2004, but still continues to be above the EU average (16%). Children are particularly affected by poverty (24%), although the rate has decreased by 5 p. p. since 2004; by contrast the poverty rate of older people at 8% is one of the lowest in the EU (6% for men and 9% for women). Total social expenditure reached 19.2% of GDP in 2006, with 61.2% of expenditure related to pensions, 20.4% to healthcare, and 9.3% to disability. Only 1.8% was spent on housing and tackling social exclusion, but there has been increase since 2000 (1.5%). The age-related expenditure is forecast to decrease by over 6 p. p. until 2050.

Between 2005 and 2006, life expectancy at birth slightly increased (70.9 years for men and 79.7 years for women). It is still below the EU average (especially for men), but has consistently risen over the last decade (67.6 and 76.4 in 1995). Although the infant mortality rate is steadily decreasing (down from 12.2‰ in 1996 to 6‰ in 2006), it is among the highest in the EU. In comparison with other countries, healthy life expectancy in 2006 was high for women (62.5 years), whereas for men it was rather average (58.2 years).

Poland is projected to face demographic trends that are similar to those of other EU Member States: the elderly dependency ratio will grow from 19% in 2010 to 27% in 2020 and to almost 56% by 2050 (slightly more than the EU-27 average of 50%).

Given negligible immigration (e.g. in 2007 the share of the population aged 15-64 born in Poland was 99.6%) the social inclusion of migrants has not been among the main challenges for social policy. The group of third country nationals most exposed to the risk of poverty and social exclusion are Chechnyans. The employment gap between people born outside/inside Poland is 21.7%, although the employment rate of migrants has increased, especially in relation to third country nationals (from 30.1% in 2005 to 38.7% in 2007).

2. OVERALL STRATEGIC APPROACH

The overall strategic approach of Poland is to promote social cohesion and equal opportunities by ensuring adequate and stable social protection systems and implementing effective social inclusion policy. The importance of investing in human capital and modernising social policies is emphasised in shaping conditions for greater employment activity. The National

Strategic Report (NSR) stresses the necessity of increasing the supply and productivity of labour by reducing access to early retirement and developing effective educational and active labour market policies. To achieve this, the NSR identifies a broad range of priorities and specific measures in the area of social inclusion, social protection, and health care. However, the information on the linkages between these fields is limited.

To a large extent the NSR priorities correspond to the areas defined in the NSR 2006-2008. The goals in focus are: addressing inequalities in education, developing labour market services, policy coordination, strengthening social services and continuing the pension reform process.

The NSR (mostly under the NAP-Inclusion) provides information on ESF support for various actions. Separate measures for Governance are planned and the representatives of various bodies were involved in preparing the NSR. To some extent, efforts have been made to define indicators for the NAP-Inclusion, but some outcome targets are missing. The gender dimension is covered, but with limited visibility (especially in health and long-term care strategies), and the multidimensional approach to people with disabilities is underdeveloped.

The links between the NSR and the National Reform Programme (NRP) are visible especially in relation to measures aimed at: supporting the social economy, reforming early retirement schemes, and reconciling family and work life. New measures in education, e.g. reforming curricula and lowering the age for entering primary education, may contribute to both economic growth and social inclusion. Nevertheless, the broader social dimension of pro-employment measures envisaged in the NSR could be better presented and the links between some NSR and NRP actions (e.g. aimed at broader access to IT) could be more developed.

3. SOCIAL INCLUSION

3.1. Key trends

Despite sustained economic growth, Poland still faces weak employment and unemployment indicators compared with other EU Member States. The risk-of-poverty rate slightly decreased, but still affects 18% of men and 17% of women. Poverty and exclusion are mainly associated with being out of work, hence significant drops in youth unemployment (almost double since 2002) and long-term unemployment rates are worth mentioning. Around 45% of the unemployed face poverty and the share of people living in jobless households, although decreasing (from 14.4% in 2006 to 11.6% in 2007) is still above the EU average. Nevertheless, access to work is not a full remedy as the level of in-work-poverty is high (13% in 2006). The groups particularly affected by poverty and social exclusion are children (24%), the disabled and people living in rural areas. There is also a high correlation between the risk of poverty and the number of children in the household. In 2007, the rate of extreme poverty[80] in households with 3 to 4 children was 10.5%, whereas for households with more children it rose to 25.4%.

Poland had a high poverty rate before social transfers (27% in 2006). The strongest effect of social transfers on poverty reduction is observed among people over 64 (mainly due to

[80] Extreme poverty (national indicator) refers to a "market basket" of goods including those needs, whose satisfaction cannot be postponed in time and consumption lower than defined by this level leads to biological deterioration

pensions), whereas for children it is relatively low. Dispersion of regional unemployment is decreasing (4.5, EU: 11.1) but intra-regional discrepancies are growing, especially in the most developed regions. In 2007, early school leavers accounted for only 5%, which was relatively low in comparison to other Member States. Access to education still remains difficult for some groups, e.g. people with disabilities. There is a need to improve equal access to the education system, especially in relation to the differences between urban and rural areas.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The priorities of the NAP-Inclusion 2006-2008 were mainly focused on: support for families with children, inclusion by activation through developing the social economy and active inclusion, as well as mobilisation and partnership by reinforcing social assistance institutions and strengthening their cooperation with labour market institutions.

Progress made in implementing the above-mentioned priorities varies: some remained in the planning phase, others are underway or started recently. Nevertheless clear progress can be seen in areas corresponding to the NAP's priorities. Between 2005 and 2007, the relative poverty rate of families with children has been reduced, although the scale of decrease is less visible in families with more children. New legislation on tax allowances for families was adopted and numerous projects targeting children from poor families were implemented. The visible increase in the employment rate of women with children under 6 years of age (by almost 6 p. p. since 2005, reaching 55.5% in 2007) and the increase in family benefits for families with several children also contributed to a decrease in poverty rate. In addition, over the last few years, many pupils benefited from different subsidies, social grants and other forms of assistance (e.g. free meals at school). Support to children at risk of exclusion is also provided by socio-therapeutic centres: until the end of 2007, over 115 of such centres were created.

Although coverage of the Active Labour Market Policy has increased, projects implemented by the Public Employment Services (PES) reach socially excluded people to a limited extent, and joint projects of the PES and social assistance institutions are not very common. Thanks to ESF assistance and new legislation, the role of the social economy in active inclusion has been enhanced, but demand for this type of support still exceeds available capacity.

3.3. Key challenges and priorities

The social inclusion strand of the NSR focuses on three key priorities: the fight against poverty and social exclusion of children (Priority 1), inclusion through activation (Priority 2) and the development of high quality social services (Priority 3). These priorities are relevant for the current situation in Poland and correspond to the common OMC objectives. The priorities also respond, to a large extent, to the specific challenges identified for Poland in the 2007 Joint Report. The strategy combines a continuation of current policies with new initiatives. Some long-term measures that could have a significant preventive effect on social exclusion (i.e. affordable housing, development of care services) are still at an early stage of implementation. Several changes in relation to the NAP 2006-2008 are visible in the approach to the issue of child poverty: it is now a priority, while previously being tackled from the perspective of assistance to families. The lack of measures aimed at better cooperation between PES and social assistance institutions is not explained, although better coordination between employment and inclusion policies remains a challenge for Poland. New measures aimed at social inclusion of people returning from abroad are planned. The expected

contribution of ESF and the links with the ESF 2007-2013 Programme for Poland are presented in detail and refer especially to developing the social economy, introducing active inclusion tools, assisting people with disabilities, and improving the system of vocational education.

3.4. Policy measures

The first priority, to combat poverty and social exclusion of children and young people, focuses on three issues: improving the income situation of families with children, developing child care services, and ensuring equal educational opportunities. The plan is to improve the income situation of families by combining income support policy with labour activation of parents. The development of child care services is among the most crucial challenges, both in the context of ensuring equal educational opportunities and vocational activation schemes for parents. Introducing mandatory pre-school care for children aged 5 is one of the actions envisaged with the potential to produce positive results, if properly implemented. However, the NAP does not specifically address the important issue of day care centres in rural areas and providing care for children with disabilities. The approach to ensuring equal educational chances is comprehensive, but the issue of segregation in schools could be further explored.

Active inclusion plans under Priority 2 will be implemented by developing the social economy and active inclusion instruments. The social economy will be supported by creating regional centres offering assistance for social economy initiatives, supporting employment in social cooperatives and introducing new legislation facilitating the participation of such institutions in public tenders. Broader use of social contracts and local activating contracts is planned together with new active labour instruments for the long-term unemployed. A specific measure targets dedicated to people with disabilities. Poland still has to address the lack of a comprehensive and multi-dimensional policy for this group. Nevertheless, the planned mix of schemes including creating a system of benefits which support activity, developing vocational advisory actions, implementing rehabilitation programmes and counteracting discrimination should help increase the employment rate of this group which is one of the lowest in the EU (13.7% in 3rd quarter of 2007).

Most of the measures under Priority 3, Access to *High Quality Social Services*, were already included in the previous NAP, though they are now revised and updated. The planned changes in the programme to combat family (domestic) violence can bring improvements to the situation of victims. New initiatives also address the modernisation of vocational education, which should help eliminate the major causes of youth unemployment. Their implementation is ensured by the relevant statutory regulations and financial mechanisms and supplementary measures planned under Priority 1. The ongoing civil advisory service programme focuses on ensuring access to legal aid for poorer people. In relation to the social housing programme, the proposed change is to speed up the construction of social housing. Nevertheless, the shortage of financial resources will remain the fundamental problem here.

The new objective to develop services for older people responds to the challenges related to an ageing population. However, the concept of improving access to services for lone elderly people, or services to support their careers should be further developed. The document contains some statistical data broken down by gender, but this is not consistent across the strategy and promoting gender equality per se is not an explicit goal.

3.5. Governance

The drafting and consultation process for the NSR involved representatives of relevant ministries, local and regional authorities, social partners, NGOs, and experts. Although an effort was made to encourage major stakeholders to take part in the process, it seems that the NSR is still not the subject of broad public debate. The NAP includes some measures for improving communication among the main stakeholders, but the development of mechanisms to improve cooperation between the authorities at various levels still remains a challenge. Progress in involving NGOs in working together is evident and the NAP provides numerous initiatives fostering this cooperation. The development of a consolidated system to monitor progress in social inclusion is planned, particularly with regional authorities maintaining the involvement of regional social inclusion observatories.

4. PENSIONS

4.1. Key trends

The statutory pension system consists of two elements, both of which are mandatory and universal (there are special schemes for farmers and some civil servants such as the military personnel, police, judges and prosecutors): a pay-as-you-go notional defined contribution (NDC) scheme, administered by the Social Insurance Institution (ZUS) and a fully funded scheme, managed by independent private investment companies (open pension funds – OPFs), supervised by the State. The financial crisis resulted in a strong decline in OPFs' assets which may particularly affect the small group of those pensioners who are to retire soon. This is backed-up by a deteriorated perception of the OPF in society and may result in a significant decrease in the inflow of people willing to open voluntary individual retirement accounts.

The statutory pension is based on the defined contribution principle, dependent on the accumulated capital in ZUS and the OPF and on the average unisex life expectancy at the age of retirement. The statutory scheme is financed by the old-age pension contributions (the contribution rate is equal to 19.52% of gross salary) collected by ZUS and divided by the contribution for the NDC pensions and for the statutory funded scheme (ZUS transfers 7.3% of gross salary to OPF). An additional contribution is paid for disability and survivor pensions (10% of gross salary in the second half of 2007 and 6% since 2008).

The statutory retirement age is 65 for men and 60 for women, but the effective retirement age is still much lower and in 2007 equalled 57.5 years for women and 61.4 years for men. In 2005 the poverty rate of people aged 65+ was one of the lowest in the EU (8%) but still higher for women (9%) than for men (6%). The aggregate replacement ratio was 0.58 according to 2007 SILC data (EU-25 average: 0.49). Since 2004, over 915 000 people have opened voluntary individual retirement accounts which provide opportunities for tax-free savings to supplement future pensions.

4.2. Key challenges and priorities

The AWG's 2005 projections show a considerable drop in public pension expenditure from 13.9% to 8.0% of GDP over the period 2004-2050 (pension expenditures decrease to 9.3% of GDP in 2050 when the mandatory funded tier is taken into account). Nevertheless, the pay-as-you-go tier is projected to remain in deficit until the mid-2030s due to transition costs. According to ISG projections, the net theoretical replacement rate would gradually decline

(by 19 percentage points till 2046) unless the balance between the years in employment and retirement is improved. This decline is amongst the highest in the EU. To maintain the future adequacy of pensions the government needs to promote supplementary pension provision and to encourage more people to work longer.

According to projections, Poland's demographic profile will follow the EU average and it is expected that the old age dependency ratio will rise from the current level of 19% to over 55% by 2050. The employment rate of older workers is one of the lowest in the EU-27, especially for women (19.4% according to 2007 data). Furthermore, the reforms of the farmers' pension scheme are delayed which results in keeping the flat rate based contributions, unrelated to the income generated and requiring significant assistance from the state budget. In light of the recent reductions in contributions, existing early retirement schemes for miners, and new mechanisms of pension indexation introduced, (through *inter alia* partial indexation on wages) it will remain a challenge to ensure a financially sustainable pension system.

The overall approach presented in the NSR in general repeats the objectives set in previous Strategies and reflects the challenges identified in the 2007 Joint Report. It covers introducing the bridge pension system that will limit the (currently large) number of professions entitled to early retirement and reforming pension schemes to enhance the employment of the disabled. In addition, there are plans to develop new mechanisms for farmers pension schemes by linking the values of contributions with the income generated. Currently, the link between the values of contributions and pensions is not visible and planned mechanisms, if properly created and implemented, may also have a positive impact on the regional dispersion of employment and agricultural restructuring. Finally, the NSR envisages completing the conversion of funded pension savings into safe annuities. These measures will by supported by schemes to increase employment rates among various groups and to develop a system to equalise the retirement age of men and women.

4.3. More people in work and working longer

The planned reform of early retirement schemes, which constitute a major route to an early labour market exit, has been delayed and the rules for the miners pension scheme have been changed back to the old system. Although some increase in the employment rate was observed, it is still almost the lowest among all age groups in relation to other EU Member States. In 2007 the indicator was 57% (63.6% for men and 50.6% for women) which still puts Poland far below the EU average (65.4%). A very slight increase was noticed in the group aged 55-64 (from 28.1% in 2006 to 29.7% in 2007) and here particularly among women (19.4% in 2007 as result of only 0.4 p. p. increase in relation to the previous year) where 4 out of 5 women do not work. In light of the ageing society the call for an increased participation in employment remains valid and should in principal include reforming early-retirement schemes, the farmers' pension scheme and disability pensions, which also influence the financial stability of the system. This should be supported with measures to increase public awareness of the links between contributions and benefits.

Acknowledging this situation, and in addition to the planned changes to the pension system, the government plans to implement the "Solidarity between generations" programme which will be aimed at achieving the Lisbon target in the employment rate of people aged 55-64. Increasing employment among all age groups is one of the main strategic goals of the labour market policy, and the NSR correlates the need for higher employment among older population with the goal of maintaining sustainable economic growth in Poland.

4.4. Privately managed pension provision

Since the 1999 reform the OPF constitutes an integral part of the insurance system. It has separate assets and is managed by private general pension societies. The cash and securities accounts of the OPF are maintained by depositaries (banks), fully independent from the societies and their shareholders. The legislation focuses on avoiding conflicts of interest between members of the OPF and shareholders of pension societies. Debt securities (bonds and treasury bills) issued by the State Treasury constitute the majority of OPF investment portfolios. The maximum levels of contribution fees charged by the OPF provide the following: until the end of 2010 fees can not exceed 7% of the contribution and this threshold will be gradually decreased to reach 3.5% in 2014. The first pension benefits from funds collected by the OPF will be paid in 2009. Given this fact, the government has recently introduced a bill in parliament on the pay-out phase of the mandatory funded scheme, proposing two kinds of payments: life annuities and temporary funded pension benefits (for women aged 60-64). In light of the recent sharp declines in the value of the OPF assets, it is positive that the government considers adopting the life cycle design in the mandatory funded scheme (an investment approach where the investment risk is gradually reduced as the person nears retirement). The mandatory character of the life cycle design should be taken into account.

4.5. Minimum income provision for older people

The guaranteed minimum pension is paid if the total pension amount - paid within the statutory system – is below the legal minimum of the pension (equal to 56% of the minimum wage). Between 2005 and 2007 the value of the minimum pension was around 23% of the average wage. The poorest pensioners may also benefit from social benefits granted under the social assistance system. The government, together with the social partners, will work to develop mechanisms to ensure that pensions will sufficiently prevent the risk of poverty among older people. Currently the influence of social transfers' on poverty reduction is quite significant, especially for men over 65, for whom the risk of poverty is diminished by approximately 30% (for women it is around 25%).

The aggregate replacement ratio is above the EU average and the poverty risk among older people is significantly lower than that of the population below the age of 65, but is around a third higher for women than for men. Partial wage indexation was recently introduced. Nevertheless, following the projected decline in the theoretical replacement rate, the adequacy of pensions may become an issue in the future, notably for those with short careers, predominantly women. The government thus needs to encourage more people to work longer and to promote supplementary pension provision. Moreover, equalising the legal retirement age for men and women would help reduce the gender gap in pension entitlements and would contribute to increased employment rates.

4.6. Information and transparency

Each person insured receives annual information about the contributions collected, both in ZUS and OPF accounts; this system is to be extended by adding more information on the value of future pensions. The standardised system of information contributes to increasing people's awareness of their future incomes and helps plan other forms of savings (e.g. opening voluntary retirement accounts). Setting up a new institution is intended to enable conducting regular forecasts on incomes and expenditures of the pension system and management of the scheme's funded pensions.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The compulsory health insurance scheme administered by the National Health Fund (NHF) and 16 regional branches provides universal coverage to insured persons (with a list of excluded services). Primary health care (PHC) is provided in the form of private individual and group practice, in private clinics and public healthcare units. Family doctors act as gate-keepers for specialist and hospital care. Specialist outpatient care is based on private medical practices or specialised health centres. Inpatient care is provided predominantly in public hospitals. The system is financed mostly by insurance contributions with state, regional, county and local budgets financing some groups (e.g. unemployed people). Private voluntary (supplementary) insurance is negligible but an increasing trend is visible. Some companies offer accident and health insurance packages (mostly outpatient care) to their workers. The National Health Strategy aims until 2013 to enhance health promotion and healthy living, increase the effectiveness of services, achieve a better value for money and reduce the health status gap in relation to the EU average.

The situation as regards reforming healthcare policy has not progressed since 2006, although some planned measures were implemented e.g. improving the medical rescue system. The new legislation on healthcare system reforms is not yet adopted. Increasing shortages of medical staff (of particular specialisations) due to mobility outside Poland have been found.

Life-expectancy continues to increase, but indicators for Poland (75.3 years) are still among the worst in the EU, especially for men (70.9 years).

5.1.2. Accessibility

Though population and service coverage is high, there are significant regional discrepancies in care availability (lack of certain specialists and equipment) and thus in access to health care. The increasing number of private hospitals does not improve the situation significantly, since - as commercial entities - they are located in richer and better developed areas. The level of self-reported unmet needs for medical care is three times higher than the EU average. Patients out-of-pocket payments are high (25.6% in 2006 of total health spending) due to co-payments and the use of private sector services, adversely affecting vulnerable groups. Waiting lists and times for some services are extensive. This follows limited access and forces patients to opt for the private sector, where they have to pay the full cost of care. The number of GPs is rather low by EU standards and the waiting list management system is ineffective. The authorities plan to develop a list of guaranteed health services to be covered by the public health insurance scheme and to introduce new insurance schemes, covering additional, not-guaranteed services. This will result in increased coverage and additional resources for the system. Further measures aimed at improving the functioning of the national medical rescue system are planned. The government also plans to introduce new formulas of running healthcare entities to improve economical stability and delivery. Further actions aimed at improved access include developing a better system of health information.

5.1.3. Quality

The Centre for Health Care Quality Monitoring (CHQM) provides independent accreditation on the basis of a published set of standards. Quality requirements, national guidelines and standards are to be developed based on independent expertise. Further schemes include developing a better system to evaluate services. The use of technology assessment will increase, leading to evidence-based contracting of services.

5.1.4. Sustainability

Total health care expenditure (6.2% of GDP and per capita PPP$910 in 2006) is low in comparison to other EU Member States. Per capita expenditure has increased over time and in real terms. Public health expenditure represents almost 70% and private around 30% of total health expenditure (2006). According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.4 p. p. of GDP by 2050 due to the population ageing. Increased demand for care is straining the financial sustainability of the system with a high, albeit constantly declining degree of indebtedness of care providers. To provide extra funding, the NHF contribution rate has been increased from 7.5% in 2000 to 9% in 2007. Further work is underway to secure more funding for the healthcare system. Additionally, efforts to improve the effectiveness and efficiency of provided services, such as setting new rules for running healthcare entities and reforming the health insurance system are underway. The total number of acute hospital beds has decreased lasting recent years. Further restructuring is necessary: the PHC needs to be strengthened and outpatient contacts need to increase vis-à-vis unnecessary and expensive specialist and hospital inpatient care. With regard to staff, the number of medical professionals is low: the constant decrease in the number of physicians employed in healthcare units per 100.000 inhabitants (229 in 2003 to 199 in 2005) and still low number of nursing staff should be particularly addressed. Wages are low although authorities have started the process of increasing them to tackle staff mobility. In addition, responding to shortages identified in particular specialisations (especially of anaesthesiologists and specialists for intensive therapy), more attention should be given to training and educating medical staff (the use of ESF funding is planned for such measures). The NSR gives also specific consideration to early identification and treatment of cancer diseases. Investment in modern equipment is planned to ensure the proper level of assistance along with ERDF funding support.

5.2. Long-term care

5.2.1. Description of the system

The long-term care (LTC) system operates within both the health and social care sectors. Under universal insurance coverage, LTC can be provided in residential or nursing units or as home care. Care services for lower-income groups can also be provided in social welfare centres. While care is funded by the NHF, food and accommodation is partly funded by patients (as co-payment). The central budget pays for vulnerable groups, people with severe problems and chronic diseases, on a means-tested basis.

5.2.2. Accessibility

Social assistance is provided in welfare houses which pay additional costs of health care that are not covered by the NHF. Local authorities test the conditions for receipt of social assistance. They means-test according to household size and income, comparing that level to

healthcare costs. Broader involvement of non-public institutions, especially in providing palliative care and increased public awareness of the challenges related to LTC is visible. In light of growing demands for LTC, the scope and availability of services are deemed insufficient. Although in most of the regions the number of LT and palliative care centres has increased, their distribution across the country is still uneven and waiting times between regions vary significantly. Ensuring well qualified staff is one of the challenges for LTC in Poland, therefore a new profession of "care assistant" has been introduced and the first assistants have started work.

5.2.3. Quality

The government plans to better focus on monitoring the services provided within the LTC entities following the conclusions of recent (2007) audits conducted by the central administration. The respective changes in legislation are under preparation. The issue of quality is also strictly correlated with introducing training programmes on palliative care in the curricula of medical studies and training for nurses.

5.2.4. Long-term sustainability

According to the 2006 EPC/EC projections long term care expenditure is set to increase by 0.1 p. p. of GDP by 2050 due to the population ageing. The financial shortages follow the risk that growing demands for care, typical for an ageing society, will not be met. This will be partly addressed by the introduction of a compulsory nursing insurance, which will provide additional resources for financing the system. Increasing the number of medical and nursing staff and developing the social infrastructure in rural areas remains a challenge.

6. CHALLENGES AHEAD

- To promote active inclusion by tackling inequalities in the education system, implementing active labour market instruments, particularly for the disabled, women and older workers, implementing policies to make work pay for recipients of various forms of social transfers and providing the social services needed to support integration in employment, especially for large families,

- To continue strengthening the administrative capacity of social assistance and labour market institutions with a better focus on developing mechanisms to improve the coordination of policies and measures at different levels and between various stakeholders,

- To continue pension system reforms (especially farmers and disability schemes) and to consider equalising the legal retirement age between men and women in order to address the future gender gap in pension entitlements, while raising the employment rate of older workers and people with disabilities and promoting supplementary pension provision,

- To review the mandatory funded scheme by finalising the legal base for converting funded pension savings into safe annuities and by ensuring that the Open Pension Funds adjust the investment risk over the life cycle, in order to guarantee that sufficient resources for adequate pensions are available;

- To ensure equal and better access to healthcare and Long Term Care services by reducing regional discrepancies in supply (notably Primary Health Care), patients direct financial

burden of care and long waiting times, by increasing public health expenditure to address under-financing, counteracting shortages of medical personnel and improving care purchasing and the administration of purchasing entities;

- To improve system efficiency by strengthening Primary Health Care, outpatient care and day-case surgery vis-à-vis inpatient care, and by developing clear national guidelines and standards to evaluate the quality of healthcare services and Long Term Care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4,3	48,2	**2000**	55,0	61,2	48,9	24,5	28,4	**2000**	16,1	14,4	18,1	35,1
2005	3,6	51,3	**2005**	52,8	58,9	46,8	22,5	27,2	**2005**	17,7	16,6	19,1	36,9
2008*f*	5,0	54,3	**2007**	57,0	63,6	50,6	n.a.	29,7	**2007**	9,6	9,0	10,4	21,7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	67,7	76,4	12,9	16,5	n.a	n.a	13,6	**1995**	5,5	72,9	27,1		-
2000	69,6	78,0	13,6	17,5	n.a	n.a	8,1	**2000**	5,5	70,0	30,0	**2005**	9,9
2006	70,9	79,7	14,5	18,8	58,2	62,5	6,0	**2006**	6,2	69,9	25,6	**2006**	9,3

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

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	19,7	55,3	19,6	4,6	5,0	1,5	14,0
2006	19,2	61,2	20,4	3,0	4,4	1,8	9,3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
		Total social expend.	Public pensions	Health care	Long-term care
2004	18,9	23,7	13,9	4,1	0,1
2010	19,0	20,2	-2,6	0,3	0,0
2030	36,0	14,4	-4,7	1,0	0,0
2050	55,7	13,7	-5,9	1,4	0,1

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	17	24	17	8	24	26	25	14	**5,3**	**2005**	21b
male	18	-	18	6	25	-	25	15	-	**2006**	16
femal	17	-	17	9	23	-	24	14	-	**2007**	13

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	n.a.	13,8	12,9	14,7	**2000**	7,4	6,0	9,1	**2000**	n.a.	n.a.	n.a.	n.a.
2004	n.a.	15,8	14,8	16,8	**2004**	10,3	9,6	11	**2004**	5,7		7,7	3,7
2007	9,5	11,6	10,4	12,7	**2007**	4,9	4,6	5,4	**2007**	5,0		6,4	3,6

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	1,04	1,12	0,99	***Aggregate replacement ratio***	0,58	0,64	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
-19	-16	-16	NDC/DC	/	-	77	/	36,9	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Portugal

1. SITUATION AND KEY TRENDS

The Portuguese economic activity expanded at a gradually faster pace in more recent years, with GDP growth reaching some 1.9% in 2007. However it has decelerated in 2008 and is estimated by the interim forecast to have been 0.2% in 2008, due to the global financial crisis. While activity rates, both for men and women are above the EU average employment rates have been broadly stagnant, registering the same value in 2007 and 2004 (67.8%), which is however above the EU average. Unemployment has doubled, reaching 8.1% in 2007 (2000: 4%), affecting more women (9.7%) than men (6.7%). Youth (16.6%) and the older generations (6.5%) are more exposed to unemployment than the EU average. Also long-term unemployment is increasing (3.8% in 2007) and is above EU average. Improving the education system is paramount to improving economic performance, given that early school leaving (36.3% in 2007) and the attainment level (54.3%) are far below EU levels. The vocational training system is also under reform, in order to adapt to labour market needs.

Despite the some improvements, poverty levels and inequality of income distribution constitutes serious structural problems. Portugal has one of the highest degrees of unequal income distribution in the EU (Gini coefficient: 38 and S80/S20 ratio: 6.5 and the poverty levels (16% for the overall population in 2006) are also an important concern. Regarding demography, life expectancy at birth has improved considerably (men: 75.5; women: 82.3 in 2006), which is above the 2004 EU average[81]. The Portuguese population lives almost ten years longer now than it did 30 years ago. Conversely, the healthy life expectancy has been fallen over the last decade. Due to the projected faster ageing, Portugal's old-age dependency ratio will increase from 26.6% in 2010 to 53% in 2050, above the EU average (25.9% and 50.4%). Consequently the total public spending, that represented 23.8% of the GDP, is expected to rise by 9.8%, representing the second highest increase in the EU25.

2. OVERALL STRATEGIC APPROACH

The National Strategy Report (NSR) for Social Protection and Social Inclusion 2008-2010 will be implemented through two (2) strategic priorities and six (6) strategic objectives. One strategic priority regards the impact of demographic changes and is composed of three strategic objectives: (i) to support the birth rate and infancy, (ii) to support the reconciliation of professional, personal and family life; (iii) to promote quality active ageing and to prevent and support dependency. The second strategic priority considers the promotion of active inclusion and the reduction of disparities, implemented by through three strategic objectives: (iv) to promote active social inclusion, (v) to improve living conditions in vulnerable territories, (vi) social inclusion of specific groups, such as the disabled, immigrants and ethnic minorities, and the homeless.

The current Portuguese NSR shows progress since the previous 2006-2008 report, since the priorities and objectives are now more focused and targeted to the factors undermining social

[81] EU average of 75,2 and 81,5 for males and females, respectively.

inclusion and social protection. Nevertheless this new strategy does not cover all existing problems, but it seems to identify the correct priorities.

The three strands have listed concrete measures. The National Action Plan for Inclusion is backed by more detailed measures, identifying financial resources, quantified targets and monitoring indicators. Measures related to the autonomous regions of Madeira and Açores are described. The alignment with the National Strategic Reference Framework (NSRF) 2007-2013 is demonstrated, and most measures will be implemented through the support of Structural Funds.

The overall strategic approach identifies links with the Lisbon Strategy. The NSR includes several measures with a direct impact on the *jobs and growth* strategy for the period 2008-2010 (active ageing, pension reform, active inclusion and flexicurity). Regarding governance, the previous governance model is kept. The following were found to be particularly useful: the political coordination among ministers, strong articulation of the three strands of the OMC, involvement of civil society and stakeholders, and adequate information to population. As regards the gender dimension, the main national body responsible for gender equality actively participated in the preparation of the report.

3. SOCIAL INCLUSION

3.1. Key trends

The Portuguese economic and social situation remains fragile, reflecting structural imbalances and deficiencies in human capital. The unemployment rate peaked at 8.1% (2007), affecting mainly women (9.7%) and young people (16.6%). Although overall employment rate has remained constant, the rates for women (61.9%) and older workers have increased (50.9%) and are both above the EU average. But youth employment has decreased considerably (2001: 42.3% to 2007: 34.9%).

All main indicators prove that social inclusion is a critical concern. The at-risk-of-poverty rate after social transfers is among the highest in the EU (PT: 18%, EU: 16%), affecting mainly children (PT: 21%, EU: 19%) and the elderly (PT: 26%, EU: 19%). Although employment is a key policy in promoting social inclusion, employment *per se* is not enough. Indeed the "working poor" are sizeable (PT: 11%; EU: 8%), which reflects low wages paid and creates a widespread social problem. The in-work poverty is highest for part-time workers (29%), compared to full-time workers (9%), reflecting high labour market segmentation.

Regarding education performance, progress has been made on early school leaving, which decreased by almost 3% (2006: 39.2%; 2007: 36.3%), its lowest level in a decade. For the first time in a decade, youth attainment exceeded 50%, (2006: 49.6%, 2007: 53.4%). Yet the disparity *vis-à-vis* the EU average is still very wide (which are 14.8% and 78.1% respectively).

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

It is welcomed that an evaluation of the NSR 2006-2008 is currently ongoing and was promised to be disclosed in early 2009. However the current NSR would benefit from such analytical underpinning. The NSR simply recalls the main measures set out for the period 2006-2008. No concrete evidence of the achievements and no assessment of the final targets'

results are given. Though an interim evaluation was conducted involving the stakeholders, this allowed to update the process and also enabled the definition of priorities for the NSR 2008-2010. One of the major improvements of the NSR 2006-2008 was the definition of concrete objectives with quantified targets, thus a final assessment of these targets is of utmost relevance.

The response to the challenges lacks sound argumentation and barely mentions how they were addressed. On the challenge "to closely monitor and evaluate the impact of the measures relating to the minimum income scheme, ensuring effective social integration of groups at risk", the NSR mentions the reinforcement and consolidation of the insertion component of the Social Insertion Income (SII). The SII was subject to a regular monitoring and assessment exercise involving different entities and stakeholders. Also the evaluation of the minimum income scheme has proved that the insertion component of the SIII shall be a central priority for the new cycle.

With regard to the challenge *"to ensure that groups furthest from the labour market benefit from mainstream measures to raise the qualifications levels of the population, with a particular focus on the large numbers of unskilled working poor and early school leavers",* the political priority to upgrade the qualifications of young people and adults is restated, through the comprehensive *"Novas Oportunidades"* initiative. It has been addressed the structurally low educational level of the population through investment in pre-school expansion, consolidation of universal basic education, an extension of steps to diversify education and training at secondary level and improvements to the quality of the education system, as well as reinforcing professional pathways. Measures to facilitate the labour integration of the groups furthest from the labour market were implemented through specific intervention programmes, targeted namely to the disabled and unemployed immigrants.

3.3. Key challenges and priorities

The promotion of social inclusion, the prevention of poverty and social exclusion, and tackling demographic trends are two fundamental key challenges for the new period. To this end the NSR 2008-2010 identifies three priorities to: (i) fight child and elderly poverty, by ensuring their basic rights of citizenship, (ii) correct the disadvantages in education and training/qualification, and (iii) overcome the discrimination and strengthen the integration of specific groups, namely the disabled, immigrants and ethnic minorities.

These priorities are consistent with the current social situation and represent continuity with the previous period. Focussing on a smaller number of priorities can render the NSR more operational. The explicit concern regarding the need to invest in structural changes and simultaneously prioritise specific initiatives, *vis-à-vis* specific groups, is consistent with the challenges faced by Portugal as regards poverty and social inclusion. This continuity reflects the need to keep on tackling the challenges identified in the 2007 Joint Report.

The selection of the NAP Inclusion 2008-2010 objectives definitely contains some positive features, namely considerable emphasis on cross-cutting measures (between the three strands of the NSR, but also the thrust of the NRP 2008-2010); reinforcement of policy areas that had formerly been under-developed (such as housing), a considerable set of new measures, incorporation of measures from Madeira and Açores. It is also important to highlight the links with the National Strategic Reference Framework (NSRF), and the contribution of the Structural Funds. The ESF co-funded Operational Programme "Human Potential" (OPHP) is expected to play a key role in financing several measures.

Globally the NAP Inclusion addresses the social inclusion strand objectives. The NSR assesses gender issues through a cross-cutting approach. The social inclusion strand contains specific measures which seek to include more women into the labour market. The legal possibility of greater sharing of family responsibility by the parents, coupled with the increasingly compulsory nature of this time can make a difference.

3.4. Policy measures

The scope of the measures included under the **first priority** has widened, which plans to *"fight child and elderly poverty, through measures ensuring their basic rights of citizenship"*. Significant structural issues were taken into account such as: income (gradual increase of the National Minimum Salary and income support during pregnancy) and housing (housing costs and a housing programme for the elderly). These measures will have an overall broader impact, and not only focus on children and the elderly, it is undeniable that measures such as direct income support will have substantial added-value in a country where the minimum wage is still very low and the proportion of working poor remains high. Furthermore, measures such as investment in social infrastructures will lead to increased female participation in the labour market. It is positive that the wide range of measures covers many aspects: income, housing, integration into the labour market, education, provision of social equipments and services. There is a description of all measures, identifying the body responsible, the beneficiaries an indicator for evaluation. The budget allocated to the measures is mostly given.

Under the **second priority**, which plans *"to correct the disadvantages in education and training/qualification"*, most measures are closely linked to the National Employment Plan and the *"Novas Oportunidades"* initiative. Previous measures have clearly stabilised (the network of pre-primary school infrastructures, alternatives curriculum paths, *"Novas Oportunidades"*), while the main new feature is the introduction of measures in the field of Information and Communication Technologies (Technological Plan for Education, broad-band networks and a School Portal). More systematic measures include the increased coverage of pre-primary education, the creation of alternative curriculum paths, more education and training courses for the young people and Education Areas of Priority Intervention. There is a clear focus on pre-primary education and on raising the qualification levels of young people (through the double-certification courses) and adults (through the recognition, validation and certification of competences). Some measures provide access to ICT for disadvantaged groups, mainly at school or in the special inclusion centres (Centres for Digital Inclusion). There are plans to include people at risk of exclusion in vocational training schemes. Special attention was also paid to the disabled. Nevertheless it appears that the gender dimension has not been fully considered, especially as regards young women from disadvantaged social backgrounds.

The **third priority** to *"overcome discrimination and reinforcing the integration of specific groups, namely the disabled, immigrants and ethnic minorities"* presents specific measures for the disabled, immigrants, ethnic minorities and the homeless. Most measures targeting the disabled, constituting a coherent set of measures (on education, qualification, health, labour market integration, accessibility, and legal advice) and are in line with the previous NAP. Measures on immigrants stem mainly from the existing Plan for the Integration of Immigrants (PII), in force since 2007, and refer to integration centres, language courses, and entrepreneurship support. The recent approval of the Plan to Combat Human Trafficking and the creation of an Observatory in this field are welcome. Also new risk groups have been included in the NAP, such as the Roma and the homeless.

3.5. Governance

The preparation of the NSR was coordinated by the Ministry of Labour and Social Solidarity, through an inter-ministerial group (representing fourteen ministries), the Government of the Autonomous Regions of Madeira and Açores and the Non-Governmental (NGO) Forum. The Non-Governmental Forum for Social Inclusion and the Local Social Networks gave stakeholders an opportunity to contribute to the process from the design stage. This improvement is highlighted in the NAPIncl 2008-2010 Assessment Report produced by the Non-governmental Forum for Social Inclusion.

Implementation of the NSR 2008-2010 will be monitored by a network of Focal Points (which will replace the former Inter-Ministerial Commission for Follow-up the NAP 2006-2008 and the Working Group of the Ministry of Labour) and by a platform of coordinators of different plans, composed of sixteen coordinators of national plans in diverse domains (such as Immigrants, Health, Culture, Drugs, Housing, etc). Regarding the Focal Points, a network involving sixteen ministries, the representatives of Madeira and Açores and from the municipalities will be created. The involvement of local actors was given a special attention and the main national representatives of the local authorities are now taking part in the governance structure, providing thus a stronger local perspective.

The creation of the national network of experts for promoting knowledge on poverty and social exclusion is important, and would add value to the whole NSR. As regards monitoring and evaluation this NSR should have given more attention to an effective and operational mechanism to monitor, assess and evaluate this ambitious strategic plan.

4. PENSIONS

4.1. Key trends

The Portuguese pension system is characterised by a statutory regime, which is a general scheme mandatory for the private sector. Occupational schemes also exist in particular for civil servants. Pension spending has been a major driver of rising government expenditure in Portugal since the mid-nineties. Quickly maturing old-age pension schemes caused by the significant growth in the number of pensioners and average pension outlay due to the longer career contribution of new retirees are responsible for the increased spending on pensions. According to AWG's 2005 projections, public spending on pensions is set to rise from 11.1% of GDP in 2004 to 20.8% in 2050. However in October 2007, the Portuguese pension reform was submitted to a peer review of the AWG, and the projections were positively revised (expected value in 2050 is 16%). In this context, Portugal was downgraded from a high-risk to a medium-risk country. A revision of these projections is currently ongoing; consequently the updated projections are foreseen to be completed this spring.

Pension reform was then at the core of the fiscal consolidation programme. The aim was to control spending and improve the efficiency of the public sector, as well as to reform public administration. Following an agreement with the social partners, a general reform of the social security was passed in January 2007 and the reform of the pension system entered in force in May 2007.

The relative median income ratio for people aged 65 years and over relative to the income of the age group 0-65 was 0.79 in 2007, the same as the year before. The aggregate replacement

ratio was 0.47 in 2007. The average retirement age was 63.1 years in 2005, which is above EU average of 61. The gross replacement rate for Portugal in 2006 was 75 (91 for net replacement rate). The gross theoretical replacement rate is expected to change by -19 % between 2006 and 2046 (-20 % for net replacement rate).

4.2. Key challenges and priorities

The main challenge facing Portugal is the fully implementation of the pension reform adopted in 2007, particularly by converging the public servants regime with the general scheme, promoting longer working lives, establishing a comprehensive active ageing strategy and reducing the poverty risk of the elderly.

The 2007 Joint Report identified the "*implementation of the pension reform*" as a major challenge for the future. Portugal has responded positively with the 2007 reform. The main measures include extending the assessment period to cover the entire career (instead of just considering the best 10 out of the last 15 working years)[82], financial penalties for early retirement (up from 4.5% to 6% on an annual basis) and incentives for postponing retirement. Other measures included a new formula to calculate pensions which would benefit persons on lower salaries; the introduction of a "sustainability factor" that automatically adjusts benefits to changes in residual life expectancy and a new indexation rule *"Indexante de Apoios Sociais"* that considers real GDP growth and consumer inflation.

As regards sustainability, the core measures are extending the assessment period to cover the entire career and the new "sustainability factor"[83]. Other important steps taken include measures to encourage births, a penalty for early retirement and benefits for working longer, the new legislation regarding unemployment protection[84], the new indexation rule (that no longer considers the minimum income wage), a new Contribution Code that adjusts the contribution basis (also for the self-employed), the strengthen mechanism to fight fraud and a new model of finance.

Portugal has clearly addressed the need of curbing public expenditure through the pension reform. However future gaps in the contributory social security system may appear. The NSR sets out the National Active Ageing Strategy (through incentives to work longer) and increased incentives for the disabled as important measures to address the future adequacy of pensions, but it remains to be seen whether this will be sufficient. It is of utmost importance that regular review and adjustment mechanisms be developed.

4.3. More people in work and working longer

Although the reform of the general pensions system introduces flexibility in the age of retirement, it also penalises early retirement (before 65 years). This penalty also acts as an

---

82 This rule applies from 2007 onwards to the general pensions system; however it will only be extended to civil servants in 2015. In 2005, **changes to the pension scheme for government employees** were adopted, resulting in its convergence to the less generous general scheme for private-sector workers. This will be accomplished through step increases until 2015 in the retirement age and eligibility periods as well as changes to the benefit formula.

83 That involves multiplying the pension formula by a penalty factor equal to the ratio of life expectancy at age 65 in 2006 and life expectancy at age 65 in the year before retirement

84 In force since 1st January 2007, the unemployment benefit scheme has been improved by strengthening activation mechanisms, reducing the unemployment period and helping people return to the labour market. Also the access to early retirement following unemployment has changed from age of 60 to 62, having the beneficiary at the date of unemployment at least 57 years old.

incentive to remain in workplace, and is a clear measure to retain more people at work. The penalty has risen from 4.5% to 6% per year. The public administration sub-system, under which the legal pension entitlement age used to be 60, is now converging to the general regime. For the first time a distinction was made for the disabled between "absolute invalidity" (with the minimum pension guaranteed) and to a "relative invalidity", in which case the pension can be topped up by a job income.

4.4. Privately managed pension provision

The NSR does not provide much information about privately managed pensions. However in the banking and telecommunications sectors occupational schemes substitute the general scheme. Companies also provide complementary retirement benefits for employees. Occupational schemes cover roughly 3.7% of the labour force. The liabilities for future pensions are covered by independent pension funds, whose assets currently amount to 14% of the GDP. A major liability of these occupational schemes is the prevalence of defined benefit pension plans. Losses in the value of pension fund portfolios, due to the current financial crisis, could seriously damage these schemes.

4.5. Minimum income provision for older people

The poverty risk for older people is currently 26%, significantly above the overall rate (18%). A specific monetary income compensation for the old-age pensioners, called the Solidarity Supplement for the Elderly (SSE)[85] was established in 2006, benefiting around 200.000 elderly people. Additional health benefits for those eligible for the SSE were created in 2007, which allow for an extra reimbursement of health expenses.

4.6. Information and transparency

The National Council of Social Security was created in 2007 in line with a Government pledge. It is the body which consults social partners and promotes the tri-party monitoring of the economic, social and financial sustainability of social security system. Additionally it is responsible for defining its objectives and following up the implementation. The NSR acknowledges the importance of a monitoring system, but gives no precise information on the development of such monitoring and evaluation mechanisms, although it is mentioned in the report on the on-line web application and the annual report on social security sustainability. On transparency, an on-line web application was created, which allows citizens to consult their contributively career and be informed about the reform in due course. An annual report on social security sustainability is annexed to the Government's budget proposal, which is presented to the Parliament. Social service centres are being modernised and access for the disabled will be improved. The social security call centre is planned for 2009.

[85] Accession is progressive: in 2006 it was available for those above 80 years old, in 2007 for elderly above 70, and in 2008 pensioners above 65 years old can require (by means-test) this income supplement.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The Portuguese Health System covers the entire population and is organised by the National Health Service (NHS), with some responsibilities delegated to regional bodies. The internal organisation of the ministry is being restructured in the context of a general reform of public administration in the country. The NHS is managed by the Ministry of Health. Overlapping with the NHS there are certain special public and private insurance schemes for certain professions (called "health subsystems"). Primary health care is provided through a network of health centres, outreach services and non-profit organisations that provide care for NHS users. In the NHS general practitioners operate as gate-keepers by referring patients to hospitals for specialist care. Hospital care is provided by hospital departments of the NHS complemented, when deemed necessary, by private and social entities with established contracts with the Ministry of Health. The system is funded by general taxation and supplemented by public and private insurance schemes and out-of-pocket payments. Co-payments apply to pharmaceuticals, consultations, hospital care and home care, but 50% of the population is exempt. The improvement in key health indicators, such as life expectancy at birth and low infant mortality is attributable to the NHS. The National Health Plan 2004-2010 focuses very strongly on enhancing effective promotion and prevention activities at all levels of health care. This Plan has prioritized four strategic programmes (cancer, HIV, cardiovascular diseases and mental health).

The total public expenditure on health care (as percentage of THE) is 70.6% (2006), and represents 10.2% of total government expenditure. Private expenditure on health care is approximately 3% of GDP (2006), while private expenditure on health compared to total health care expenditure is 30.3%, which is well above the EU average of 24.1%, and may represent a financial burden on more vulnerable groups. Policy measures to counteract this situation include the promotion of greater access, namely through the integrated management lists for surgery and medical appointments. The fact that some groups with their own social insurance scheme (like ADSE for civil servants and SAMS for the banking sector) can access both the NHS and other providers means that some sections of the population are allowed to choose their providers, while others are restricted to the NHS.

5.1.2. Accessibility

A key challenge is to reduce waiting times, both for primary and hospital care. Although waiting times are still perceived as being too long in many hospital specialities and despite the regional disparities, Portugal has achieved significant strides in recent years. In four years the waiting time for all surgeries has decreased by 50%. Improving access to hospital care is a top political priority, as is equal access for all citizens. The main measures include adopting integrated nationwide systems to manage waiting lists for surgery and to manage access to hospital medical appointments (timely access programme for hospital speciality consultations). Both systems were designed to assure that people receive health care according to their needs and take into consideration their clinical situation. These two information and management systems show the need for specific intervention programmes, like to the current ophthalmology or the obesity programmes. With regard to redistribution of services and the regional disparities in the access and supply of those services, there is an ongoing plan covering different areas of the country including mobile care units. Services

must be redistributed to improve access in some geographical areas and to enhance efficiency in others.

Measures under the health chapter include implementation of the "e-agenda (facilitating appointments and complementary diagnosis and therapeutic means through multi-channel technological platforms, 24h counselling helpline and a health portal), the revision of agreements/contracts with the private sector to improve the access for beneficiaries of the NHS, campaigns to promote health for specific groups, reorganisation of psychiatric emergency assistance are some of the other projects which will be set up. The NHS exempts from any fee or co-payment patients suffering from chronic diseases (e.g. diabetes, oncologic and neuromuscular) and vulnerable groups (such as pregnant women, children and elderly benefiting from the national minimum wage). Also special programmes have been implemented on dental care for those vulnerable groups, given the NHS shortages in this field. The policy on pharmaceuticals also contains important elements regarding access, namely stepping up incentives to prescribe generics, revising medication subsidies and access to pharmaceuticals.

5.1.3. Quality

The government ensures quality standards for public and private institutions, through a system of audit, inspection, national accreditation and the qualification of infrastructures. The main measures to enhance quality include implementing an experimental model of integrated disease management, implementing and developing national programmes to prevent and control non-transmissible diseases, and reorganization of maternity services. There will also be measures aimed at guaranteeing the accreditation/certification of hospital rules and procedures, the development of the National Programme to Qualify Health Centres, the preparation of national guidelines about good practices, the development of internal and external clinical audit in order to progressively improve the quality of health care, and the progressive qualification of human resources.

An important aspect of quality in the health care system is human resources. Portugal has experienced staff shortages and has had to overcome them by, for instance recruiting foreign staff from Spain and Eastern Europe. This has been occurring across the staff grades (too few GPs, nurses and dentists). To this end, two new medical degrees have started at universities and a specific allocation from the ESF is available to health care professionals for the period 2007-2013 through the OP Human Potential.

5.1.4. Sustainability

The sustainability of the health care system is largely dependant on the consolidation of public spending, and on overall economic growth. Health expenditure continues to grow faster than the GDP (1995: 7.8%, 2006: 10.2%). This is the result of the complexity of the process coupled with increased demands on the health budget because of new technologies, new pharmaceuticals and new services. However the health authorities have implemented reforms to curb the high costs associated with health care, in particular through efficiency programmes, reducing the costs of pharmaceuticals and general reforms of the NHS (concentration of hospitals centres, the creation of ten new Public Corporate Entities/"enterprise-hospital", primary health care reform, network of integrated continuous care). These measures highlight a tight control over the expenditures in health system, which made possible to reach the objectives and targets within the budgetary allocation, avoiding the need to resort to corrective budgets.

Similarly to the pension system, the health care system is at the core of current fiscal consolidation efforts. Control spending on health care and the new "enterprise-hospital" management model had important implications for the fiscal sustainability. Reforms in the health sector are having a positive impact, such as the creation of a central purchasing unit (thus more economies of scale), the adoption of a contracting model on the basis of activities and performance, the revision of NHS agreements and update of co-payments for access to NHS.

5.2. Long-term care

5.2.1. Description of the system

Until recently there were only limited long term care services available. Only the *"Misericórdias"* and a few non-profit organisations provided of long term care facilities such as, day care and nursing care for the elderly and for those living in situations of dependence. In 2006 was approved the National Network of Integrated Continuous Care, which aims to provide all levels of integrated continuous care (convalescence, mid, long-term and palliative care). This network is a partnership between the Ministry of Health and the Ministry of Labour and Social Solidarity, and also involves the "social sector" (*"Misericórdias"* and charity institutions) and the private sector. It aims to promote the continuous health care and social support for all citizens who dependant on others either temporarily or permanently. Moreover, this measure is designed to have a major impact on the reconciliation of family and professional life of women, helping them remain/return to labour market. Geographical functioning seems to have been properly addressed and to this end three levels of coordination (central, regional and local) have been established.

5.2.2. Accessibility

Although the scope of the National Network of Integrated Continuous Care should be seen as an initial step, the NSR 2008-2010 has established measures to be implemented regionally and locally with the view of creating convalescence units[86], medium-term and rehabilitation units[87], long-term and maintenance units[88], palliative units and day-care units.

This network will be an important step forward for the elderly above 65 years old. It will also be important for those who are dependant. In addition it will have the major added-value of getting closer the goal of the full participation of women in the labour market.

5.2.3. Quality

A training plan for long-term care professionals, a systematic and continuous process of results assessment, an evaluation of the degree of users satisfaction and a system of feedback and complaints are all implemented.

---

86 810 beds by 2008 and 1446 beds in 2009

87 Expected to rise from 1100 beds in 2008 to around 1500 in 2009

88 Foreseen to reach 7000 beds in the National Network of Integrate Continuous Care by 2009

5.2.4. Long-term sustainability

The National Network of Integrated Continuous Care will be implemented over a framework period of ten years (2006-2016) to ensure its sustainability. A programme to fund this network was created in May 2008 to back up this political priority with appropriate financial means.

6. CHALLENGES AHEAD

- To tackle child poverty, by adopting comprehensive strategies to provide better support for family incomes and facilitating labour market integration.

- To ensure that the groups furthest from the labour market benefit from mainstream measures to raise the qualification levels of the population, with a particular focus on the large numbers of unskilled working poor and early school leavers.

- To closely monitor and evaluate the impact of measures of the National Action Plan for Inclusion, in particular measures relating to the minimum income scheme, in order to ensure the effective social inclusion of groups at risk.

- To further develop and regularly review the monitoring mechanism of adequacy for future pensioners.

- To improve equity and efficiency (notably by reinforcing primary care, adjusting hospital capacity and controlling pharmaceutical expenditure) and implement comprehensive all-ages promotion policies to improve health status and reduce health inequalities.

- To enhance the provision of long-term care and reduce geographical disparities of care supply.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,9	78,0	**2000**	68,4	76,5	60,5	41,1	50,7	**2000**	4,0	3,2	4,9	8,8
2005	0,9	76,9	**2005**	67,5	73,4	61,7	36,1	50,5	**2005**	7,6	6,7	8,7	16,1
2008*f*	0,2	73,7	**2007**	67,8	73,8	61,9	34,9	50,9	**2007**	8,1	6,7	9,7	16,6

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	71,7	79,0	14,7	18,1	59,6	63,1	7,5	**1995**	7,8	62,6	n.a.		-
2000	73,2	80,2	15,4	18,9	60,2	62,2	5,5	**2000**	8,8	72,5	22,2	**2005**	4,7
2006	75,5	82,3	16,6	20,2	59.6b	57.6b	3,4	**2006**	10,2	70,6	22,8	**2006**	5,0

s: Eurostat estimate; p: provisional; b: break in series **THE: Total Health Expenditures*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	21,0	41,1	36,2	5,3	5,2	0,4	11,8
2000	21,7	44,7	32,0	3,7	5,4	1,4	12,7
2006	25,4	49,1	29,2	5,5	5,1	1,2	10,0

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
		Total social expend.	Public pensions	Health care	Long-term care
2004	25,9	23,8	10,5	6,7	n.a.
2010	26,6	0,4	1,4	0,1	n.a.
2030	36,6	4,2	3,4	-0,1	n.a.
2050	53,0	9,8	5,5	0,5	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	18	21	15	26	24	26	27	19	6,5	**2005**	n.a.
male	17	-	14	24	24	-	27	14	-	**2006**	n.a.
femal	19	-	16	27	24	-	27	22	-	**2007**	n.a.

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	3,6	4,3	3,7	4,9	**2000**	1,7	1,4	2	**2000**	42,6	35,1	50,1
2004	4,3	5,3	5,0	5,7	**2004**	3	2,6	3,4	**2004**	39,4	30,6	47,9
2007	5,1	5,7	5,3	6,1	**2007**	3,8	3,2	4,5	**2007**	36,3	30,4	42

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,47	0,50	0,48	***Aggregate replacement ratio***	0,47	0,5	0,48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
-20	-20	-20	DB	/	-	81	/	33	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Romania

1. SITUATION AND KEY TRENDS

The macroeconomic performance of Romania has improved significantly since 2000. The growth rate of real GDP for 2007 was 6% and the latest forecast for 2008 was 7.8%. The immediate effect of the current financial crisis will be a fall in economic growth in the forthcoming period. The latest forecast from the European Commission for 2009 is only 1.8%. The GDP per inhabitant in PPP[89] represents only 43.6% of the EU average. Despite the registered growth in GDP, the employment rate has been relatively constant since 2002. Following a slight increase in 2006, the employment rate in 2007 stabilised at around 58.8%. Employment in agriculture, characterised by very low monetary income, and therefore a source of poverty, still accounts for quite a high proportion of jobs. The labour force participation rate in 2007 was 63%, and was higher for men. The female employment rate (52.8%), the youth employment rate (24.9%), and the rate of employment for older workers (41.4%) remain lower than the European average. The unemployment rate fell to a record level of 6.4% in 2007, lower than the European average. However, owing to the financial crisis, we can expect an increase in 2009. This is a worrying development for young people, despite recent decreases (20.1% in 2007).

The strategy identifies a poverty risk of 19%, with higher values for the rural population, the Roma, children, the unemployed and elderly women. From a demographic point of view, the population of Romania is decreasing steadily as a result of intra-Community mobility, the low fertility rate (1.31 in 2006), life expectancy at birth being one of the lowest in the EU (69.2 years for men and 76.2 years for women in 2006) and a relatively high rate of mortality at birth. The rate of mortality at birth is still one of the highest in the EU, although there was an improvement (12%) in 2007. The projected demographic dependency ratio is estimated at 21.3% for 2010 and 54% for 2050. Welfare expenditure represents 14.2% of GDP (2005), one of the lowest levels in the EU (27.2% of GDP).

2. OVERALL STRATEGIC APPROACH

The general objectives set in the new strategy are directed at continuing efforts to create a society of inclusion, solidarity and prosperity based on equality and social justice for everyone, in accordance with the objectives of the open coordination method for protection and social inclusion, the Lisbon Strategy and the sustainable development strategy. For the new period, the focus will be on active inclusion. The modernisation of the social protection system continues to be the central issue in social policies, with a particular focus on avoiding dependence on the system and encouraging active inclusion. The strategy attaches importance to the implementation of reforms which have already been initiated in the field of social protection. Overall, the strategy can be described as ambitious, but, owing to a lack of quantified objectives, it risks simply being a declaration of good intentions on a rather general level. One of the important objectives is to develop integrated policies and ensure the effective implementation of sectoral strategies. The strategy outlines the implementation difficulties and the need to develop monitoring and assessment instruments and procedures

[89] Purchasing power parities (PPP)

aimed at increasing the effectiveness of policies. The ESF is mentioned as the instrument which can help to attain the strategy objectives (for example, measures to increase the participation of vulnerable groups in the labour force, the strengthening of administrative capacity at both local and central level, and the supply of efficient, high-quality services on a decentralised basis). The strategy sets the priority of developing a common understanding and raised awareness among citizens and professionals of the concept of active inclusion, in order to improve efficiency in the design and implementation of social policies. However, few actions have been taken so far to materialise this declaration. Little reference is made in the strategy to the issue of child poverty, although this is a constant priority on Romania's social agenda and a national strategy on the protection of children's rights was adopted for the period 2008-2013; the matter of children whose parents have left to work abroad is not even mentioned, despite it being a widespread phenomenon. The strategy tackles the gender dimension: actions will continue to be adopted to foster equal opportunities on the labour market and reconcile work and family life. The strategy covers disabilities in the context of the reduction of discrimination, social integration, employment and long-term healthcare.

3. SOCIAL INCLUSION

3.1. Key trends

The poorest social categories are the Roma, the rural population, children, elderly women, single-parent families, households with three children or more, single people and women in long-term unemployment. As regards regional distribution, the north-east region is the poorest (26.2%), followed by the south-east and south-west regions (24.2% and 23% respectively). The poverty rate remained relatively constant in the period 2004-2007, at around 18-19%. However, the risk of poverty is higher among children, young people under the age of 25 and women over the age of 65. The number of children living in jobless households is falling steadily (10% in 2007 compared with 11.1% in 2004). Trends in the 18-59 age bracket remain unchanged. The rate of long-term unemployment is also falling, with a value of 3.2% in 2007 (3.6% for men; 2.7% for women). Youth unemployment remains a source of concern (20.1% in 2007). The percentage of young people leaving school early remains high in relation to the European average (19.2% in 2007). In rural areas, this phenomenon is even more pronounced. The situation is still very worrying among the Roma, for whom a low school attendance rate is noted. The strategy indicates that 9% of Roma enter secondary education and only 2% go to university. The illiteracy rate remains very high (28%). For almost 40% of the Roma population, the main sources of income are welfare benefits and the minimum guaranteed income. Participation in the official labour market remains low, with most Roma working on the parallel labour market.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The strategy and the progress report give a rather descriptive view of the programmes and projects targeting vulnerable groups, and fail to provide a sufficient analysis of the results. Progress has been made, but the figures presented are misleading because there is no overall evaluation of the impact of the measures. Even though connections between the projects presented and the existing sectoral strategies/programmes of national interest doubtlessly exist, the wording of the strategy does not make this very clear. Furthermore, the lack of quantified objectives for the short-, medium- and long-term makes it difficult to compare past, present and future situations. Progress in terms of employment (objective 1): this section

contains information on the programmes aimed at increasing employment in the various vulnerable population groups. The increase in the number of employed people in vulnerable groups is a positive aspect, but employment does not cover all the social aspects of inclusion: an integrated approach is necessary. Progress relating to access to rights and services (objective 2): measures have been taken in the social assistance sector to achieve the objective of reducing poverty by implementing policies to support people on low incomes and providing services for the various vulnerable groups. The strategy provides statistical figures which indicate a fall in the number of people claiming various types of social benefits. It is unclear whether the numbers have decreased owing to the effectiveness of the policy or for other reasons (such as limited access to information, complicated procedures, etc.). There is no reference in the current strategy to the objective of the previous strategy to ensure equal, high-quality access to education for all. Given Romania's somewhat disappointing performance in the field of education (for example, a percentage of early school-leavers which remains high, low participation of adults in lifelong learning measures), this should still be a central objective for the future. Improving the situation of the Roma (objective 3): the information contained in the section on progress makes little reference to the strategy itself. Some information is provided on job exchange centres for Roma and the employment caravans, but the results seem to be rather modest. The report does not mention developments as regards identity papers, a major source of social exclusion for this category. As with previous objectives, not enough information is provided to evaluate the success of the programmes undertaken.

3.3. Key challenges and priorities

The priority objectives for the period 2008-2010 are still to meet the challenges identified in the JIM and in the strategy on inclusion and social protection for 2006-2008. Progress has been noted on social inclusion (for example, legislative and institutional developments, strategies and action plans, programmes of national interest), but the objectives set in the former strategy will be carried over as priorities for the new period, as many efforts have been made to find solutions to emergency situations or to meet new needs, and it has not always been possible to stick consistently to the initial plan. As regards pensions and health, the priority of continuing with the respective reforms remains.

3.4. Policy measures

The three priorities chosen by Romania are detailed below.

The aim is to increase the level of employment in the most vulnerable population groups, promote integrated family policies, and continue with efforts to improve the living conditions of the Roma.

– *Increase the level of employment of disadvantaged people.* In the new strategy, emphasis is laid on developing the social economy sector. The disabled are specifically targeted by these social economy measures, although they can also benefit other vulnerable groups. A certain number of crucial points still need to be addressed: lack of accompanying support services, a generally low wage level, a difference in income levels between women and men; disparities and imbalances between rural and urban areas, inconsistencies between training provision and available jobs; a low rate of participation in lifelong learning, etc.

– *Promote integrated policies (packages of measures, benefits and social services).* The measures under this priority are aimed at continuing efforts to ensure a reasonable income

for all members of society and providing better access to resources and high-quality services. The strategy comprises a more integrated approach which combines financial aid and social services. Romania's priority here is to develop childcare facilities and reach an adequate level of social allowances.

– *Continue with efforts to improve the living conditions of the Roma.* In the presentation of this objective, there is some confusion between the objectives and the measures envisaged. Little indication is given as to how the problem of premature school-leaving/illiteracy will be reduced or how the participation in education of the Roma will be improved. Romania will continue in its endeavour to improve access to the health services, and will also continue the programmes to train health/school mediators, develop national programmes to encourage the Roma to participate in the official labour market, and promote anti-discrimination policies. The commitment to implement the monitoring and evaluation system for programmes and policies to help the Roma population is a positive factor, as is the collection of the data needed to develop suitable policies. However, the weak point remains the lack of quantified objectives. The strategy will have to focus more on the situation of Roma women.

The objectives and measures seem to be realistic and correspond to needs, but in the absence of quantified objectives, they may amount to no more than a declaration of good intention at a rather general level which would be difficult to assess.

3.5. Governance

While the development of the strategy for 2008-2010 proved to be a high-level exercise which remained virtually invisible for certain actors in the field of social inclusion, in daily practice, there has been some improvement as regards the creation and strengthening of the capacity of the relevant competent institutions, and the participation of the social actors, particularly with regard to the social dialogue. Nevertheless, a clearer division of roles and responsibilities should result from a consultation process between all parties concerned at all levels. Many non-governmental organisations, local authorities, and individuals (including journalists and politicians) were not informed of the development of the current strategy. Their potential contributions remain an untapped resource in the search for solutions to eradicate poverty and the fight against social exclusion. For each priority objective, the strategy identifies the institutions responsible for implementation. Romania's efforts in relation to the new period will focus on consolidating the national mechanism to foster social inclusion, to make it the framework for the coordination and development of social policies. This objective will be achieved through the implementation of a programme financed by the ESF as of 2009.

4. PENSIONS

4.1. Key trends

Like most EU Member States, Romania must face significant demographic challenges in both the short and the long term.

The early retirement systems adopted over the first decade of transition have considerably increased the number of pensioners (80% between 1990 and 2003). The early retirement policy designed to solve the problem of growing unemployment resulted in a fall in the average age of pension entitlement. Consequently, the number of contributors per retired

person fell from 3.43 in 1990 to only 0.79 in 2003, while pension expenditure as a percentage of GDP decreased from 7.2% to 6.5% over the same period. In order to cover the growing deficit in the pension funds, the government increased contributions by 49.5% in 2005. Owing to high employee taxation (around 50% of gross earnings), the government has decided to reduce this contribution to 40.3% by the end of 2008. The Romanian pensions system has undergone numerous reforms in recent years (particularly with the introduction of a private component in 2007). The new pensions system has three entirely functional pillars: pillar 1 (public, financed entirely and run according to the PAYG system, earnings-related, compulsory, DB), pillar 2 (private, financed entirely and run by private funds, compulsory for those under the age of 35 and optional for those aged 35 to 45) and pillar 3 (private, optional), which is mainly intended for the self-employed and farmers, but is also open to public- and private-sector employees. Pillar 1 (public, compulsory, succeeding the old PAYG system), was introduced in 2000 with a contribution rate of 29% of gross earnings (shared between the employer and the employee) and has 5.5 million contributors from a total working population of 8.8 million. The number of pension points was increased several times, mainly in 2007, to reach 37.5% of the average salary, and there are plans to further increase it to 45% of the average salary.

4.2. Key challenges and priorities

Romania is facing considerable challenges in relation to the sustainability of the pensions system in both the short and the long term. On the one hand, it must confront short-term collection problems and, on the other, problems due among other things to the relatively low number of contributors to the system in comparison to the number of beneficiaries, the still low level of employment among older workers (41.4%), the substantial percentage of work which is not declared (around 20-50% of total employment according to the definitions used), and resources which are still insufficient. National data indicate an expenditure level of 7.3% of GDP for 2008, which is still lower than the European average. One significant challenge in terms of sustainability lies in the introduction of the pre-financed component of the first pillar, with consequences on the reduction of funds available for today's pensioners and also on the deficit of the PAYG system.

The Romanian government has taken a series of measures to deal with these challenges (for example, increasing the minimum contribution period from 10 to 15 years, increasing the minimum retirement age from 57 to 60 years for women and from 62 to 65 years for men by 2014, measures to encourage the employment of older people, etc.). In the near future, the reform priorities will focus on including farmers and self-employed workers in a contribution scheme, reducing differences between pensions, and increasing the number of people on the labour market in order to maintain the financial sustainability of the first pillar. Attention should continue to be focused on improving the collection of contributions and combating undeclared work.

4.3. More people in work and working longer

Romania has an ageing population, which raises the question of system sustainability. The figures who that the employment rate is lower than the European average (58.8%, in comparison to 65.4% in 2007). Over the most recent period, the rate of employment of older workers has remained relatively stable (41.4%), lower than the European average (44.7%), and with significant differences between men (50.3%) and women (33.6%), despite the growth registered by Romania in recent years. The minimum period of contribution to the pensions system is 25 years for women and 30 years for men. The strategy also mentions the

possibility of establishing equal contribution periods for men and women, but no precise information is available concerning the date of the discussions. The number of people receiving a disability pension is a cause for concern: these are actually early retirement pensions (in 2005, this rate was abnormally high and represented almost 14% of the total number of retired people). The objective of pensions policy in the years ahead will be to establish a financially viable system which can offer adequate pensions for everyone. In order to achieve this objective, the Romanian government has made a number of political decisions to lessen the burden of ageing, at least in the short term (for example, through an increase of the minimum contribution period and the retirement age, measures to encourage older people to stay in work after the retirement age, strict limitations on early retirement introduced recently in order to discourage this common practice, the establishment of a national programme to promote the employment of older people for the 2008-2011 period, etc.).

4.4. Privately managed pension provision

Two pillars corresponding to the private pensions system were introduced in 2007: pillar 2 (regulated by Act 411/2004) and pillar 3 (regulated by Act 204/2006). Pillar 2 (private, incorrectly referred to as the "*pilier 1bis*" [pillar 1a]) is compulsory for everyone up to the age of 35. Contributions are optional for those aged between 35 and 45. Pillar 2 (or "*pilier 1bis*") is the pre-financed component of the first pillar, as a portion of social security contributions is mandatorily channelled into privately-managed pension funds. The contribution rate over the first year is 2% of gross income and will rise to a maximum of 6% by the end of 2016. The number of contributors registered in this system was 4.15 million (March 2008). Pillar 3 (private, voluntary), is intended mainly for self-employed workers and farmers, but is also open to public- and private-sector employees; contributions are limited to 15% of gross monthly income, and employers may participate in this contribution. The first contributions started in May 2007. One year later, 88 000 contributors were registered (80% of them in urban areas). The authority responsible for regulating and monitoring private pension funds is the CSSPP (Monitoring Committee for the Private Pensions System), established in 2005, as an independent body accountable to the Romanian Parliament. A pensions fund can function with a minimum capital in RON equivalent to 4 million euros; over the first three years, the fund needed to attract at least 50 000 contributors.

4.5. Minimum income provision for older people

The data indicate that the risk of poverty among older people is approximately the same as for the total population of Romanian (19%), but with significant differences between men (13%) and women (22%). The Romanian social welfare system offers guarantees for the most underprivileged. Romanian legislation does not set a minimum pension level because the level depends on the contributions paid. Nevertheless, retired people with insufficient pensions are covered by various social assistance schemes, the most important one being the guaranteed minimum income. According to one study, the impact of the guaranteed minimum income is greater among older people: the rate of poverty in the population aged over 65 has decreased from 22.2% to 19.1%.[90]

[90] Zaman and Stanculescu, 2006

4.6. Information and transparency

In 2007, a national campaign was conducted to inform the population of the recent changes in the pensions system. The results of the survey which followed this campaign show that 78% of Romanians are well informed about the private pensions system, 52% know that the private pension is correlated with the policy of investment in a pensions fund, 78% are aware of the existence of the CSSPP and 88% have a positive opinion of this institution. Whereas 61% of the people interviewed have no confidence in the public pensions fund, 60% are in favour of private pensions, and 73% of them are well informed about the third pillar of the system.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Eurostat figures indicate a rather precarious state of health for Romanians in comparison to other EU countries: they have one of the lowest life expectancies at birth in the EU (69.2 for men and 76.2 for women in 2006), and one of the highest maternal and infant mortality rates in the region despite recent improvements. The most common causes of death in Romania are cardiovascular diseases (62.1%), cancer (17.6%), digestive illnesses (5.5%) and respiratory illnesses (4.9%). The Roma have the worst health record. The results of a survey carried out in 2000 show that only 34% of Roma have sickness insurance. In general, the Romanian health system is perceived by the population as one of the most corrupt elements of society. [91]

Major reforms in the field of healthcare aim to transform the centralised system into a decentralised, pluralist system based on contractual relations between the health insurance funds as purchasers and healthcare providers. It operates on the principle of insurance, with compulsory participation correlated to the status of employee. Contributions are a percentage of income and are paid by the employer and the insured person. Private practices are authorised although hospitals are mainly state-owned.

The aim of this strategy is to improve the health conditions of the population and help to create a modern, efficient health system which is compatible with the health systems of the EU. In the medium term, the Romanian government is trying to improve access to basic medical services and service quality. A certain number of strategies have been developed to achieve this, the most important of which are linked to the development of infrastructure and of preventive medicine. Preventive medicine is currently an essential priority for the government, given the results of the national programme recently established to evaluate the health of the population. According to the conclusions of this evaluation, around 37% of the Romanian population is at risk of illness.

5.1.2. Accessibility

For certain categories, there is the issue of accessibility to medical services: a) people without sickness insurance (around 5.7% of the population), b) people living in remote rural areas (who must travel large distances between their homes and the nearest health institution) and c) insured people who are living in poverty and are unable to pay for related services (for

[91] Study carried out by Transparency International, 2006

example, medicinal products, services not covered by insurance). Access to healthcare is particularly low in the case of the Roma minority. Differentiated access to services is also due to the heterogeneous territorial distribution of hospitals, hospital beds and medical staff. Access to care has recently improved, above all as regards universal access to pre-hospital/hospital emergency services for insured and non-insured persons alike. For example, in the pre-hospital sector between 2007 and 2008, 2 420 ambulances and 71 vehicles to transport traumatised patients were purchased, while in the hospital sector, 167.7 million euros were invested in modern equipment for 313 hospital units to deal with emergencies). Access to health programmes (e.g. oncological treatment, diabetes, programmes for mother and child, etc.) is also provided for non-insured persons to the same extent as for insured persons. The report presents a series of measures envisaged to improve the accessibility of healthcare in the near future. Among the objectives set for the new period, the government intends to build 28 new hospitals, renovate 15 emergency hospitals, purchase 1 520 ambulances, and recruit 500 community medical assistants per year and 50 Roma mediators per year.

5.1.3. Quality

In 2007/2008, considerable investments were made in the purchase of medical equipment in hospitals. However, not enough medicinal products are available as the most expensive medicines are the first choice in medical prescriptions. Obstacles to improving quality are posed by poor distribution and the low salaries of medical staff. It is customary to pay health staff "under the table". According to certain estimates, illicit payments to medical staff amount to around 285 million euros per year. Efforts have been made to channel resources into the best health establishments and eliminate hospitals and specialised centres of lower quality. The purchase of equipment is problematic in general. Certain measures are set out in the strategy in this respect, but there are no quantified references, without which the strategy could simply remain a declaration of good intentions, with overly general objectives. Attention should continue to be focused in Romania on the regional disparities in the purchase of equipment.

5.1.4. Sustainability

In 2004, Eurostat estimated total health expenditure at around 5.5% of GDP. In 2004, public health expenditure represented 66.1% of total health expenditure, which is increasing, while non-reimbursed payments accounted for 31.7% of total health expenditure. Furthermore, like the pensions system, the health system is based on a system which functions according to the contribution principle. Demographic trends and the fall in the number of contributors will threaten financial stability. The use of supplementary sickness insurance, provided by private institutions, could be a solution, but access to this service will remain limited to people on high incomes. Financial sustainability looks highly insecure when we compare health expenditure in Romania to the EU average. Human capital is one of the concerns relating to the sustainability of the system: Romania faces high intra-Community mobility of medical staff, who prefer to work in other EU Member States where the pay is higher. Romania must therefore envisage a suitable human resources strategy to improve the quality of their employment conditions, and also encourage them to stay in Romania to work. As regards training, Romania must use the support offered by the ESF in this field.

5.2. Long-term care

5.2.1. Description of the system

According to the strategy, the beneficiaries of the system are older and disabled people, a large majority of whom are assisted by their families or live alone. Only those who need permanent medical care are included in the system. Reforms in this field of long-term care have shifted responsibilities from the central budget to the local authorities and the regions. The financing of the system is mixed and combines resources from the national and local budgets. Cuts in community-based services are continuing and, despite some progress, the system is still underdeveloped and NGOs play an important role in terms of organisation and funding. The National Authority for Disabled People is responsible for developing the social services system for the disabled. Progress has been made (an increase in the number of social services, the adoption of a strategy for disabled persons for the period 2006-2013, the development of an assessment tool to identify and analyse social service needs), but efforts must continue, above all in relation to quality.

5.2.2. Accessibility

The number of establishments providing long-term care has increased. The number of retirement homes for the elderly has risen from 19 in 2005 to 68 in 2007 (financed by local budgets) and 38 other institutions have been created since 2005 (financed by the NGOs). Nevertheless, the strategy does not give indications as to their geographical distribution. With regard to the second category of long-term healthcare beneficiaries, namely the disabled, the government has tried to develop the capacity of specialised institutions by converting over 140 residential health establishments into institutions for the disabled. The majority of these institutions were retirement homes or hospitals for the chronically ill, but almost no special alterations have actually been made to adapt the establishments to patients' needs.

5.2.3. Quality

The improvement in the quality of long-term healthcare and in the living conditions of the beneficiaries of residential long-term healthcare remain a priority for the Romanian authorities, as does the development of a network of social workers and the improvement of both sanitary conditions and the qualifications of staff working in this sector. Measures are envisaged, but the strategy must set indicators which will be useful for subsequent evaluations. The strategy also includes a commitment to encourage home care for dependent people. Measures envisaged include the possibility of paying and properly training family members involved in the care.

5.2.4. Long-term sustainability

The strategy does not give many indications on this subject: it refers only to the fact that, in order to be sustainable in the long term, the system must be reformed (payment of services by the "customer"; on the one hand, state intervention for those who cannot afford this expenditure and, on the other, sufficient guaranteed resources for the local authorities).

6. CHALLENGES AHEAD

- To continue efforts to break the cycle of poverty among the most vulnerable (above all children in vulnerable situations), with emphasis on the effective implementation of

sectoral strategies and the development of the instruments necessary for adequate follow-up.

- To ensure that strategies in the field of social inclusion and employment dovetail. To continue efforts to increase the participation of everyone concerned in the development of suitable policies and in their implementation.

- To pursue efforts to improve the capacity of local authorities to better identify and implement priorities in the social domain, so as to increase the quality and efficiency of services on a decentralised basis, and reinforce local/regional administrative capacity to ensure better use of European funding in this sector.

- To continue efforts to improve the situation of the Roma (with particular emphasis on increasing their participation in education, training and the official labour market, solving the issue of identity papers and combating all forms of discrimination).

- To strengthen the functioning and sustainability of the current and future pensions system, in the short term through improved collection of contributions and in the longer term by increasing the number of contributors to the system and the general rate of employment (particularly among older workers), in parallel with a decrease in undeclared employment. Efforts must continue to reduce the inequalities which persist for a large category of people.

- To continue efforts to solve the problems of the accessibility of healthcare and of good quality, long-term care, and above all to reduce geographical disparities and tackle the issue of high private expenditure on healthcare and pharmaceutical products.

- To pursue efforts to develop a decentralised, functional social health system which is capable of ensuring long-term financial sustainability and the efficient use of resources. A human resources reform must be envisaged in order to meet the challenge posed by the intra-Community mobility of medical staff and the problem of corruption.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	2,1	25,9	**2000**	63,0	68,6	57,5	34,0	49,5	**2000**	7,2	7,8	6,4	20,0
2005	4,2	35,0	**2005**	57,6	63,7	51,5	24,9	39,4	**2005**	7,2	7,8	6,4	20,2
2008*f*	7,8	44,3	**2007**	58,8	64,8	52,8	24,9	41,4	**2007**	6,4	7,2	5,4	20,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	65,3	73,1	12,6	15,1	n.a.	n.a.	21,2	**1995**	n.a.	n.a.	n.a.		-
2000	67,7	74,6	13,4	15,7	n.a.	n.a.	18,6	**2000**	4,6	74,1	25,9	**2005**	-
2006	69,2	76,2	13,6	16,5	n.a.	n.a.	12,0	**2006****	5,5	70,3	25,3	**2006**	-

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	13,2	48,5	25,6	7,7	10,0	0,4	7,9
2006	14,0	45,0	34,8	2,7	8,9	1,2	7,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
		Total social expend.	Public pensions	Health care	Long-term care
2004	21,3	n.a.	n.a.	n.a.	n.a.
2010	21,3	n.a.	n.a.	n.a.	n.a.
2030	30,3	n.a.	n.a.	n.a.	n.a.
2050	54,0	n.a.	n.a.	n.a.	n.a.

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	19 (p)	25 (p)	17 (p)	19 (p)	23(p)	26 (p)	23 (p)	19(p)	5,3 (p)	**2005**	n.a.
male	18 (p)	-	17 (p)	13 (p)	23 (p)	-	23 (p)	17(p)	-	**2006**	n.a.
femal	19 (p)	-	16 (p)	22 (p)	24 (p)	-	23 (p)	20(p)	-	**2007**	n.a.

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2000	6,8	8,7	7,7	9,6	**2000**	3,5	3,6	3,4	**2000**	22,3	23,3	21,3
2004	11,1	11,1	10,4	11,7	**2004**	4,5	5,2	3,6	**2004**	23,6 (b)	24,9 (b)	22,4 (b)
2007	10,0	10,4	9,3	11,5	**2007**	3,2	3,6	2,7	**2007**	19,2	19,1	19,2

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,89 (p)	n.a.	n.a.	***Aggregate replacement ratio***	n.a.	n.a.	n.a.

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
52	39	39	DB/DC	/	-	n.a.	/	29	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Slovenia

1. SITUATION AND KEY TRENDS

The positive macroeconomic context and strong performance recorded over the last couple of years boosted the employment rate and brought down unemployment to a low level. However, inflation in Slovenia was 6% in August 2008, the highest in the euro area. The Slovene economy experienced a 6.8% growth in GDP in 2007 and 1.9% in the first quarter of 2008 (EU 0.6%, Eurostat). However, partly as a result of the global financial crisis, growth has started to slow down. It is forecast to reach 4.0% in 2008 and 0.6% in 2009, as a result of a broad-based deceleration in investment activity. Unemployment is forecast to reach 4.5% in 2008 and 5.2% in 2009.

GDP per capita reached 88.8% of the EU average in 2007. Although the employment rate is slightly above the EU average (67.8% in 2007), and the unemployment rate is one of the lowest (4.9%), the labour market is characterised by low employment of elderly workers (33.5%), especially elderly women (22.2%; the employment rate of older men was 45.3%). Although this is improving, this indicator is still one of the lowest in the EU and considerably lags behind the Lisbon target of 50% by 2010. The labour market is also characterised by a relatively high youth unemployment rate (10.1% compared to the 4.9% average in 2007). The GDP spent on social expenditure is estimated at 24.2% for 2004-2010, with 12% of the population at the risk of poverty in 2007 (10% of men and 13% of women), which is below the EU average. The shares of social expenditure as a percentage of total benefits were spent on pensions (45.4%), followed by healthcare benefits (32.1%), 8.6% on family and children (benefits linked with pregnancy, birth, adoption, child rearing and care for other family members), 8.5% on disability, 3% on unemployment and 2.5% on housing and social exclusion. Slovenia is expected to face similar demographic trends to most EU Member States in the coming decades: the old-age dependency ratio (23.9% in 2006) is estimated to more than double (to 59.4% in 2050). Life expectancy at birth has risen substantially in the last decade, reaching 82 years for women and 74.5 years for men in 2006. Slovenia had the eighth lowest birth rate in the EU in 2007 that is 0.98%.

2. OVERALL STRATEGIC APPROACH

The general strategic approach of the NSR 2008-2010 is based on the thrust and substance of Slovenia's Development Strategy, which functions as an umbrella strategic national document for the period until 2013. The NSR recognises that globalisation, competitiveness and the ageing of Slovenian society require adjustment and modernisation of the social protection systems to promote a sustainable social state. On the other hand, strengthening individual responsibility and awareness of the need for constant personal development, education and training is essential.

The key social inclusion priorities of the NSR are to provide adequate income support to vulnerable groups to prevent social exclusion, to raise the potential of an inclusive labour market in combating poverty and social exclusion and to provide access to social services of general interest. The NSR recognises that demographic trends, changes in the labour market and globalisation affect the pension system and the link between employed insured persons

and retirees. Regarding the health sector, the strategy concentrates on reducing overall regional and population differences in health status, by improving access to and quality of services and by raising awareness of individual responsibility for one's health. These priorities largely correspond to the country's specific challenges. There is an overall continuity with the 2006-2008 strategy report and the objectives and the priorities correspond sufficiently to three newly defined priorities.

However, gender and disability issues are not systematically mainstreamed into policies.

Social inclusion and social protection policies are closely linked to the Lisbon Strategy for growth and jobs. Unfavourable demographic trends require further steps to boost employment, especially for the elderly and for young people. Measures to fight poverty and to support integration into the labour market are considered an investment in people as well as in the national economy, as they ease the burden on the government budget and promote growth by increasing the supply of labour.

The ESF is partly involved in achieving the key challenges, especially for social inclusion. €41 million from the structural funds is due to be invested in promoting social inclusion for vulnerable groups and €30 million in social infrastructure for the period 2007-2013.

3. SOCIAL INCLUSION

3.1. Key trends

In 2006, 12% of the population was at the risk of poverty, still among the lowest in the EU. However, this figure was high among certain groups of population, such as single person households (39%), women above 65 years (25%), the unemployed (36%) and single parents with at least one child (29%). The intensity of poverty in Slovenia is less severe than the EU average, which is reflected in the relative median at-risk-of-poverty gap of 19% in 2006, one of the lowest in the EU. Poverty in Slovenia is defined as living on €466 per month or less in 2006.

Due to the high employment rate and one of the lowest unemployment rates, only 6.5% of adults lived in jobless households in 2007, while the EU average is 9.3%. More women than men lived in jobless households. The situation has improved, since 8.2% of adults lived in jobless households in 2001. The trend is also positive for children, since the figures fell from 3.8% in 2001 to 2.2% in 2007 living in jobless households (compared to the estimated average for the EU27 of 9.4%). Moreover, 5% of people in gainful employment had an income below the poverty threshold and can be considered as 'working poor' in 2006, compared to the EU25 average of 8%.

The inactivity trap for single persons with no children was 71% in 2006. The unemployment trap in Slovenia is the highest in the EU-27 and increased from 80.5% in 2001 to 94.09% in 2006 (EU27 average: 75.39% in 2006). The indicators on education and skills are good: in the academic year 2007-2008, 48.2% of the population aged 19-23 attended post-secondary vocational training or higher education and the share of early school leavers was low at 4.3% in 2007. Nonetheless, 41% of welfare recipients had a low education level (according to national data), pointing to the need to ensure access to education and training.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Overall, Slovenia has made progress on the objectives set in the NSR 2006-2008. However, some indicators had no quantified target or were not reported on, and it is therefore difficult to assess their implementation. Regarding the challenge to increase the active inclusion of people depending on social assistance, progress has been made as the number of beneficiaries receiving cash social assistance has decreased and nearly 1000 beneficiaries of assistance have found permanent employment. However, in October 2008, the number of social aid assisted increased by 51.18% (from 1061 to 1604), which is presumably due to the initial impact of the economic downturn. In terms of the priority to provide housing to vulnerable groups, progress has been made regarding the number of places for individual vulnerable groups and for temporary residence. Regarding the fight against discrimination and the social inclusion of migrants into society, the NSR reported on measures taken (including an anti-discrimination campaign, research project, etc.), but not on the indicators defined in the NSR 2006-2008 report.

The fourth priority on social protection for the elderly is closely linked to the HLTC and the indicators achieved.

The challenge set in the 2007 Joint Report '*to strengthen the active inclusion of people depending on social assistance, especially young long-term unemployed persons, by ensuring proper accompanying measures and adequate incomes to ensure that those furthest from the labour market are not marginalised further'* is addressed in the NSR report on implementation. However, it is not clear whether regional differences were taken into account. The second challenge of social inclusion '*to undertake with all relevant stakeholders, a thorough analysis of the extent and nature of the discrimination and adapt the suitable strategy'* was only partly addressed. The "Roma Community in the Republic of Slovenia Act" has been adopted. Nevertheless, it is not clear whether a suitable strategy has been adopted.

3.3. Key challenges and priorities

The general strategic approach of the NSR 2008-2010 is based on the thrust and substance of Slovenia's Development Strategy document.

The main quantitative objectives to prevent poverty and social exclusion by 2010 are to: reduce the at-risk-of-poverty rate from 11.7% to 11%, reduce the at-risk-of-poverty rate of people older than 65 from 20% to 18%, reduce the unemployment rate to 3–4% by 2013 with an interim goal to reduce registered unemployment to 6.3% by 2010 (currently 7.4%); reduce unemployment among disabled people to the average rate for Slovenia; reduce waiting periods for integrating persons with disabilities into vocational rehabilitation to under three months. These targets seem ambitious, particularly given the current economic downturn.

The priorities identified in the Report are, to some extent, a reformulation of previous priorities to: (i) provide adequate income support to vulnerable groups in order to prevent social exclusion; (ii) realise the potential of an inclusive labour market in the fight against poverty and social exclusion; and (iii) provide access to social services of general interest in order to prevent social exclusion. These priorities globally correspond to the three pillars of the active inclusion approach. Compared to the 2006-08 period, additional importance is given to child benefit.

However, more attention should be given to employment conditions, especially for young people, and their housing problem, since 66% of young people aged 16-24 years work with fixed-term contracts (of which 76% are women). Most banks do not grant loans or mortgages to employees with such contracts. The discrepancy between salaries and real estate prices is also growing. This is the start of a vicious circle of a low permanent employment rate of young people, housing problems, consequently low birth rate and high budgetary pressure on pensions.

To tackle the expected rise in unemployment, special emphasis should be placed on the efficiency of employment services to allow quick redeployment measures for those made redundant. Flexicurity, upgrading skills, matching these to labour markets and maintaining household's income are vital under the current circumstances. In addition, the effectiveness of active inclusion policies in cushioning the impact of the financial crisis on vulnerable groups should be examined.

3.4. Policy measures

The Report sets a number of targets, although target values are not defined for all indicators.

The first priority objective, which aims *to provide adequate income support to vulnerable groups in order to prevent social exclusion* includes a number of existing social benefits, such as child support, subsidies for kindergartens (to reach a 90% kindergarten attendance rate for children in the second age group and to maintain the current rate of children in the first age group - this target does not seem very ambitious), subsidised school meals, scholarships and income support for persons with disabilities. It also includes support for the elderly, a basic amount of minimum income and cash assistance as a consequence of price changes and the fact that social support may not be adequately indexed to meet these changes. Most of these benefits already exist, therefore the priority measures are not considered to be very ambitious. The NSR does not mention the ESF contribution, even though it is used in some measures, i.e. scholarships. No mention is made of gender differences.

The second priority's objective *to realise the potential of an inclusive labour market in the fight against poverty and social exclusion* will be implemented through a number of ESF measures, including access to employment and training for vulnerable groups, promoting equal opportunities and social inclusion among young persons, and raising public awareness of equal opportunities as a positive social value. The focus is on people with disabilities, migrants and their children, Roma, refugees and their children, women, youth, reconciling family and professional life, social entrepreneurship and innovative ideas for new approaches to employment for the vulnerable groups.

The third priority's objective *to provide access to social services of general importance in order to prevent social exclusion* is tackled via a number of measures to improve access to housing, access to social assistance services (help at home, institutional care of the elderly, occupational activity centres) and access to kindergartens. The measures include increasing the number of places available in various care institutions. Targets for better access to services are: to involve 36% of persons with disability status in day care programmes in occupational activity centres under the Act on Social Care of mentally and Physically Handicapped persons; to increase the capacity of maternity homes and shelters for women to a total framework capacity of 350 places; to increase the capacity of admission centres and shelters for the homeless to a total framework capacity of 250 places; to increase the capacity of the therapeutic programme network providing psychosocial assistance to children, adults and

families to achieve full coverage (approximately one expert providing psychosocial assistance per 50 000 inhabitants) and to include vulnerable groups or persons with special needs in social assistance services, with a special emphasis on developing innovative or alternative forms of service.

3.5. Governance

Good governance is promoted by involving stakeholders in the preparation of the NSR. The Ministry of Labour, Family and Social Affairs coordinated the preparation of the report, which was prepared by a working group split into four subgroups according to subject. The NSR was also presented and discussed at a public consultation event organised for the general public, representatives of interest groups, local communities, NGOs, social partners, providers of the social assistance services, state administration and experts in specific fields. However, closer cooperation with ESF departments would further improve the quality of the preparation of the NSR, given the fund's substantial contribution to social inclusion.

Governance of the social OMC would also be improved by extending the use of quantified targets and establishing appropriate monitoring mechanisms to measure progress. This would also facilitate the work of the evaluation group, which is due to be established by the end of 2008 and will prepare two interim reports.

4. PENSIONS

4.1. Key trends

Low birth rate and prolonged life expectancy puts increasing pressure on the Slovenian pension system. Similarly to EU trends, the ratio between employees and retired people fell from 2.3 in 1990 to 1.7 employees per one retired person in 2007 (national data). In addition, Slovenia still has a low employment rate of older workers (55-64 years), although it rose from 29.0% in 2004 to 33.5% in 2007. In 2007, the average retirement age of men was 61 years and 10 months, and 57 years and 7 months for women. The effective labour market exit age was 59.8 years in 2006, which is one of the lowest in the EU27 (average 61.2 years).With long careers and some years spent caring for children the minimum pensionable age for women and men is 56 and 58 years respectively in 2008 (national data).

The at-risk-of-poverty rate for people over 65 years stabilised between 2004 and 2006 at 19 %. However, the gender gap persists and is widening, as the breakdown in 2006 was 25% for women and 11% for men. The at-risk-of-poverty rate before social transfers is 35% for women and 23% for men. Pensions are indexed to salaries. The relative median income ratio for the age group 65+ in 2007 is 0.86%.

A mandatory earning-related scheme financed on a PAYG basis covers the risks of old-age, disability and survivors. All employees and self-employed persons are covered, and specific categories of inactive persons may join the system voluntarily. The total contribution rate is 24.35% of gross wages. Employees pay 15.5% and employers pay 8.85%. Compensatory contributions for people absent due to unemployment, temporary sickness or caring duties are paid by the general state budget. In the year 2000 a comprehensive pension reform was introduced with a transitional period until 2024. It implies that the pensionable age for women will be gradually raised to 58 years and at least 38 years of pensionable service, while for men

a precondition of 58 years and 40 years of pensionable service is already in force. The reform also introduced a fully funded, voluntary supplementary pension scheme.

4.2. Key challenges and priorities

The 2007 Joint Report stated that the challenge ahead is to address financial sustainability and to ensure the adequacy of pensions, notably by considering a further pension reform and by taking complementary measures to increase the employment rate of older workers. During the period 2006-2008 no major reforms of the pension system were undertaken but improvements promised in the NSR for 2006-2008 were introduced, including the One-off Pension Allowance Act (2008), the Minimum Pension Support Act (2008) and the social state pension for people without entitlements. The basic aims of these were to reduce the high pressure caused by rising living costs, especially for pensioners with low pension income, and to ensure a minimum income for older people. In the absence of an agreement with the social partners and sufficient political consensus in 2006, proposals for further changes to the pension system to increase sustainability have been left pending. It remains to be seen whether it becomes part of the new government programme.

Budgetary pressure due to age-related expenditure is higher in Slovenia than in most other Member States. The old-age dependency ratio is projected to double - from 23% in 2008 to 59.4% in 2050. According to an AWG forecast in 2005, public pension expenditure is due to increase to 18.3% of GDP in 2050, a rise of 7.3 percentage points of GDP from 2004. Without policy changes, overall government debt, currently contained at 29.1% of GDP, would rise to about 287.2% of GDP by 2050. The net theoretical replacement rate is projected to rise by 2 percentage points 2006-2046 for an average wage earner retiring at age 65.

According to the NSR, Slovenia aims to have a pension system which not only protects against old age poverty but also maintains pensioners' standard of living. Supplementary pension insurance was introduced to partially compensate for the planned long-term reduction in pension levels under mandatory insurance. In 2007, the ratio of pension/salary was 61.5% and it is predicted to fall to 56.33% by the end of the reform transitional period in 2024 (national data). The at-risk-of-poverty rate for people over 65 at 19% is almost twice as high as the figure for 18-64 year olds (10%). On average a person over 65 has 86% of the average income of a person up to that age.

Changes to the pension system are needed in order to achieve both long-term sustainability and adequacy. In particular, change should focus on promoting longer working lives and reforming the pension system (higher pensionable age, longer contribution periods etc.). However, longer working lives must be supplemented with measures enabling older workers to find suitable employment. Not much has been done in this respect in Slovenia, despite the awareness of the need to achieve higher employment rates among older workers. An active ageing strategy was announced in 2005 but has still not been adopted. Reducing early exits from the labour market and encouraging and enabling older workers to continue working longer, coupled with major changes to the pension system, would be key to ensuring future adequacy and sustainability.

4.3. More people in work and working longer

The employment rate of older workers (55-64) has gradually risen (from 2005 to 2007 by 2.8%) but at 33.5% it is still one of the lowest in the EU, reflecting a long tradition of pensionable ages below 60 and insufficient measures to encourage and enable people to work

longer. Currently only 17.7% of all pensioners have a working career lasting more than 40 years, of which 34.2% are men and 5.3% are women (national data).

Existing pension and employment legislation does not provide effective incentives for staying longer on the labour market. Moreover, there is a lack of employment opportunities for the elderly. Therefore an overall active ageing strategy composed of coherent measures targeting both individuals and organisations is essential.

4.4. Privately managed pension provision

Supplementary pension insurance organised by licensed, privately administered pension funds was introduced as part of the pension reform in 2000. Of those covered by supplementary insurance, only 5.48% are on individual schemes, the rest being insured by collective schemes. 55.19% of people covered by statutory pension and disability insurance are also members of a supplementary pension scheme. On the basis of past trends, contribution rates and the return on investments will not be sufficient to compensate for the planned reduction of replacement rates in statutory pensions; this was the case even before the financial crisis. The problem is recognised under the NSR 2008-2010, but no policy response is given. This is another issue where reforming the pension system is much needed.

Supplementary pension insurance is compulsory for persons whose employment is particularly challenging, harmful to their health or those employed in professional activities which cannot be successfully performed after a certain age.

4.5. Minimum income provision for older people

In 2006, the at-risk-of-poverty rate for women over 65 is 25%, for men it is only 11% and the total stands at 19%. The at-risk-of-poverty rate is much higher for older women than men, also according to data before social transfers (for women over 65 it is 35% and 23% for men). The problem of a high risk-of-poverty for older people has been recognised by the government, which aims to reduce it to 18%.

A large share (22.1%) of retired people receives pensions of between €300 and €400 per month, with only 18.3% of pensioners receiving pensions of over €700. However, the amount of average net pension is similar to the minimum wage, which was around €513 in 2007 (national data).

People without sufficient entitlements under the mandatory scheme may claim a means-tested state pension. In 2007 the average monthly state pension was €158.69. In the same year, state pension recipients represented 3.2% of pensioners under mandatory insurance.

4.6. Information and transparency

The level of financial literacy regarding the supplementary pension insurance system (voluntary part) is rather low and the NSR mentions the need to increase ‘financial literacy’, especially concerning the supplementary pension insurance system.

General information is provided on the Institute of Pension and Disability Insurance (IPDI) website. However, this is not the most effective channel, given the low level of internet usage (20%) among the age group 55-64. Another way to access this information is directly from the IPDI. Since the number of people interested in this information is growing but the number

of staff employed at the IPDI remains the same, the response time is becoming longer. A new information mechanism is therefore needed to ensure high quality information.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Slovenia has an insurance-based compulsory healthcare system, financed by the social contributions paid by employees and their employers. A public-private partnership funding model is operated by the Health Insurance Institute of Slovenia and insurance companies. Public funds include compulsory health insurance and state and community budget funds. Private sources include voluntary health insurance funds, part of accident insurance company funds, direct payments from individuals for healthcare services, medicinal products and medical devices, as well as funds of various companies, charity organisations and donors. Statutory health insurance covers almost the entire population (98.7%) and provides a wide range of benefits.

Healthcare provision is delivered by public institutions and private undertakings holding a concession for performing an activity financed by public funds. The municipalities are responsible for capacity and organisation at primary level while secondary and tertiary level healthcare provision is the responsibility of the state. Primary-level provision is seen as insufficient to meet the needs of the ageing population.

The fifth priority of Slovenia's Development Strategy (SDS) and related Action Plan on 'Health as Part of the Quality of Life' sets the framework for the Slovene health strategy. During the last 12 months several acts (Mental Health Care Act), amendments to acts (amendments to Health Care and Health Insurance act) and resolutions (Resolution on National Plan of Health Care 2008-2013) were passed to help improve the efficiency and quality of healthcare. Amendments to the Health Care and Health Insurance act provide a significant contribution to greater social inclusion by providing funding from the national budget for co-financing health services up to their full price for the socially disadvantaged.

Regarding health status, many schemes focused on promoting a healthy lifestyle, prevention and individuals' own responsibility for their health. However differences persist between regions and population groups, although most respondents declared themselves to be in good or very good health. Life expectancy at birth is on the rise (78.3 years in 2006) and is higher for women (82.0 years) than men (74.5 years). Infant mortality is decreasing (3.4 ‰ in 2006), which is among the lowest in the EU-27.

5.1.2. Accessibility

Accessibility is improving. According to OECD data, 98.7% of the population was covered by health insurance in 2005. Those not covered include refugees, asylum seekers, former prisoners and foreigners with temporary residency. In 2006 self-reported unmet needs for total medical and dental care are well below the EU average (SLO 0.2; EU 3.1). Equal access is provided to all citizens at primary level with evenly distributed basic primary and hospital-level healthcare capacity (with the exception of some remote rural areas). Access to specialist outpatient hospitalisation services is not so even and is mainly concentrated in towns and

major cities. Differences between regions exist and therefore a minimum level of coverage of the public health service network should be established to ensure more equal access to care.

Compulsory health insurance covers 100% of the costs of treatment only for certain groups of people (children, pupils, students) or for certain services (diagnoses and conditions). For other groups of persons and services, co-payment is requested. The share of out-of-pocket payments (payments for pharmaceuticals and services excluded from the benefits package and access to physicians on a private basis) has increased since 2002. It represented approximately 11.6% of expenditure on health in 2004 and exceeded 12% in 2005. The insured persons pay for these services out of their own funds or take out voluntary supplementary health insurance. This arrangement is in part unfavourable for those without income or in a low income family and may represent a serious financial burden for people in lower socio-economic groups.

Waiting periods have been shortened to some extent but still remain long for orthopaedics, orthodontics, open-heart, cataract and goitre surgery as well as for some more demanding diagnostic tests. The waiting period increased for vascular surgery. Slovenia aims to cut waiting periods to below the maximum permissible periods for closed treatment of primary diseases, with regard to individual treatment groups, through the measures laid down in the draft Resolution on the National Programme of Safety and Health at Work.

5.1.3. Quality

In general, Slovenia is one of the EU-12 that can boast good quality healthcare. The Patients' Rights Act adopted in January 2008 ensures equal treatment for all. To improve quality, authorities introduced six indicators regarding the quality of hospital services to be monitored. Patients have a representative in the Assembly of the HIIS and participate in the management of health institutes. Another important institute is the Ombudsman for Patient Rights.

The introduction of new technologies represents a serious challenge due to a lack of economic evaluation. It is not evident from the NSR that Slovenia would use either the ESF or the ERDF to improve access.

5.1.4. Sustainability

Total expenditure on health (8.5% of GDP and 1.959 per capita $PPP in 2005) is below the EU average (9.0% and 2.454 $PPP) and expenditure as a share of GDP has not changed substantially in the past years. Compulsory health insurance funds accounted for 6.05% of GDP in 2007. An increase was found in private health expenditure. Social insurance contributions represented the main source of funding of health care (72%), followed by the health insurance institute (13%) and payments from households (12%).

As regards coverage of healthcare professionals, a certain deficit in physicians (primary level) and nursing staff (secondary and tertiary levels) has been noted in recent years. Slovenia had around 2.48 doctors, 0.65 dentists, 1.9 nurses (or 6.4 health care providers) and 4.76 hospital beds per 1 000 inhabitants in 2006 (national data).

Great emphasis is laid on carrying out and implementing health promotion programmes, early detection of risk factors for chronic and degenerative diseases and on educational and awareness-raising programmes to heighten citizens' responsibility for their own health.

5.2. Long-term care

5.2.1. Description of the system

Although preparation of the new law on long-term care had commenced in 2005, Slovenia still lacks a coherent system of long-term care. Services and benefits are provided by the system of health care, social security, pension and disability insurance and by special regulations governing the status of persons with disabilities and war veterans, but coordination is poor. The main source of funding is compulsory health insurance. Providers, both public and private, provide different services under institutional forms of assistance and integrate healthcare and social areas, although assistance has not been integrated in the context of forms provided in the living environment. Some services are provided in the form of institutional health care as well as home care by close relatives. The current organisation of long-term care does not fully provide users with quality, equal and needed access to services.

5.2.2. Accessibility

As regards available capacity, the situation is improving, but demographic trends are not favourable and the current capacity available in the health and social security system does not cover actual needs. The waiting periods to receive a number of services are still relatively long, geographical coverage is uneven and there is a lack of doctors and medical nurses. Provision of home-care services is insufficient and underdeveloped. In addition, demographic changes and the reconciliation of work and family life mean that fewer and fewer families are able to take care of elderly family members at home.

5.2.3. Quality

The quality, rights and access to long-term care differ between individuals in institutional care and those cared for at home. While the former can get quite comparatively good treatment the latter is not ensured the same quality. Lack of capacity in institutional care and underdeveloped home care coupled with the lack of coordination are the main challenges to quality provision.

5.2.4. Long-term sustainability

More than half of the expenditure on social services for long-term care is funded from public sources, with the rest covered by private funds, comprising extra payment for lodging and food in homes for elderly and other types of institutional care. The draft Act Amending the Health Care and Health Insurance Act is expected to provide for more stable financing of health care, shaping healthcare programmes and services and their prices in partnership. The objective of the Act is also to improve the payment of contributions and to more effectively manage healthcare expenditure. New long-term care insurance is also due to be introduced, aiming to bring in personal co-payments and voluntary insurance for long-term care.

6. CHALLENGES AHEAD

- To promote social and labour market inclusion of young people and to address the barriers to accessing housing.

- To improve governance, particularly by extending the use of quantified targets, establishing appropriate monitor mechanisms to measure progress and enhancing cooperation with ESF departments.

- To reach agreement on and carry out major changes to the pension system in order to address the long-term financial sustainability and adequacy of pensions and to substantially step up efforts to increase the employment rate of older workers.

- To further improve access to the healthcare system, notably by further reducing waiting lists and improving access to new pharmaceuticals, while continuing to improve system efficiency.

- To establish a coherent and better coordinated long-term care system with sufficient capacity and services provided by trained personnel.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4,4	79,8	**2000**	62,8	67,2	58,4	31,2	22,7	**2000**	6,7	6,5	7,0	16,3
2005	4,3	87,4	**2005**	66,0	70,4	61,3	34,1	30,7	**2005**	6,5	6,1	7,0	15,9
2008*f*	4,0	89,3	**2007**	67,8	72,7	62,6	37,6	33,5	**2007**	4,9	4,0	5,9	10,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	70,8	78,5	13,6	17,6	n.a.	n.a.	5,5	**1995**	n.a.	n.a.	n.a.		-
2000	72,2	79,9	14,2	18,7	n.a.	n.a.	4,9	**2000**	8,4	74,0	11,5	**2005**	0,3
2006	74,5	82,0	15,8	20,0	57,6	61,0	3,1	**2006****	8,5	72,4	12,4	**2006**	0,2

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	**2004**	23,0	24,2	11,0	6,4	0,9
2000	24,2	45,2	30,7	4,3	9,2	1,6	9,0	**2010**	23,9	-0,2	0,1	0,3	0,2
2006	22,8	45,4	32,1	3,0	8,6	2,5	8,5	**2030**	40,8	4,4	3,4	1,2	0,6
								2050	59,4	9,6	7,3	1,6	1,3

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	12	11	10	19	19	21	19	20	**3,3**	**2005**	12b
male	10	-	10	11	19	-	20	15	-	**2006**	11
femal	13	-	10	25	20	-	19	20	-	**2007**	10

	People living in jobless households					Long Term unemployment rate				Early school-leavers			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female		Total		Male	Female
2001	3,8	8,2	7,1	9,4	**2000**	4,1	4,1	4,2	**2000**	n.a.	n.a.	n.a.	n.a.
2004	3,8	7,5	7,0	8,0	**2004**	3,2	3,1	3,4	**2004**	4,2u		5,8u	2,6u
2007	2,2	6,5	5,5	7,5	**2007**	2,2	1,8	2,7	**2007**	4,3u		5,7u	2,7u

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,86	1	0,81	***Aggregate replacement ratio***	0,44	0,51	0,39

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions: Estimate of current (2002)	pensions: Assumption
2	-4	-4	DB	/	-	100	/	24,35	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Slovakia

1. SITUATION AND KEY TRENDS

Slovakia continued to register a high GDP growth rate - the highest in the EU in 2008 at 7.1% (forecast at 2.7% in 2009). GDP per capita increased by 5 percentage points (pp) to 68.4% and then to 69.1% of the EU average in 2007 and 2008, respectively. Strong growth was only partially reflected in better labour market performance in 2007, with total employment increasing by 2.1% to 60.7%, and female and male employment growing by 2.2% and 2.0% to 53% and 68.4% respectively. Despite the fact that the employment rate for older people (55-64 years) has been steadily increasing from 23% in 2002 reaching 36% in 2007 (men: 53%, women: 21%), mainly due to the raised minimum pension age, it is still one of the lowest in the EU. Since 2000, the employment rate for young people (15-24 years) has been among the lowest in the EU: in 2007 it stood at 27.6% (men: 30.9%, women: 24.1%). The unemployment rate, despite slowly but steadily decreasing from 18.8% in 2000 to 11.1% in 2007 (men: 9.9%, women: 12.7%), remains the highest in the EU. It particularly affected young people, at 20.3% in 2007, even if it fell dramatically from 37.7% in 2002. Significant regional employment and unemployment disparities persist.

The poverty risk rate was 11% in 2007, with a higher risk for children at 17%. By contrast, people over 65 faced a significantly lower risk at 8% (men: 3%, women: 11%). Infant mortality (6.1 in 2007) is the seventh highest in the EU although it has improved considerably over the years (10.2 in 1996).

The current and projected old-age dependency ratio 65+ is well below the EU average: it is set to increase from the present 16.6% in 2008 to 16.9% in 2010, 32.3% in 2030 and 55.5% in 2050. Total gross social protection expenditure in 2006 decreased by 3.5 pp. to 15.9% of GDP compared with 2000. Health and pensions represented the bulk of expenditure in 2006 (31% and 45.3% respectively).

The NSR does not mention that a significant proportion of the labour force is currently working abroad (ca 7%), which has a favourable impact on the employment, unemployment and poverty rates. The largest minorities are Hungarians (ca 10% of the population) and Roma. According to estimates, up to 380 000 Roma live in Slovakia, of whom 60% live integrated and scattered among the majority population.

The Slovak government announced in its Resolution from December 2008 a number of measures aimed to support the financial sector and real economy including labour market in the light of the current financial crisis. The cutting of public expenditures is necessary in order to reach the planned deficit of 1.7% in 2009; however, the Government declared that savings cannot be made in the social area, where an ambitious social package for 2009 had been approved. The Government does not envisage any tax increase or decrease and intends to continue in the fiscal consolidation. It appealed to social partners to keep the wage increase very modest in the coming period, and it will introduce a monitoring system for price development. The Government wants to support citizens endangered by massive redundancies also through ESF (counselling, education, and requalification) and support job creation, establishment of new companies and self-employment.

2. OVERALL STRATEGIC APPROACH

The new NSR outlines the same priority objectives as the NSR 2006-2008: this could be seen as an advantage, as continuity in the social inclusion area facilitates mobilisation of resources. On the other hand, it cannot go unnoticed that the text of sections devoted to priorities has been largely taken from the previous NSR, suggesting a 'time-saving' approach to drafting and reduced political importance assigned to NSR preparation. Main strategic messages identified in the previous NSR are no longer highlighted. NSR acknowledges its links to the Slovak and Renewed Lisbon Strategy, Modernisation Programme Slovakia 21, and NSRF. ESF co-financing is planned for all three policy measures although no concrete financial data are provided. The texts of both 2007-2013 ESF OPs plan projects to improve education for disadvantaged groups and marginalised Roma communities (MRC), further education for employees in the healthcare sector, support for employment growth through ALMP and modernisation of employment services, support for social inclusion through increased availability and efficiency of social care services and community work, and capacity building for the public service and NGOs. Gender equality is to be ensured through legislative activity and coordinated by the Slovak Government Council for Gender Equality. Disability is mainstreamed, but the approach is fragmentary and a commitment to ensure accessibility for disabled to public services is missing. In general, the NSR seems to be a compilation of existing and draft policies rather than a strategic planning document.

3. SOCIAL INCLUSION

3.1. Key trends

Since 2004, the risk of poverty, with a negligible gender difference, has dropped slightly (from 13% to 11%), as has the risk for children (from 19% to 17%), while the risk for people 65+ has risen a little (from 7% to 8%) compared to 2007 data. The share of adults and children living in jobless households has decreased since 2006 (9.6% and 11.8% respectively) to currently 8.9% (men: 8.1%, women: 9.6%) for adults (EU: 9.3%) and 10.6% for children (EU: 9.4%). The poverty gap is slightly below the EU average translating into 19% for the total population and 21% for children while people 65+ are better protected at 12%. In 2006, the poverty threshold stood at 1988 EUR in Slovakia which is 4 times less than EU25 average.

Full time in-work poverty at 5% is in 2007 below the EU average of 8%. An annual increase of 0.7% on average was recorded over last three years in the rate of early school-leavers, reaching 7.2% in 2007 (EU: 14.8%). The unemployment trap fell from 70% in 2003 to 44% in 2006 (EU: 75%), as well as the low-wage trap for 1 earner couple with 2 children from 124% in 2002 to 29% in 2006 (EU: 62%).

The gender pay gap (22% in 2007) placed Slovakia in the second highest position (EU: 15%). A survey of living conditions of Roma in Slovakia published by the UNDP in 2007 estimates that 10.5% of Roma men and 4.6% of Roma women of productive age are employed.

The SK report does not devote sufficient attention to some important trends, e.g. labour force migration outflows or regional disparities. Neither does it cover the question of the social protection system and a minimum income, despite references to 'state social benefits' in some parts.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

Some progress has been recorded under all priorities. Positive developments towards targets set for employment and poverty rates in Slovakia are arguably attributable not to the social inclusion policy alone but inter alia to overall economic growth and intra- and extra- EU labour mobility. Nonetheless, it is important to note the fact that EU-SILC did not take into account Roma population living in marginalised communities (ca 100 000 people in mostly jobless households), which is not mentioned in the NSR. 'Reducing child poverty' priority is reported to be tackled by education policy and related financial support programmes, assuming that the new Education and Upbringing Act suffices to solve the problem of poverty of children in MRC, as no other positive and/or equalising measures are described. Most of the quantified indicators have been achieved, except the most important one, namely inclusion of Roma children in standard schools. 'Increasing inclusion' priority reports on the progress by describing several activities in the area of legislation, housing development, a scholarship grant programme, and cultural needs development, but without presenting a comprehensive picture with clear policy co-ordination. Quantified objectives were mostly reached: the availability of social services, quality of social protection, or availability of housing for vulnerable groups increased slightly. SK authorities dealt with 'Improving labour market access' priority primarily through the 2008 amendment of the Employment Services Act, which introduced new ALMP tools such as creating social enterprises or engaging municipalities. ESF projects have been implemented in order to create local social inclusion partnerships supporting the Roma minority. 'Governance' priority was greatly assisted by EU-SILC as regards the quality and reliability of data. Both rather ambiguous targets (creation of a webpage and ESF-supported local partnerships) were achieved.

3.3. Key challenges and priorities

Priority objectives of the 2008 NSR are identical to NSR 2006, with slightly expanded and adjusted indicators. These objectives are in line with the jointly defined 2007 challenges, although the social inclusion of vulnerable groups in particular MRC through e.g. housing measures is not sufficiently addressed. The contribution of the ESF is expected under all three priorities; exact financial allocations are not presented.

The text of new NSR suggests a lack of coordination in the inclusion policies and a tendency to narrow the aim of ensuring 'access for all' to legislative changes instead of comprehensive equalising measures. NSR formally deals with all seven EU key policy priorities; least emphasis is put on sustainable social protection schemes together with minimum income schemes and decent accommodation. For the first time, the NSR aims to strengthen the gender equality principle, through a new gender equality body and labour market measures, although work and family reconciliation is seriously neglected.

3.4. Policy measures

– Reduce child poverty and eliminate its inter-generational transmission by preventive measures, and support families with children.

Without presenting a coherent strategy, the NSR describes several multi-dimensional but not integrated measures in the field of education: equal opportunities in access to and quality of education, pre-school education, new Lifelong Learning Act; and social security: increasing child benefit and parental allowance with proper targeting and subsidiarity, and raising the

quality and quantity of social work. Quantified targets have been set for reducing child poverty risk, improving access to education for low-income families, enhancing social inclusion of Roma children into education, and reducing the average length of stay of children in children's homes. The NSR does not raise the legal problem of identifying Roma children: in Slovakia, ethnic data are based on self-declaration which precludes assessing the effectiveness of measures implemented.

– Raise inclusion and fight discrimination of vulnerable population groups by supporting the availability of public services, developing local solutions and raising participation of excluded groups in the life of society.

Improving social services (availability and quality, modernisation and variability) is seen as a key tool to reach this objective; other measures are providing support for affordability of housing, access to health care, and digitisation of the Slovak cultural heritage. The legislative framework will be further developed by a draft Act on financial benefits to compensate for severe disability and a Social Services Act. However, it is not clear what measures will be taken in the area of housing or health care. The main objectives of planned measures are to improve social services, raise the quality and effectiveness of measures for socio-legal protection and social guardianship, map the current social network, increase the availability of housing, improve access to health care, financial programmes, and untraditional forms of education for vulnerable groups.

– Improve access to the labour market and raise the employment and employability of groups at risk of exclusion.

Assuming that 'employment growth is the most effective means of economic growth in developing an inclusive society', Slovakia aims to address long-term unemployment through new active labour market policy measures (co-financed by the ESF), and a new Action plan for the prevention and elimination of violence against women, with particular attention to immigrants and ethnic minorities. Efforts of all stakeholders should be merged into establishing a comprehensive flexicurity approach. It is important to strengthen the role of education and training and participation in lifelong learning in raising the employability of persons at risk. Plans to establish social enterprises as a new tool for supporting employment of disadvantaged jobseekers could be seen as a positive step in the active inclusion of vulnerable groups. Quantified objectives are set for reducing the long-term unemployment rate, youth unemployment, share of people living in jobless households, and expanding social development programmes, etc.

In general, some indicators lack a baseline or normative direction, precluding the assessment of their achievement. Slovakia provided six examples of good practice but their presentation is rather formal and cannot serve as a learning experience for other MSs. Disability aspects have been taken into account by a fragmentary rather than a cross-sectional approach. Gender perspective is limited. A description of current situation is missing in many cases (housing, health care, child poverty), so policy measures do not logically follow from the analysis. Specific vulnerable groups other than Roma are not directly targeted. Mainstreaming of social inclusion does not seem to be achieved; the issue of elderly people is underestimated.

3.5. Governance

Preparation of the NSR, coordinated by a working group comprising representatives of the central administration and publicised on a new web site focusing on social inclusion, received

no media attention. For the first time in the history of the OMC in Slovakia there were no consultations with NGOs or any other stakeholders, such as people suffering from poverty or experts dealing with gender equality. No arrangements for stakeholder- involvement over the full policy cycle are envisaged. Although gender equality is proclaimed to be an important aspect of social inclusion, the gender dimension in the NSR is negligent. Current legislation is at a sufficient level but more efficient implementing mechanisms need to be developed. Implementation part of the NSR is limited to a description of monitoring mechanisms for ESF implementation, which is clearly insufficient. Monitoring and evaluation of the NSR is claimed to be ensured through an ESF project 'Statistical monitoring of living conditions of selected target groups, in particular Roma communities', as well as the creation of a new national database of indicators in the field of poverty and social exclusion. For this priority, no quantified objectives have been set.

4. PENSIONS

4.1. Key trends

The pension system in Slovakia consists of three pillars: a public DB PAYG scheme (mandatory pension insurance) operated by the Social Insurance Agency, a privately managed funded scheme on the basis of defined contributions (old-age pension saving, previously mandatory and recently made optional for new entrants to the labour market), and a voluntary supplementary privately funded pension scheme. The 2005 pension reform, resting on reshaped pension insurance and the introduction of a fully funded second pillar, made important steps to improve the long-term financial outlook of the pension system as regards the ageing population, low employment rates and disincentives to pay social insurance contributions. With almost 1.6 million entrants to the newly created pension savings scheme, transition costs exceeded projected expenditures needed to cover the shortfall in PAYG revenues.

The standard retirement age is set at 62 years for men and women; men at present retire at 62 years of age, while women will reach the uniform retirement age of 62 in 2024. The effective exit age from the labour force in 2005 was 59.2 years (men: 61.1, women: 57.6) and it even decreased in 2007 to 58.7 years. Persons who have joined the private scheme contribute 9% of their gross wage to the public pillar and 9% to the private scheme against 18% for persons taking part only in PAYG. Aggregate replacement ratio in 2007 is 0.54 in total.

According to 2006 ECFIN-EPC report, the projected increase in total pension expenditure is higher than EU25 average of 2.7 percentage points, rising by 4 pp of GDP between 2004 and 2050. Theoretical replacement rates for a worker retiring at 65 after 40 years of average earnings should remain stable over the coming decades, with the net rate increasing slightly from its present level (2006) of 63.1% by 1.9 pp until 2046 and the total gross rate from 49.4% by 1 pp until 2046.

4.2. Key challenges and priorities

The financial sustainability of pensions has become an urgent priority. This issue was pointed out also in 2006 Synthesis report on adequate and sustainable pensions, which stated that 'additional measures to reform the PAYG scheme further might be needed in order to avoid running into heavy debt'. According to DG ECFIN assessment, Slovakia overall appears to be at a medium risk with regard to the sustainability of public finances. However, NSR avoids

discussing the deficit in the public pension fund. Another future challenge is the fact that employed people paying minimum social insurance contributions (low-income workers, self-employed) could be entitled to future pensions below the minimum subsistence level.

Slovakia tried to address 2007 challenges aimed at ensuring the long-term sustainability of public finances through several approved or soon to be approved legislative amendments of the second pillar. Facts presented suggest they contribute merely to a short-term alleviation of financial pressure in the public pension scheme without truly reforming it, largely at the expense of the second pillar. Changes to conditions in the pension system could be seen as controversial as they risk weakening the reliability of the whole system and undermining its long-term sustainability.

Some positive effects brought by 2006 reforms include greater solidarity on account of the merit principle bringing higher benefits for low-income insured persons. On the other hand, extension of the period of insurance necessary for claiming an old-age pension from 10 to 15 years may exclude certain groups of women. Currently, the actual average level of pensions is significantly lower for women (lower wage, less years worked), but by way of example no specific measures in case of divorce are envisaged.

Key challenge for Slovakia is first to ensure long-term sustainability and subsequently to bring stability to the pension system by creating a transparent and stable legislative environment. In order to strengthen the contribution base and allow people to accrue additional pension rights, it is necessary to raise employment rates for both men and women in general and older workers in particular and to lower unemployment.

4.3. More people in work and working longer

Employment rates of older workers have increased quite markedly in recent years (26% in 2004 compared to 35.6% in 2007) mainly due to a rise in the legal retirement age and increased work incentives introduced by the 2005 pension reform. Participation of women at 21.2% falls clearly behind that of men at 52.5% in 2007, as a consequence of the slower increase their in retirement age and probably also traditions.

As of 1 January 2008, the revised pension legislation tightened access to early retirement, namely early pensions can be claimed no sooner than 2 years before reaching official retirement age after at least 15 years of pension insurance contributions, reduced by 0.5% for every 30 days of early retirement. The legislation preserved the possibility for pensioners to concurrently receive a pension and a salary from employment.

The NSR does not mention the rising trend in economic inactivity of disabled people and the increasing number of recipients of incapacity benefit (up 6.7% in 2007 on 2006).

4.4. Privately managed pension provision

.On 31 December 2007, 1.56 million savers had personal pension accounts in 6 pension management companies, representing 40% of the productive age population or 59% of the economically active population. The overhaul of the pension system effective from 1 January 2008 comprised a temporary opening of the second pillar (6 months period during which savers had the chance to leave or join the 2nd pillar – more than 104 000 persons left, and some 20 000 joined, reportedly on account of the financial crisis it was opened again from 15 November 2008 until 30 June 2009; measures to tighten limits on investments in different

types of securities were also approved), an increase in the minimum saving period needed for pension entitlement from 10 to 15 years, and the 2nd pillar being made optional instead of mandatory for new entrants to the labour market (data from 2006/07 suggest that less than half of young people signed contracts with pension management companies). This change will immediately increase funds for public pensions in the 1st pillar, thus postponing the full positive effect of the establishment of the 2nd pillar.

4.5. Minimum income provision for older people

Act on Minimum Subsistence has increased as from 1 January 2009 the minimum subsistence level to 28.8% of the average wage in the economy in 2007. This change would represent a significant increase of the minimum subsistence level and a significant restriction of entitlements to an early pension. Pensioners whose income is below the effective minimum subsistence level are entitled to material need benefits.

The latest 2007 EU SILC data on risk poverty rates confirm that older people are the population group least under threat; only 13% of people 65+ (6% men, 17% women) before social transfers except old-age and survivor's benefits are threatened compared to 18% of the total population. Social transfers play an important role in preventing the risk of poverty: they reduce it to 8% for people 65+ and 11% for the total population. Relative median of the poverty risk gap for 65+ people is 12% (19% men, 11% women), compared to 19% for the total population.

The provisions for the minimum pension are not established. The material need allowance for a single person is ca 56 EUR and for a couple ca 97 EUR per month. In case of all types of pension benefits including old-age, early retirement and invalidity, the level of pensions received by men in comparison with women is on average by 36.5-59.7 EUR higher – men receive on average 236-331 EUR. The average period of pension insurance for newly-awarded old-age pensions is 5-7 years longer for men than for women. Slovakia suggests that positive improvements could be expected due to the coverage of pension insurance periods in case of defined situations such as caring for children, where pension insurance premiums and contributions for old-age pension savings have been paid by state since 2005.

4.6. Information and transparency

The amendment effective as of 1 January 2008 introduced the obligation for the Social Insurance Agency to allow every insured person passive access to information on changes to the balance of their individual account free of charge via its website (1st pillar), and for fund management companies to provide the National Bank of Slovakia every working day with information on transactions involving assets in the pension fund (2nd pillar).

NSR does not ascribe any role to social partners or other stakeholders. Provision of adequate information for personal pension planning remains highly important, in particular due to frequent changes in pension legislation and the presumably insufficient level of financial literacy and awareness among the population.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

A compulsory social health insurance scheme, with multiple health insurance companies acting as purchasers of care, provides universal comprehensive coverage to almost all residents. The provision of health care is decentralised and based on a public-private mix. Service providers operate on the basis of contracts concluded with health insurance companies. Most hospitals and polyclinics have been decentralised to municipalities. The social insurance system is financed mainly by insurance contributions and by state contributions on behalf of certain groups. Voluntary health insurance has a limited but growing role and informal under-the-table payments are common. Certain groups of population suffer from worse health status; in particular marginalised Roma communities and the homeless.

The complex reform package of six major laws on the health-care system launched in 2004 aimed to improve efficiency of the system by promoting role of the private sector in health care provision and insurance, stipulating universal coverage, a basic health care package, and introducing symbolic out-of-pocket fees for patients. The legislative amendments adopted after 2006 suggest a certain distrust of policy makers towards market principles, for example forbidding private insurance companies to pay out profit to shareholders, forbidding patients' fees, and giving preferential treatment to state healthcare providers. It is not clear to what extent the described measures can ensure accessibility, sustainability and quality.

Slovakia had in 2006 one of the lowest life expectancies of men (70.4 years) with better prospects for women (78.4 years). According to the most recent information (2002), median lifespan in the Roma population is under 60 years. Healthy life years are 54.3 for men and 54.4 for women in 2006.

5.1.2. Accessibility

The vast majority of population is covered by health insurance (96.3% in 2006) and health care services are broadly and freely accessible to the population. Symbolic out-of-pocket payments (0.7-1.7 EUR) for drug prescriptions and outpatient and institutional care were abolished in 2006. The system features some additional charges for medicines, dental treatment, or prostheses: in 2006, the out-of-pocket payments represented 25.9% of the total health expenditure. Regional discrepancies and inequalities in access for some vulnerable groups still persist.

The new 2007 amendment on healthcare introduced healthcare districts whereby first-contact doctors in each of these districts are obliged to provide healthcare to persons residing in their district (general practitioners for adults, for children, gynaecologists, and dentists) whilst preserving freedom in choosing a healthcare provider. Another new 2007 amendment on healthcare providers established a general minimum public network of care facilities including a fixed network of emergency healthcare services.

The Ministry of Health is running the programme "Supporting the Health of Disadvantaged Communities in Slovakia", which so far has only been implemented in some marginalised

Roma communities. As from 2009 it should be extended to other disadvantaged groups such as refugees or homeless.

The access to general medical services and dental care is considered to be satisfactory: self-reported unmet medical and dental care needs were 2.8% and 3.5% in 2006, respectively, compared to the EU averages of 3.1% and 5%, but with worse self-perceived access for the poor. Although not mentioned in NSR, 2007-2013 ESF programmes should support the access of disadvantaged groups to health care.

5.1.3. Quality

The awareness of patients and medical personnel of patients' rights is rather low and patients' involvement is not encouraged. The use of information technology is rather underdeveloped. The Health Insurance Companies Act from 2004 established an obligation for each company to evaluate the quality of healthcare providers and rank them according to their success rate in fulfilling criteria for quality indicators drawn up by the Ministry of Health. The Ministry also issues expert guidelines in order to introduce new, effective and uniform diagnostic and medical procedures in the treatment of selected, society-wide serious illnesses. Currently there is no evidence that this system is working effectively. The Operational programme Health may enhance the quality of health care with ERDF total allocation of 250 million EUR. Specific measure was introduced in 2007-2013 ESF Operational Programme Education aimed at education of healthcare specialists.

An order under preparation by the Ministry of Health on minimum requirements for staffing and material and equipment provision for individual types of healthcare facilities is reported to contribute to improving quality in the provision of health care and patient security. Institutional health care is provided on approx. 37 thousands beds, while insurance companies are obliged to conclude contracts for min. 29 thousands bed.

5.1.4. Sustainability

Total health expenditure (7.1% of GDP and 1130 US$ PPP per capita in 2005) has followed a relatively stable and slightly rising trend since the beginning of data provision for Slovakia (5.7% of GDP and 564 US$ PPP per capita in 1997). Both indicators are currently among the lowest in the EU. The share of public expenditure spent on health was 68.3% in 2006, down from 91.7% in 1997. DG ECFIN age-related projections show an increase in public expenditure of 1.9 percentage points of GDP between 2004-2050, which is among the highest in the EU (EU25: 1.6 pp), from 4.4% in 2004 to 6.3% of GDP in 2050. Expenditure on pharmaceuticals was the second highest in the EU as a share of GDP in 2005 (2.3% of GDP).

Despite being singled out as a challenge ahead in the 2007 Country fiche, the area of financial sustainability is completely neglected in NSR. One of the key features of the current system is the very weak link between contributions and benefits, which may result in disincentives to pay health insurance contributions, weakened responsibility for people's own health condition, insufficient motivation to demand quality services, or excessive demand for 'free' care.

The NSR basically neither mentions crucial problems of Slovakia in the area of financial sustainability nor presents solutions. The debt in health care facilities according to Report on Development of Debts in Health Care rose from 186 million EUR in 2006 to 270 million in 2007, even despite a significant increase in public expenditures on health care. The reasons

include strong economic development and the associated wage growth and the increase in payments by the state on behalf of economically inactive policyholders.

5.2. Long-term care

5.2.1. Description of the system

NSR understands long-term care as provision of social services and a financial contribution for care and personal assistance. Residential and non-residential care is provided mostly by municipalities and self-governing regions in pensioners' homes, lodging houses, nursing service facilities, day or rehabilitation centres, at home (chiefly through nurses), in regional integration centres and in state-owned care facilities. The system is financed by a mix of public (state budget, public health insurance funds) and private funds (with co-payments based on income).

Almost all measures described in the 2006 NSR relied on the approval of the Act on Social Services which has came into effect on 1 January 2009, so hardly any of them have been achieved. Similarly, the 2008 NSR in the area of long-term services depend entirely on provisions of the above Act, presenting a thorough analysis of challenges (population ageing, increased need for assistance to dependent persons, co-ordination of social services and health care) and proposed measures and policies to alleviate them. The long-awaited Act is seen as a milestone in the reorganisation of social services and almost a panacea. However, it has been heavily criticised by NGOs, mainly on account of restrictions as concerns freedom to choose a service provider. Basic legislative conditions for tackling challenges identified in the 2007 report were fulfilled as the Bill was passed; however, Slovakia needs to be aware that the real implementation of challenges starts only now.

5.2.2. Accessibility

The report highlights that the availability of social services is significantly influenced by policies of regional authorities, some of them being insufficiently equipped in terms of personnel, expertise, and technical equipment. The implementation of the Social Services Act should eliminate admission waiting lists within two years and reduce regional inequalities in provision of services. Its main assets include the authorisation and registration of care providers, a broader spectrum of care and provision of services, community development support, interconnection and coordination of health care and social services, income protection, financing mechanisms, qualification requirements with regard to human resources, monitoring and supervision of provision of services.

5.2.3. Quality

The NSR acknowledges the absence of quality standards and supervision, and underdevelopment in the area of human resources education. Available information suggests that services of higher quality are delivered by private care providers. Personal assistance is seen as one of the most progressive forms of social aid to severely disabled, based on the philosophy of independent living. The Social Services Act explicitly lays down recipient's right to choose the type and form of the service, enabling them to remain in a home environment, and also guarantees a residual income after paying for a social service.

5.2.4. Long-term sustainability

The NSR claims that the most fundamental problems of the current legal situation affecting financial sustainability remains the insufficient funds for covering the needs of dependent persons, the unequal position of public and non-public social services providers, and the insufficient support for the family caring for a relative. The Act should eliminate the above-mentioned shortcomings, allowing social services to be funded also from other sources (funds from associations of municipal and county authorities, health insurance company funds, income from social enterprises). However, except for the above, the NSR does not specifically address the issue of long-term financial sustainability. DG ECFIN age-related projections show an increase in public expenditure of 0.6 percentage points of GDP between 2004-2050 from 0.7% in 2004 to 1.3% in 2050.

Even if not mentioned in the NSR, 2007-2013 Structural Funds could be used in this area, in particular as regards synergies between social services and long-term care. Some support for informal carers is already established and should be further developed by the new Act (existing: financial contribution for care, pension insurance premiums paid by state for carers, new: respite care). Gender aspect is completely neglected in this field.

6. CHALLENGES AHEAD

- To increase the overall employment rate and reduce the unemployment rate, to improve access to the labour market and to increase the employability of vulnerable population groups through more targeted measures. To intensify provision of employment services at regional level to ensure a smooth transition of the potentially released qualified labour force to available job vacancies in the context of the financial crisis.

- To promote an integrative and comprehensive active inclusion policy and the social inclusion of vulnerable population groups in particular marginalised Roma communities, through support for public services and by addressing housing shortages, and to raise public awareness and step up fight against discrimination. To build a reliable institutional background for taking up this challenge.

- To strengthen the co-ordination, management, implementation, and monitoring of policy measures at national, regional, and local level with the participation of all stakeholders, and to reduce regional disparities.

- To ensure that sufficient resources for adequate pensions are available in the long run, and ensure that the pension system is predictable and that the transition costs of the partial shift into private funded schemes can be met and the long-term sustainability of public finances maintained.

- To ensure universal access to high-quality healthcare and better access to long-term care services by improving their provision and funding. Given the low population health status and reasonably good economic growth more funding could be allocated to effective and targeted health promotion, disease prevention and ensuring equitable access to care.

- To develop a stable, adequate and financially sustainable healthcare and long-term care systems based on a rational use of resources, the integration of health and social care

sectors into one comprehensive system, and addressing the issue of human capital management and patients direct financial burden of care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	1,4	47,5	**2000**	56,8	62,2	51,5	29,0	21,3	**2000**	18,7	18,9	18,5	37,1
2005	6,5	55,0	**2005**	57,7	64,6	50,9	25,6	30,3	**2005**	16,3	15,5	17,2	30,1
2008*f*	7,1	69,1	**2007**	60,7	68,4	53,0	27,6	35,6	**2007**	11,1	9,9	12,7	20,3

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	68,4	76,3	12,7	16,1	n.a.	n.a.	11,0	**1995**	n.a.	n.a.	n.a.		-
2000	69,2	77,5	12,9	16,5	n.a.	n.a.	8,6	**2000**	5,5	89,4	10,6	**2005**	3,2
2006	70,4	78,4	13,3	17,3	54,3	54,4	6,1	**2006**	7.1**	68,3	25,9	**2006**	2,8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	18,5	38,1	33,0	3,5	14,0	4,6	6,8	**2004**	16,6	16,2	7,2	4,4	0,7
2000	19,4	37,2	34,9	4,8	9,0	6,5	7,6	**2010**	16,9	-0,8	-0,5	0,3	0,1
2006	15,9	45,3	31,0	3,5	7,8	3,6	8,7	**2030**	32,3	0,3	0,5	1,3	0,2
								2050	55,5	2,9	1,8	1,9	0,6

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap				Income inequalities	Anchored at-risk of poverty	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	11	17	9	8	19	21	20	12	3,5	**2005**	13b
male	10	-	9	3	22	-	22	19	-	**2006**	9
femal	11	-	10	11	17	-	19	11	-	**2007**	5

People living in jobless households				Long Term unemployment rate				Early school-leavers		
Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24		
Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	9,3	10,0	9,6	10,5	**2000**	10,3	10,3	10,2	**2000**	5,6	6,7	4,6
2004	12,8	10,8	10	11,6	**2004**	11,8	11,3	12,4	**2004**	7,1	7,8	6,4
2007	10,6	8,9	8,1	9,6	**2007**	8,3	7,4	9,3	**2007**	7,2	8,1	6,3

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,86	0,75	0,87	***Aggregate replacement ratio***	0,54	0,53	0,57

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions Estimate of current (2002)	Assumption
2	1	1	DB/DC	/	-	100	/	28,75	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Finland

1. SITUATION AND KEY TRENDS

.Finland's GDP grew by 4.4% in 2007 and continued to grow in 2008. However, the forecast for 2009 shows negative growth of 1.2%. The employment rate, standing at 70.3% in 2007, was well above the EU average (65.4%) and has shown a positive trend in recent times (67.2 in 2000); this, however, is expected to decrease by -1.5% in 2009 as a result of the economic downturn. The unemployment rate had also fallen below 7% (in April 2008 the cyclically adjusted unemployment rate was 5.8%), but is predicted to reach 7.8% in 2009 and 8.0% in 2010. The rise in unemployment will be counterbalanced to some extent by the decline in labour supply, since larger cohorts will retire and smaller ones enter the labour market.

Long-term unemployment has fallen but remains a major cause for exclusion and is often associated with other risk factors. The youth unemployment rate continues to decrease but is still relatively high (16.5%). The employment rate of foreigners born outside the EU-25 was 55.8% in 2007 while the employment rate of natives was 70.5% and that of those born in another EU country 74.8%. The unemployment rate of persons born outside the EU-25 was as high as 19.1% in 2007.

In 2007, 13% of Finns lived on less than 60% of the median income (in 2003 11%). The number of those at relative risk of poverty has risen even though the income of those on a low income has also increased. Certain households have a higher than average risk of poverty: elderly women (24%) and unemployed (41%). Finland has had no major problems in the area of child poverty (11%), which is well below the EU-27 average (19%).

The most important long-term challenge is the ageing of the population. Finland has implemented several measures to tackle the ageing problem. For the most part, the baby boomers still remain in the labour force, which may help making provisions for the change in population age structure.

Life expectancy at birth (75.9 years for men and 83.1 for women in 2006) shows a steady increase over time. Healthy life expectancy (men 51.7 and women 52.4 in 2005) is however decreasing. The infant mortality rate (2.7 in 2006) is one of the lowest in the EU.

Finnish gross social protection expenditures were 25.4% of GDP in 2006, which was close to the EU-27 average (25.8%). The biggest items in relation to GDP were old age and survivors benefits (9.6%), health and sickness (6.7%) and disability (3.4%). The growth of the expenditure is moderate during the present strategy planning period 2008-2010, but is expected to be rapid in the period 2020-2040.

2. OVERALL STRATEGIC APPROACH

The report does not present a clear overall strategy with quantified targets, but it describes the various policy programmes developed since 2007. The Report is more a summary of existing policies than the product of a real strategic planning process. Most elements of this strategy report are undergoing a far-reaching policy review process, which have a follow-up of their own. Such processes include social protection reform (SATA), the national development plan

for social welfare and health care (KASTE) and the restructuring of municipalities and services (PARAS). Because of the nature of the preparatory work carried out in these governmental committees, the report only anticipates limited results.

The 2008-2010 Strategic Report on Social Protection and Social Inclusion of Finland (the Report) does not make many explicit references to the Lisbon strategy. It is, however, well coordinated with the Finnish Government's policy programmes, which support the Lisbon strategy.

As regards the financing of the social policy programmes, the greatest threats are related to the international environment. Maintaining and developing the universal nature of some social services may be difficult when the financial environment changes rapidly in an unfavourable direction.

Various ministries, organisations representing the poor and socially excluded, health organisations, labour market organisations, research institutes, local government representatives, and social work representatives of religious organisations and churches have participated in the strategy process. Three hearings were organised and the stakeholders were given an opportunity to make written comments on the draft report before it was finalised.

The disability perspective has been addressed in the strategy, some positive trends have been demonstrated and goals for future development are outlined. This special problem has not, however, been given much weight. The disability legislation will be reformed during 2009-2010.

As regards gender equality, or equality more generally, the perspective is well established in the report. The role of the Structural Funds is not mentioned in the Finnish report. The policy has been to use the Structural Funds to supplement the national policy programmes.

3. SOCIAL INCLUSION

3.1. Key trends

On the basis of the indicators used in the comparison between EU countries Finland can consider its current social situation to be relatively good. Social security benefits, social and health services and other public services covering the entire population have contributed to the fact that poverty and social exclusion are relatively uncommon and gender equality well achieved.

The development of the labour market has continued in recent years. The activity rate of the population in total (15-64) was as high as 75.6% in 2007 and was growing before the economical downturn. This favourable trend also covered older workers (55-64), the employment rate of which was 55%. The youth unemployment rate has, however, still been rather high (16.5%). The employment of foreign born persons has remained at a significantly lower level than that of natives. The unemployment rate of the total population has fallen during the past years, but is expected to grow due to the negative economical growth. The working poor group has stayed small, as the in-work-poverty risk was as low as 4% in 2006 (8% in EU-25).

Employment is seen as the primary measure in the creation of an inclusive society. However, only an integrated policy response could reach the most vulnerable and long-term

unemployed. At the same time, reintegration into employment is more difficult in certain geographic areas, where job opportunities are scarce.

Contrasting with the good results of PISA surveys, increased demand for child welfare has raised concerns, as has the sufficiency of personnel resources e.g. in child and youth services and mental health services. The risk of social exclusion among substance abusers and some groups of children and young people seems to have increased recently.

The level of relative poverty in Finland, standing at 13% (2007), is still among the lowest in the EU-25, although it has increased since the mid-1990s (7% in 1995). While poverty as such is not a general problem in Finland there are some groups that deserve more attention to: the long-term unemployed, children and young people threatened by social exclusion, the homeless, substance abusers, people guilty of a criminal offence and immigrants. The programme points out actions to improve the inclusion of each of these groups.

People in these groups face multiple disadvantages, which require more integrated approaches. There seems to be a gender bias concerning the above mentioned groups, as they consist mainly of men. Two groups of women are also at risk of poverty: lone parents and 65+ year-olds. The Report does not, however, mention them in the special or risky groups.

The report names alcohol consumption as a major reason for exclusion and a threat to health. The growth in consumption has increased the demand for services for alcohol abusers and the number of alcohol-related periods of hospital care. In 2006, A-clinics had approximately 44 400 clients. Detoxification and rehabilitation centres had approximately 11 200 clients. Drug experimentation and use increased in the 1990s throughout the country.

Alcohol and substances abuse has been mainly a problem involving men, but alcohol-related episodes of hospital care among women have also risen steadily year by year. The government intends to reverse the growing trend in alcohol consumption and has set the target of reducing consumption to the level of 2003.

The social problems of micro- and small entrepreneurs are not identified in the report. Small enterprises are often created in externalisation or privatisation processes and as a result of economic restructuring. The new entrepreneurs normally lose the social benefits provided by their former employers. In an economic downturn this group, which often has insufficient safety networks, is at risk of exclusion, although they have the same social rights and services as other citizens.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The 2006-2008 report did not establish explicit quantified targets. However, Finland has progressed well in terms of all the policy objectives, and it is fair to say that the current social situation in Finland is relatively good. The baseline level was already high and most of the indicators show positive development. Despite the positive general development there are big variations in the availability of services.

Guaranteeing work opportunities for as many as possible. In 2007 the employment rate edged up to 70.3% and unemployment fell to 6.9%. This positive trend, however, ended in the end of 2008 and unemployment is currently rising.

Preventing social problems and social risks. Finland has been successful in fighting poverty. The poverty risk was 29% before social transfers and only 13% after social transfers in 2007.

Safeguarding the continued existence of measures that prevent and correct social exclusion and poverty. Positive economic development has made it possible to maintain the level of social transfers and social services.

Ensuring the supply of skilled labour in services safeguarding the welfare of residents. Finland has introduced a system of care guarantee, but the system still needs to be developed further. Over a third of the population lives in an area where there are occasional problems in making immediate contact with the health centre. It has become more common for the waiting time for an appointment with a doctor in a non-emergency case to exceed two weeks. Over a third of the population (37%) lives in an area where the waiting time for an appointment with a doctor exceeds 14 days if the need is non-urgent. This situation has deteriorated over the last two years. The health guarantee does not remove the problems of poor organisation or lack of professional staff which may hamper the supply of services.

3.3. Key challenges and priorities

The challenges (policy objectives) of social inclusion are the same as in the 2006 report:

– Guaranteeing work opportunities for as many as possible;

– Preventing social problems and social risks;

– Safeguarding the continued existence of measures that prevent and correct social exclusion and poverty;

– Making the service system work better.

Key challenges in the 2008 report follow the government programme. In addition, some risk groups requiring special measures are mentioned. They include the long-term unemployed, the homeless, substance abusers, the over-indebted, people guilty of a criminal offence and immigrants threatened by social exclusion.

3.4. Policy measures

No specific policy measures are presented for the challenges above. The Report states that targets will be monitored according to the Government's welfare policy programmes. In addition a set of measures is outlined for special risk groups. Overall, the measures outlined cannot be considered ambitious. In this context, the following key areas of action could be mentioned:

Long-term unemployment. This has decreased but remains a problem for special groups. The strategy analyses the structure of these groups but does not present any real measures to tackle the problem. The legislation on social enterprises will be reviewed. A social enterprise can be a solution in big cities, but in rural areas the individual problems could better be solved by creating a special model contract for social work.

High share of youth with only basic education. The strategy proposes increasing the attractiveness and appreciation of vocational education. Vocational education should be oriented towards working life and the related intakes should be raised.

Health inequalities among social groups. The report states that one of the most important problems of Finnish public health, also when international comparisons are made, lies in socio-economic health inequalities, which have continued to widen. These inequalities will be reduced, especially through an impact on groups with the highest health risks, such as those exhibiting smoking, alcohol abuse and obesity.

Insufficient supply of welfare services (including psychiatric care) for children and youth. The report does not mention any concrete measures but refers to the Government Programme of Prime Minister Vanhanen's second cabinet. This policy programme sets general objectives and indicators, but specifies neither baselines nor measurable targets.

Consumption of alcohol and substances. The most urgent task with respect to the development of public health is to reverse the growing trend in alcohol consumption. The Government has set a target: the total consumption of alcoholic beverages is to be reduced to the level of 2003. The concrete measure to meet this target level is the reform of tax on alcoholic beverages.

Low employment rate of immigrants. Although unemployment among foreign-born persons is rather high, Finland has planned to start promoting work-based immigration. The administrative culture will be improved and structural development of the administration will be emphasised in the immigration policy. As the economic growth is turning negative, employers' interest in importing labour may wane for the period of downturn.

3.5. Governance

In Finland, the Administrative Procedure Act regulates the principles of good governance. The report was prepared in cooperation with various ministries, organisations representing the poor and socially excluded, health organisations, labour market organisations, research institutes, local government representatives, and social work representatives of religious organisations and churches.

The results of actions combating poverty and social exclusion are to be assessed in separately organised events or occasions. In the assessment of policies pursued, efforts will also be made to use the available qualitative descriptions of the development of Finnish welfare.

4. PENSIONS

The main objective of the Finnish pension system is to ensure that the population is covered against the economic risks caused by old age, disability or death of a family provider. Two pension schemes, an earnings-related pension scheme and a national pension scheme together form the total statutory pension for a pensioner. The statutory pension provision can be supplemented with a third-pillar individual pension arrangement.

The earnings-related pension scheme provides insurance-based pensions, which ensure to a reasonable degree that all wage and salary earners and self-employed persons retain their level of consumption after retirement.

The national pension scheme provides the whole population with a residence-based minimum pension which supplements the earnings-related pension.

4.1. Key trends

The pensions system was reformed in 2005. The most important objectives were to raise the effective retirement age in the long term by two to three years and to adjust the pension system to increased life expectancy. Measures to achieve these objectives have comprised, among other things, dismantling early retirement pension schemes, encouraging people to continue working longer by means of increased pension accruals, and introducing a life expectancy coefficient. The general retirement age was made flexible so that people can retire between the ages of 63 and 68. There seems to have been good progress in achieving the objectives of the reform as the effective labour market exit age had increased by more than half a year to 62.4 in 2006 since 2005.

The financing of earnings-related pensions is a combination of a pay-as-you-go (PAYG) system and a pre-funded system based on pension contributions from both employers and employees. The PAYG system covers approximately three quarters of the earnings-related pension outlays, and the pre-funded scheme covers the rest. Despite being partially funded Finland's earnings-related pension scheme is of the defined-benefit type. During the last 10 years the pension funds' capital has tripled to 120 billion euros. Recent economic developments will halt the positive trend, but there is no reason to doubt the sustainability of the system.

4.2. Key challenges and priorities

The challenges for the sustainability of the pension system are linked to population ageing and increased life expectancy. These challenges have been identified and the necessary changes in the legislation have been made. The economic sustainability of the pensions system in Finland has been good. The economic downturn may have a deteriorating effect on the situation. Pension expenditures amounted to 11% of GDP in 2006, which is below the EU-25 average (12%). The projected costs in 2050 are estimated to be 13.7%, which is above the EU-25 average.

4.3. More people in work and working longer

Extension of active working life is made possible and encouraged by material incentives. The retirement age is flexible (62-68) and pensions accrue from the age of 18 to 52 at the rate of 1.5% of wages a year, from 53 to 62 at 1.9% and from 63 to 68 at 4.5% a year without any cap. Despite the incentives the exit age from the labour market is only around 62 years. The successful extension of working life has not only been a result of the material incentives, but also due to positive economic conditions. In the economic downturn early retirement may become a common solution both for enterprises and for older employees, in particular in cases of corporate restructuring. The threshold to enter the labour market may also become higher for the most vulnerable groups.

4.4. Privately managed pension provision

The Finnish pension system (the first pillar) is made up of two statutory pension schemes: one is the national pension scheme based on residence that provides a guaranteed minimum pension whereas the other is the employment-based, earnings-related pension scheme.

Voluntary pension schemes (the second and third pillars) play a minor role in Finland due to the lack of pension ceilings and the extensive coverage of the systems. In 2007 about 18% of households had individual supplementary pension insurance.

The popularity of individual pension insurance has increased in recent years, and this trend is expected to continue. There are several reasons for this. Almost all of the collective supplementary pension arrangements have been closed, and new employees can no longer join them. The individual pension arrangement now replaces the collective arrangements. A very common personal motive for acquiring a voluntary pension scheme is early retirement. Another reason, especially as regards women who often have a shorter working career, can be the insufficient replacement ratio. Individual pension saving has also been favoured in personal income taxation.

4.5. Minimum income provision for older people

In 2006 the average total pension of pensioners who received a pension in their own right (earnings-related and national pensions, including survivors' pensions) was €1 194 a month (gross). This was about 48% of the average income of wage and salary earners and of the self-employed in 2006. Pensioners' average pension in their own right (does not include survivors' pensions) was €1 113 a month in 2006, about 45% of the median income in the said year. In 2006 the average pension in their own right (earnings-related and national pensions) of those who had retired in that year on an old-age pension was €1 558, about 63% of the average income for people in employment. The level of old-age pensioners' total pension compared to the income of economically active people has remained fairly stable, at about 50%, since the beginning of the 1990s.

The minimum level of the income of pensioners is composed of the full amount of the national pension and the statutory supplements payable to them. In 2008, the full national pension of a single pensioner is €558.46 a month and that of a married or cohabiting pensioner €495.35 a month.

Elderly people have a higher poverty risk than the national average (13%) and the risk is considerably higher among elderly women (26%). Elderly women who receive only the minimum pension are identified as a particularly vulnerable group. Under the Finnish pension system, pension entitlements are not divided between spouses in case of divorce. A potential risk group could be foreign-born persons with a short working life in Finland and hardly any pension rights from their country of origin.

4.6. Information and transparency

As the earnings-related pension system in Finland is based on work and pay, the issues regarding earnings-related pensions are prepared together with the key labour market organisations. Employees are generally well aware of their pension rights. Pension companies and institutions send annually a pension data record to all private-sector employees aged 18 to 67 years who are resident in Finland.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

The 399 municipalities are required to arrange health services for their residents. Based on the provisions of general law local authorities organise the services themselves, together with other municipalities, by purchasing services from private service providers or from abroad, or by distributing service vouchers to users for purchasing services from a private provider. A wide range of services include primary health care – PHC (in health centres), specialist and hospital care (in outpatient clinics or inpatient wards). Public hospitals are run by municipal federations, i.e. hospital districts. There are 20 hospital districts in Finland.

Two major reforms will have a strong influence on the health services. The municipal and service structure reform (PARAS) creates a minimum population base of approximately 20 000 inhabitants for the organisation of services and to allow for activities in some hospital districts.

The national development plan for social and health care services (KASTE) launched in 2008 aims to identify needs and implement reforms in cooperation with interest groups and actors in the field, especially municipalities. The objective of the programme is to reduce social exclusion, boost the involvement of municipal inhabitants and improve their well-being and health, reduce inequalities in well-being and health between population groups, raise the quality, effectiveness and availability of services and narrow down regional inequalities.

The average life expectancy at birth was 79.6 years in 2006. In 20 years there has been an increase of almost 5 years. In terms of gender there is a big difference: the life expectancy of men is 75.9 years while that of women is 83.1 years.

5.1.2. Accessibility

According to a study carried out in April 2008, over a third of the population lives in an area where there are occasional problems in making immediate contact with the health centre and it is common for the waiting time for an appointment with a doctor in a non-emergency case to exceed two weeks.

The availability of healthcare services in the municipal system has been improved through amended legislation, which came into force on 1 March 2005, with time limits for access to non-emergency treatment and the choice of another hospital when the wait is exceeded. This system is assessed by healthcare authorities. Each hospital district's joint municipal board is responsible for the organisation of specialised medical care within its area based on uniform medical grounds. The reform of access to non-urgent treatment has significantly reduced the number of patients waiting for such treatment.

The whole population is covered by the municipal health services and the sickness insurance system. This does not, however, mean a free health service. Most municipal health services involve a fee for the client. These fees have two main purposes: to fund operations and direct demand. The share of operating expenses borne by households varies with the services involved so that in 2006 it was on average 11.4% for social welfare services, 7.6% for primary health care, 20.4% for oral health care, 4.3% for specialised care, and 17.1% for inpatient care for the elderly.

5.1.3. Quality

Good professional skills ensure a high-standard service for clients. The report does not give any results of quality measurements and it does not refer to any explicit quality targets. There are, however, national evidence-based Current Care Guidelines which have been prepared for the treatment of various diseases (the total number of these Guidelines was 90 in the autumn of 2008). Quality recommendations have been prepared e.g. for health promotion, mental health care services, substance abuse services, services for older people, and pupil and student health care. The development of quality standards takes place in the context of the development of patient safety, which has been one of the focal points of health care. The utilisation of assessments and feedback from clients and patients has increased in the assessment of the quality of services.

Although the report does not show any new quality measurement results, there is one convincing indicator, child mortality, which has been low and continues to decrease. The prenatal mortality rate is very low (3.0), while the EU average is 6.0.

5.1.4. Sustainability

In Finland, expenditure on healthcare services was 8.2% of GDP in 2006, below the EU average level (9.0%). The low level of salaries of Finnish healthcare workers explains this. According to the new statistics, healthcare expenditure has grown in real terms since 1993 by approximately 3.3% each year. Expenditure on medicines has grown by approximately 8.0% each year during that period. Dental care expenditure has increased by 5.4% each year due to the expansion of dental care coverage. Since December 2002, the entire population has been entitled to publicly-funded dental care. Occupational health expenditure has also grown considerably, by 5.2% a year. Other expenses have grown at a significantly slower pace.

Although in general healthcare workers appear sufficient there are large regional differences and the shortage of doctors has remained almost unchanged during the 2000s. The lack of doctors particularly concerns remote areas and is greater in PHC than in specialised care. However, the lack of dentists in health centres has been growing. The shortfall in nursing staff numbers (nurses, auxiliary nurses, and nursing assistants) is considerably smaller. The evolution of the need for healthcare staff is regularly monitored.

It is estimated that 43% of municipal social welfare and healthcare staff working in 2003 will retire by 2020. Efforts have been made to increase the number of study places for doctors and dentists, in basic professional education in the field of social welfare and health, and in polytechnic education.

Pharmaceuticals constitute an essential part of modern health care, and their significance is increasing. More than a billion euros went to medicine reimbursements in 2007. Reviews of medicine prices and generic substitution with competing medicines have slightly slowed down the pace of expenditure growth.

According to the Government Programme, the medicine reimbursement system will be overhauled to further limit current annual growth in medicine expenditure of 10% to a maximum of 5% in 2008-2011. This includes taking into account the cost-effectiveness of new medicines and promoting safe pharmacotherapy.

5.2. Long-term care

5.2.1. Description of the system

Long-term care provision is like healthcare provision. A municipality may provide services alone or in cooperation with other municipalities, purchase them from private or public providers or distribute service vouchers to users. Long-term care is provided in the inpatient wards of health centres and non-medical long-term care in institutions for older persons. Municipal social welfare and health services also include rehabilitation and maintenance of functional capacity for the aged and services for the disabled, including a personal service plan to establish the required service and support measures in consultation with the disabled person and his or her carer or family members.

The field of informal care has been put on the political agenda. The Informal Care Act entered into force as of the beginning of 2006 and is a major milestone in reforming the system. It defines informal care as encompassing services necessary to the client, together with compensation for the informal care, leave and support services for the carer included in the care and service plan. As of the beginning of 2007, the Act was amended to increase the caregiver's number of statutory days off from two to three days per month. The minimum amount of support for informal care is €317.22 per month. The ongoing municipal and service structure reform (PARAS) has significant impacts on the service system.

5.2.2. Accessibility

The coverage of services has developed in Finland as follows: at the end of 2006, 90.1% of over-75s were living at home. This calculation excludes all those in long-term hospital care, old people's residential homes and housing with 24-hour assistance. In 2005, 11.5% of over-75s received regular home care and 3.7% received informal care support, 3.9% were living in sheltered housing with 24-hour assistance, and 6.5% were in long-term institutional care.

Traditional long-term institutional care has been replaced especially by intensified sheltered housing. This change reflects older people's own wishes to live in a homely environment, such as sheltered housing units with 24-hour assistance. There are, however, significant regional differences.

5.2.3. Quality

Qualitative objectives have also been set for developing services in the National Framework for High-Quality Services for Older People. High-quality services are:

– Client-oriented and allow clients and their families to participate in service planning, decision-making and assessment;

– Based on a comprehensive assessment of service needs, the living environment and client resources, assessing the individual's physical, cognitive, mental, social, linguistic and cultural needs and resources, as well as environmental factors;

– Goal-oriented and regularly assessed against a single written plan for care, rehabilitation and/or services;

– Based on a work method that promotes functional capacity and rehabilitation;

– Implemented in cooperation with the client, the various service providers, and relatives and friends;

– Given in a safe and timely manner;

– Using existing research results and information on good practices; and

– Effective, i.e. attain the individual and social targets set for the services.

The National Framework is not only qualitative, it also contains quantitative targets.

5.2.4. Long-term sustainability

Although Finland will see more rapid ageing of its population than most other countries it is well prepared for the change in the age structure. The country has also succeeded in containing costs, as evidenced by the small share of healthcare expenditure in relation to GDP. In 2005, the share of GDP devoted to healthcare spending was 8.3%, which is below the average level for OECD countries (9.0% in 2005).

In the funding of social welfare and healthcare services, user fees will be set at levels such that services are available for everyone and people are guided towards appropriate use of the services.

6. CHALLENGES AHEAD

- To implement more effective policies for tackling the root causes and consequences of excessive consumption of alcoholic beverages in terms of social exclusion and to improve social services provided to adolescents.

- To closely monitor the adequacy of future pensions with special reference to women, micro-entrepreneurs, immigrants and people with a short working history, while also facilitating efforts to extend working lives for these groups and the rest of the population.

- To continue with ongoing reforms in the healthcare system (PARAS reform) with a view to improving the overall efficiency of the system (including through better organisation of resources in health institutions), while improving accessibility in terms of reducing both waiting times and regional differences.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64						15+			15-24
				Total	Male	Female	15-24	55-64		Total	Male	Female	
2000	5,0	117,3	**2000**	67,2	70,1	64,2	41,4	41,6	**2000**	9,8	9,1	10,6	21,4
2005	2,8	114,3	**2005**	68,4	70,3	66,5	40,5	52,7	**2005**	8,4	8,2	8,6	20,1
2008*f*	1,5	114,1	**2007**	70,3	72,1	68,5	44,6	55,0	**2007**	6,9	6,5	7,2	16,5

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	72,8	80,4	14,6	18,7	n.a.	n.a.	3,9	**1995**	7,7	74,1	20,5		-
2000	74,2	81,2	15,5	19,5	56,3	56.8*s*	3,8	**2000**	7,0	73,4	21,0	**2005**	3,0
2006	75,9	83,1	16,9	21,2	52.9b	52.7b	2,7	**2006**	8,2	76,0	18,7	**2006**	2,5

s: Eurostat estimate; p: provisional; b: break in series — **THE: Total Health Expenditures*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits — ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old age dependency ratio (2006) Eurostat	Expenditure (% of GDP) Level in 2004 and changes			
										Total social expend.	Public pensions	Health care	Long-term care
1995	31,5	32,8	20,9	14,4	13,4	3,6	15,0	**2004**	24,8	25,4	10,7	5,6	1,7
2000	25,1	35,8	23,8	10,5	12,5	3,5	13,9	**2010**	25,7	0,2	0,5	0,2	0,2
2006	26,2	37,8	26,2	8,5	11,6	3,2	12,7	**2030**	43,9	4,7	3,3	1,0	1,3
**including administrative costs*								**2050**	46,6	5,2	3,1	1,4	1,8

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	13	11	11	22	14	12	17	10	3,6	**2005**	12
male	12	n.a.	12	18	15	n.a.	18	10	-	**2006**	11
female	14	n.a.	11	24	14	n.a.	16	10	-	**2007**	11

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	-	-	-	-	**2000**	2,8	2,8	2,7	**2000**	8.9b	6.5b	11.3b
2004	5,7	11	11,2	10,9	**2004**	2,1	2,3	2	**2004**	8,7	6,9	10,6
2007	4,4	9,1	9,6	8,6	**2007**	1,6	1,7	1,4	**2007**	7,9	6,3	9,7

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,74	0,79	0,72	***Aggregate replacement ratio***	0,46	0,46	0,48

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
									Occupational & voluntary	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	Statutory pensions	Estimate of current (2002)	Assumption
-11	-13	-12	DB	/	-	100	/	21,6	/	-

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Sweden

1. SITUATION AND KEY TRENDS

In 2007 there was a deceleration in the Swedish economic growth rate, with GDP growth at 2.7% in 2007 compared to 4.1% in 2006. The global financial turmoil has depressed the economic outlook and the forecast shows a fall by 1.4% in 2009, followed by a slight growth in 2010.[92] The employment rate is one of the highest in the EU, with an overall rate of 74.2%, well over the EU target of 70%. This is mainly due to a high female employment rate of 71.8% and a large number of older workers in employment (70%). The youth unemployment rate is however still very high at 19.1%, way above the EU average (15.53%). Foreign-born are overrepresented among the unemployed youth. The overall employment gap between persons born inside and outside the country is one of the highest in the EU (at 13.1 percentage points in 2007). This remains a challenge, as Sweden is currently experiencing its highest level of immigration ever. According to national statistics, nearly 100 000 people settled in Sweden in 2007, most of whom are people who have been granted a residence permit after having applied for asylum, or for family reasons.

The overall at-risk-of-poverty rate is still low (11% in 2007 compared to 16% in the EU-25), and compared to other EU countries Sweden has one of the most equal income distributions. Nevertheless, both relative and absolute poverty vary in different population groups. Single adult households with children have a considerably higher poverty rate (24%). According to national statistics, the poverty rate is almost three times higher among foreign-born compared to native-born persons. Child poverty is also highest among those whose parents are born outside Sweden: among these 38.8% are poor according to national statistics.

Sweden is projected to face less challenging demographic trends than most EU Member States. The fertility rate is relatively high compared to other Member States (1.88 in 2007, according to national data). The old-age dependency ratio is estimated to increase from 27.8% in 2010 to 46.7% in 2060 (the EU average will over this period increase from 25.9% to 53.5%). Both life expectancy at birth (78.8 for men and 83.1 for women) and healthy life expectancy (67.1 for men and 67 for women) show a steady increase over time. Gross expenditure on social protection in relation to GDP is the highest in the EU (32.0% in 2005), but is expected to decline until 2020, followed by a slight increase for the period 2020-2040. In 2006 the biggest expenditure items in relation to GDP were pensions (12.1%), health care (7.8%) and disability (4.5%).

2. OVERALL STRATEGIC APPROACH

The overarching aim of Swedish social policy is to provide social protection for the whole population, with supplementary support to specific groups only when necessary. The Swedish National Strategy Report (NSR) identifies a range of social conditions where improvements are needed. The overall policy objective for the period 2008-2010 is strongly focused on reducing exclusion through labour market integration. A higher employment rate is seen as essential for securing a future generous welfare policy as well as important for personal and

[92] According to the European Commission Interim Forecast, January 2009.

social development and for participation in society. In the area of health care, more efficient use of resources is identified as a main challenge. Both gender and disability policies in Sweden are mainstreamed in all policy areas.

Sweden's priorities for European Social Fund (ESF) funding 2007-2013 are well in line with the overarching objectives in the NSR. These include improving the adaptability and employability of workers, and increasing the labour supply by addressing particularly youth, people with a migrant background and those on long-term sickness leave. Furthermore, the European Regional Development Fund (ERDF) will partly be used to support entrepreneurship and thus lead to the creation of new jobs.

3. SOCIAL INCLUSION

3.1. Key trends

The overall at-risk-of-poverty rate has increased from 9% in 2005 to 11% in 2007. The reason for the increase in the relative poverty rate is, according to the NSR, growing income inequalities (although the S80/S20 income quintile share ratio is still among the lowest in the EU in 2007, at 3.4). Groups with higher poverty rates are single-parent households (24%) and elderly women (14%). As stated, national statistics show that foreign-born and children with a migrant background also have a considerably higher poverty rate than the rest of the population. The in-work poverty rate is just below the EU average, at 7% for the total population (8% for men and 6% for women) and, in general, people outside the labour market have a higher risk of poverty (26% for unemployed and 31% for other inactive). The poverty-reducing effect of social transfers is however evident, as these reduce poverty by more than 50%. The poverty threshold in Sweden is also among the highest in the EU.

The employment rate has risen from 72.5% in 2005 to 74.2% in 2007, with some improvement both among youth and among people with a migrant background. The gap between persons born outside and persons born in the country has however decreased only slightly (from 13.8 in 2005 to 13.1 in 2007). There has also been a slight decrease in youth unemployment, from 21.3% in 2006 to 19.1% in 2007, but it still remains very high. Overall, unemployment is expected to rise significantly from 6.2% of the labour force in 2008 to about 8.5% in 2010.[93] Sick leave rates are continuing to fall and the number of people in receipt of sickness benefit has fallen by around 50% since the peak in 2002. The number of people receiving long-term sickness or activity compensation[94] is declining slowly, however. According to national data, 542 494 persons received sickness or activity compensation in August 2008, a 1.9% decrease since August 2007.

According to international comparisons, the educational system generally performs well in terms of quality and of preventing social exclusion. The main problem is the lower attainment of children with a migrant background. Another issue of concern is the rise in the rate of early school leavers, reaching 8.6% in 2007 (10.2% for male and 7% for female) but still remaining below the EU average, however. Again, children with migrant backgrounds are overrepresented among this category.

---

93 European Commission Interim Forecast, January 2009.

94 Sickness and activity compensation is the equivalent of disability pension.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

The previous action plan for social inclusion, presented by the then newly appointed government in April 2007, identified four priority areas for social inclusion: employment and education, integration (i.e. social inclusion of people with a migrant background), homelessness and exclusion from the housing market, and vulnerable groups within the population.

Recent *labour market reforms* have focused on strengthening work incentives, and favouring the entry of disadvantaged groups into the labour market through subsidised employment, job and development guarantees and more efficient rehabilitation. As stated, sick leave rates are continuing to fall but the number of people receiving long-term sickness and activity compensation has remained constant for the last couple of years. As also stated, the employment rate has increased slightly among the young and foreign-born, but among people with disabilities there has been an increase in unemployment. As for *education*, recent and announced reforms address issues of basic skills, quality of teaching, greater emphasis on vocational education and transition from school to work.

The policy aim to *improve the social inclusion of people with a migrant background* has been closely connected to the general labour market reforms and measures in the area of education. Several initiatives are in progress to ensure that new arrivals are offered work-oriented programmes early on and that their knowledge and experience are put to better use through assessment of diplomas obtained abroad and supplementary training for university graduates. Foreign-born accounted for almost half of the increase in employment during the first half of 2008. The employment gap between foreign-born and the native-born population still remains high, and for women the gap has in fact remained constant. A special national strategy for the education of newly arrived children and youth has been devised, and special measures to improve educational conditions in vulnerable areas have been taken. Nonetheless, there has been an increase in the rate of students with a migrant background leaving compulsory school without meeting basic requirements.

In the area of *homelessness* statistics are being developed which will monitor the trend more satisfactorily from 2009 on. The target mentioned in the 2006-2008 report that no children should be evicted has not been achieved. Initiatives taken to *strengthen groups in particularly vulnerable situations* include measures to improve the quality of social care for children and adolescents. No progress in reducing violence against women is reported, but several measures have been taken and the knowledge of how to address the problem is improving (the fact that crimes reported to the police have increased is most likely a result of this). The number of people in misuse care has remained constant and the number of care episodes in non-institutional psychiatric care has increased, particularly among women.

3.3. Key challenges and priorities

The Swedish NSR presents four key policy objectives 2008-2010 to combat poverty and social exclusion. The priority objectives build to some extent on the previous period (2006-2008) and are focused on:

– Increasing the possibility of social inclusion for the elderly;

– Reducing exclusion among young people;

– Reducing absence from work due to ill-health; and

– Strengthening groups in particularly vulnerable situations.

Reducing the gap on the labour market between those born inside and outside Sweden is specifically mentioned as 'an important starting-point for continued efforts' in the new NSR, but has been dropped as a priority. The former priority on homelessness has been included in the objective of strengthening vulnerable groups. Overall, the priorities are well in line with the challenges identified in the Joint Report 2007.

The NSR identifies the direction in which it wants to push development and indicators for follow-up are specified for each objective. No measurable targets are, however, mentioned.

3.4. Policy measures

The demographic development has made *social inclusion for the elderly* a priority. The focus is on keeping the elderly active through continued labour market participation and through the promotion of an active and social lifestyle. Tax reductions and employment subsidies for older workers will improve incentives to stay longer in the labour market. Priority will also be given to improving physical accessibility in society and long-term care. Economic conditions for primarily the least well-off pensioners will also be improved, which hopefully will reduce the high at-risk-of-poverty rate among elderly women.

To *reduce exclusion among young people*, the reform initiatives continue to focus both on education and the labour market, as well as improved matching between the two. A special national strategy for the education of newly arrived children and young people has been devised and extra funds are being invested to enable Swedish teaching to be developed for those born outside Sweden, with the aim of speeding up the possibility of work and education. Increased mental ill-health among teenage girls and young women is an issue of particular concern and a development centre for the mental health of children has been established to improve preventive measures, early detection and early support.

In order to *reduce absence from work due to ill-health*, active rehabilitation measures and improved support are mentioned, with a focus on early action and reinforced links to the right to sickness benefit. Improved prevention care and rehabilitation at company level will be further supported. Furthermore, a pilot activity with alternative actors (mainly social enterprises) in rehabilitation has been introduced.

The continued priority given to s*trengthening groups in particularly vulnerable situations* includes continuous promotion of the quality of social services, strengthening support for women who are subjected to violence and their children, fighting honour-related violence, strengthening care of people with misuse and addiction problems and their families, as well as continuing the previous priority of combating homelessness and exclusion from the housing market.

Gender aspects and mainstreaming of social inclusion of people with a migrant background are generally well reflected in the policy measures and there is a balance between prevention and alleviation. A weakness in the NSR is that it does not include any discussion on how the strong work-line policy for social inclusion will be affected by weakened labour demand in an economic downturn. People who remain outside the labour market are increasingly exposed to poverty. Furthermore, groups with a weak labour market attachment are usually the first ones

to lose their job when demand is falling. A risk with the extremely high focus on activation is accordingly that it may increase exclusion among those who for various reasons cannot find an entrance into the labour market.

3.5. Governance

Different state authorities, NGOs and social partners have had the possibility to participate in the process of preparing the Swedish strategy for social inclusion. Some NGOs, however, have argued that no opportunity for real dialogue was provided and have asked for an earlier dialogue in the future. The strategy report is, however, more a summary of existing policies than the result of a real strategic planning process, and the importance of a continuous dialogue with stakeholders is underlined in the report. NGOs, the Swedish Association of Local Authorities and Regions and the National Board of Health and Welfare take part in a commission for service user influence on social development issues in the Ministry of Health and Social Affairs, and the public inquiry system is recognised as an important tool in policy making.

General indicators for monitoring progress towards the achievement of each priority policy objective have been identified in the report. Monitoring and evaluation arrangements are made through mechanisms already in place.

4. PENSIONS

4.1. Key trends

The Swedish statutory pension system has since 1999 been in the process of gradually changing over to a new system. The former system was a defined-benefit system based on the fifteen best income years of thirty worked. The new system is a defined-contribution system where all income earned, up to a certain ceiling, influences the pension. The contribution constitutes 18.5% of the wage earned, up to a ceiling. 16 percentage points finance pensions on a pay-as-you-go basis through the mechanism of notional accounts (income pension) and 2.5 percentage points are invested in one or more funds selected by the individual (so-called premium pension). The statutory pension system is supplemented by sector-wide occupational pension schemes.

The retirement age is not specifically stipulated. The lowest possible age to receive an income pension and premium pension is 61. From 65 a guarantee pension may be obtained by those with a low-income pension, and 67 is the lowest age for mandatory retirement. Many of those aged over 60 are still working and the effective labour market exit age is at 63.9 among the highest in the EU.

The Swedish pension system generally ensures an adequate standard of living. A gender gap can still be seen — the relative median income of the elderly was 84% for men and 73% for women in 2007. This is however a reflection of past career profiles and gender differences in the age structure of the elderly. Considering the high employment rate among women the gap will diminish in time. On the other hand, the current pay gap between women and men and the higher share of women in part-time jobs will to some extent maintain differences in retirement income. The aggregated replacement ratio was 61% in 2007 (63% for men and 54% for women). Calculations for current and projected theoretical replacement rates show that net pensions in relation to net earnings at the point of retirement in Sweden will drop by

13 percentage points between 2006 and 2046 for an average earner retiring at age 65 reflecting the affects in increasing longevity. Public pension expenditure, including funded statutory pensions, is projected to increase from 10.6% to 11.2% of GDP between 2004 and 2050, which in comparison to most other Member States is very low.

4.2. Key challenges and priorities

The Swedish public pension system is adequate and financially stable. In order to keep the replacement rate constant, however, longer working lives and increased participation rates among older workers are required. The described change in the income-related pension system is intended to encourage higher labour force participation and longer working lives, as the size of the annual pension will be decided by lifetime earnings and the chosen age of retirement. Pensions increase the later a person chooses to retire, due to further-earned pension rights during the additional working years and decreasing remaining life expectancy. The retirement age has increased slightly in recent years. However, projections show that even if people work longer to compensate for the effect of an ever longer life the period of time in retirement continues to increase for all cohorts. According to current projections, a worker retiring at 65 after 40 years with average earnings would see the replacement rate decrease by 13 percentage points from 2006 to 2046, partly due to increases in longevity. Even if a person retiring in 2046 were to compensate for this longevity effect by working longer, he or she would still be in retirement longer than a person who retires at 65 in 2006. Public expenditure on pensions is projected to increase very slowly until 2050 (by only 0.6 percentage points).

The outcome of the pension reform is continuously monitored. In previous years the balance between assets and liabilities has shown a marginal surplus only. In the calculation of assets the current value of the large reserve funds is included, causing the balance to be sensitive to volatility on the financial market. A deficit in the system causes the indexation of pensions and earned pension entitlements to be lowered by automatic adjustment.

4.3. More people in work and working longer

The employment rate of older workers (67% for women and 73% for men) is the highest in the EU. As stated, the principle of lifetime earnings — fundamental to the national pension system — provides good incentives to work. Spreading information about the clear correlation in the statutory pension schemes between contributions and the size of the future pension is thus part of the strategy in the NSR to get people to stay longer in the labour market. Judging from the different pension schemes affecting retirement incentives it is important to study how different schemes affect the incentives to work longer for different income groups. For low-income groups the level of the guarantee pension creates lower incentives to work longer, but the NSR argues that price-indexation of the pension provides an incentive to earn more income-related pension. In income groups where incomes exceed the ceiling in the statutory schemes, it is important to study the incentives in occupational schemes as these schemes take on a more important role in retirement.

As stated, a current challenge for Sweden is the late age of establishment in the labour market, defined as when 75% of an age cohort is employed in the labour market. This age is 27 according to the NSR, compared to just over 20 in 1990 and the issue needs to be addressed in order to secure economic growth and adequate pensions in the future.

4.4. Privately managed pension provision

Around 90% of wage earners are covered by some form of occupational pension scheme. The schemes are based on premium reserves with a large proportion of their assets consisting of shares, partly depending on the choices made by the individual participant. Generally speaking these schemes are not mentioned much in the NSR and yet they provide a large share of retirement income for many people, especially those with incomes above the ceiling in the statutory system. Accordingly, it would be interesting to know more about how these schemes affect work incentives and income gaps and address gender issues.

According to national statistics, 38% of 20-64 year olds are also covered by individual private pensions. Women, more often than men, have private pensions and high-income earners are more likely to take out private pensions than people with lower incomes. The importance of these private pensions has been rising steadily over the last 10 years.

4.5. Minimum income provision for older people

In 2007 the poverty rate among the elderly in Sweden was the same as for people below the age of 65. However, while the risk is much higher for women (10% for people under 65 and 14% for 65+) the risk is actually lower for elderly men (11% compared to 7%). As with the total population, social transfers reduce poverty among the elderly to a great extent (from 23% before social transfers to 11% after).

The old-age guarantee pension, means-tested only against other income-related statutory pensions, provides a minimum pension level for persons from the age of 65 years. The guarantee pension provides a high level of protection compared to many other EU Member States. The guarantee pension is price-indexed, which indicates that the relative level of this pension will fall over time. The means-tested housing allowances also supplement the incomes of numerous pensioners. For those who have not been resident in Sweden long enough to be eligible for a full guarantee pension there is special maintenance support for the elderly. This support is means-tested, price-indexed and tax-free and intended to guarantee a reasonable standard of living for people aged 65 or over.

4.6. Information and transparency

All those insured under the national pension system receive annual information on the evolution of their own pension. The annual information provides accumulated pension entitlements as well as projections of the pension an individual would receive if he or she chose to retire at some alternative pension ages. This information does not, however, include information on collectively bargained or private pensions. An internet portal that also provides information on occupational pensions is available, but few people use it.

According to a survey by the Swedish Social Insurance Agency from December 2007, 40% say that they know the national pension system quite well. Accordingly, despite past efforts to inform people about the Swedish pension system, knowledge of the system among the insured remains inadequate, and is increasing only very slowly. Improving information about the national pension is an ongoing task for the government.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Health care in Sweden is coordinated at municipal, county and national level. The county councils and municipalities levy taxes to finance health services and their autonomy means that services can be organised and prioritised differently in different parts of the country. Health care is almost entirely tax-financed and healthcare services are mainly supplied by public providers but private care providers are being promoted by the government to some extent and private care is likely to become more important in future. The government's objective for Swedish healthcare policy is for the population to be offered needs-orientated, accessible and efficient care of high quality. The policy has thus come to focus on initiatives that improve accessibility, quality, freedom of choice, and diversity of care providers.

5.1.2. Accessibility

Accessibility to health care is generally good in Sweden and all residents are covered by public or primary private insurance. Adult asylum-seekers are, however, only entitled to subsidised emergency care, and undocumented people have to pay the full cost of all treatment, including emergency procedures. However, no one is denied emergency health care because of difficulty with payment. In practice, some regions and county councils have nonetheless decided to provide health care for asylum-seekers and undocumented migrants on the same basis as for resident persons, which mean that there are regional disparities in accessibility for these groups.

The self-reported unmet need for medical care (due to waiting time, costs or distance) is increasing. At 2.9% in 2006, it is still slightly under the EU average. For dental care the corresponding percentage is much higher, 7.7% in 2006 (EU average 5%). Under the National Care Guarantee the county councils are required to offer care within certain time limits. Despite this and other initiatives aimed at improving accessibility, long waiting times remain a problem. More resources have been made available to psychiatric health in recent years, but waiting times are still lengthy here as well. A strengthened care guarantee is under implementation, which would mean that waiting times for visits and treatments would not exceed 30 days for child and adolescent psychiatry (rather than 90 days, as stated in the general care guarantee). As part of a larger inquiry appointed in 2007, the possibility of transforming the National Care Guarantee into a statutory regulation is currently being investigated. The government has also initiated a special government grant based on performance, which means that compensation is only distributed if the county council has performed well against the National Care Guarantee (the grant is €1 million per year, starting in 2010 based on evaluation of the accessibility statistics from 2009).

Outpatient care, hospital care and prescribed medicines are usually provided with only patient co-payment fees to be paid. Maximum, total co-payments per year per patient apply in most areas (so called high-cost schemes), but county councils can apply different co-payment rules and amounts.

5.1.3. Quality

The National Board of Health and Welfare and the counties' administrative boards are responsible for supervision, follow-up and evaluation of county council and municipal healthcare services. Several measures have been taken over the past couple of years, aimed at ensuring quality in health care. These include the government's Strategy for Good Care, aiming to improve the use of information and communication technology within health care as well as improving the freedom of choice for the individual. The strategy points out the importance of interplay between measures for open comparisons, advanced benefit systems, the effective supply of information and the diversity of care providers through such means as employee takeovers. Patient safety is another priority issue mentioned in the NSR. A review of patient safety from a legislative point of view is currently being undertaken.

Improving quality in psychiatry is considered a crucial issue. Investments have been made especially in child and adolescent psychiatry. Efforts have also been made to raise expertise in psychiatric health care and in social services for people with mental disabilities.

A challenge with the decentralised health care system is that there are considerable differences between different regions, with regard both to health indicators and to patient-received quality. The NSR does not, however, provide information on the actual situation regarding regional variations in performance.

5.1.4. Sustainability

Total healthcare expenditure has remained fairly constant in the last two decades (9.2% of GDP and 3 202 PPP$ per capita in 2006). This is slightly above the EU average, but compared to most countries which are similar to Sweden in many other respects, healthcare costs are relatively low. Public healthcare expenditure as a percentage of total healthcare expenditure has fallen steadily from 92% in 1980 to 81.7% in 2005. According to projections, public healthcare expenditure is projected to increase by 1% of GDP by 2050 due to population ageing.

Many healthcare professionals are close to retirement age and as the educational system is not producing enough new ones, the Swedish healthcare system is facing a lack of qualified personnel. Many professionals are now recruited from other countries, for example Poland and Germany. In psychiatry the situation is particularly problematic as a good knowledge of the Swedish language is essential for being able to work in that speciality. An expansion of the number of students in medicine and care at Swedish universities would accordingly also be important.

5.2. Long-term care

5.2.1. Description of the system

Municipal long-term care is seen as an important guarantor of social protection and inclusion for the elderly population and people with disabilities. The 290 municipalities have a statutory duty to meet the social service and housing needs of persons with disabilities and the elderly, but their autonomy means that services are organised and prioritised differently in different municipalities. The individual's need for subsidised support is assessed in relation to income. The national policy for the elderly and the national disability policy stipulate that both groups should be able to live independent lives and should be enabled to live in their own home as

long as possible. Long-term care has been restructured over the last 15 years, with a reduction in institutional living and care and an increase in those living and receiving services provided at home.

5.2.2. Accessibility

Access to long-term care depends on the municipality a person is living in, and varies in different parts of the country. The above-mentioned restructuring and downsizing of institutional care has in some cases led to a noticeable lack of places in institutions/special housing, resulting in long waiting times. New provisions have been introduced to tackle this, e.g. municipalities that do not implement a decision on special accommodation within a reasonable time will have to pay a charge to the central government.

The proportion of elderly people who receive health and medical care from the private sector has increased in the current decade. Various client-choice systems have been introduced in some municipalities, giving the elderly the option to choose providers themselves, either private or local-authority.

5.2.3. Quality

The NSR underlines that a number of measures have been adopted and that more resources have been allocated to counties and municipalities to develop quality in long-term care. These initiatives have the effect of driving the development of better national statistics and quality indicators that provide the necessary basis for open comparisons of quality in health and social care of the elderly. No description of quality in long-term care is included in the NSR but, as has been stated, there are wide local differences between municipalities and there may also be wide differences in quality, costs and outcomes within a municipality.

5.2.4. Long-term sustainability

The long-term sustainability of care of the elderly is dependent on sound public finances and high labour force participation to finance projected care needs. Public long-term care expenditure is projected to increase by 1.7% of GDP by 2050 due to population ageing (reaching 5.5% of GDP in 2050).

The Ministry of Health and Social Affairs is currently working with the Ministry of Finance on a project which is intended to shed light on the long-term demand for and costs of welfare services, including health and social services for the elderly.

6. CHALLENGES AHEAD

- To continue to address the high youth unemployment rate as well as the employment gap between the foreign and native-born population and to continue to support the transfer of the high stock of people in sickness and disability pension schemes to the labour market. This includes pursuing efforts to reform the education system, including improved vocational training, in order to reduce drop-outs and social exclusion among young people, in particular those with a migrant background.

- To address the higher levels of risk of poverty among lone parents, elderly women and people with a migrant background, especially children.

- To continue efforts to improve the general knowledge of the pension system, especially clarifying the different sources of a person's pension.

- To address the regional differences in access and quality performance of the healthcare services provided.

- To ensure access to long-term care, especially in special housing, provided by the municipalities within an acceptable time, and to ensure that persons can move freely from one municipality to another and receive the necessary support and care.

- To further pursue improvements in psychiatric care, notably the capacity to immediately take care of persons with mental problems that are seeking care.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4,4	126,7	**2000**	73,0	75,1	70,9	42,2	65,0	**2000**	5,6	5,9	5,3	10,5
2005	3,3	120,3	**2005**	72.5b	74.4b	70.4b	38,7	69.4b	**2005**	7.4b	7.5b	7.3b	21.1b
2008*f*	0,5	118,1	**2007**	74,2	76,5	71,8	42,2	70,0	**2007**	6,1	5,8	6,4	19,1

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate (2007 instead of 2006)	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	76,2	81,4	16,0	19,6	n.a	n.a	4,1	**1995**	8,0	86,6	n.a.		-
2000	77,4	82,0	16,7	20,0	63,1	61,9	3,4	**2000**	8,2	84,9	13,8	**2005**	2,6
2006	78,8	83,1	17,7	20,9	67.1b	67.0b	2,5	**2006**	9,2	81,7	16.2**	**2006**	2,9

s: Eurostat estimate; p: provisional; b: break in series

**THE: Total Health Expenditures; ** 2005 instead of 2006*

3. Expenditure and sustainability

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

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	33,6	37,7	21,8	10,9	11,4	6,3	11,9
2000	30,1	39,4	27,0	7,1	9,0	4,4	13,0
2006	30,7	40,2	26,0	5,5	9,8	3,6	14,9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes			
		Total social expend.	Public pensions	Health care	Long-term care
2004	26,7	29,6	10,6	6,7	3,8
2010	27,8	-1,4	-0,5	0,1	-0,1
2030	37,4	1,3	0,4	0,8	1,1
2050	41,9	2,2	0,6	1,0	1,7

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	11	12	10	11	20	17	24	11	3,4	**2005**	9
male	11	-	11	7	22	-	26	11	-	**2006**	11
femal	11	-	10	14	18	-	22	12	-	**2007**	9

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	:	:	:	:	**2000**	1,4	1,7	1	**2000**	7,7	9,2	6,2
2004	:	:	:	:	**2004**	1,2	1,4	1	**2004**	8,6	9,3	7,9
2007	:	:	:	:	**2007**	0,9	0,9	0,8	**2007**	8.6b	10.2b	7.0b

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,78	1	0,73	***Aggregate replacement ratio***	0,61	0,63	0,54

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Estimate of current (2002)	Assumption
-13	-13	-11	NDC/DC	-2	DB	100	90	17,2	13,7	13,7

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

United Kingdom

1. SITUATION AND KEY TRENDS

The UK enjoyed solid economic performance during recent years, and GDP grew by 3% in 2007. The crisis in the financial and housing markets has depressed the economic outlook and the UK economy is expected to slow to 0.7% in 2008 and to contract in 2009.

The employment rate is high for all groups and the UK exceeds all quantitative Lisbon targets on employment. However, the high rate of people living in jobless households (10.7% of adults) continues to be a cause for concern despite strong economic growth and the government's activation measures. The problem is especially acute for children, as 16.7% live in a household where nobody works and which is the highest in the EU (the EU-average is 9.4%). The female employment rate is high (65.5%) partly being due to a flexible labour market and opportunities for part-time work thus facilitating reconciliation between work and family life. Eurostat data suggests that only 7.8% of part-time work is involuntary (the second lowest in the EU) but the high proportion of women working part-time (42%) also affects gender pay gap, under-utilisation of women's skills and child poverty**.** Further improvements, such as increasing the availability of full-time childcare and improving the quality of part-time jobs would be beneficial. The number of people who are economically inactive because of poor health continues to be a concern.

Income inequality in the UK is high, both compared to other EU countries and by historical standards as the substantial increase which took place in the second half of the 1980s has not been reversed. This has significant impacts upon people's life chances because in the UK there is a much stronger correlation between educational achievement and socio-economic background than in most other countries. The relative poverty rates also exceed the EU averages for all groups.

The structure and share of social protection expenditure of GDP (26.4% in 2006) is around the EU average. Social transfers (excluding pensions) reduce poverty by 11 percentage points or by 37% (from 30% to 19%), which is around the EU average. The UK faces similar demographic trends to other EU Member States, though to a somewhat lesser extent. The projected old age dependency ratio (38 in 2050) is significantly below the EU average of 50.4. Between 2004 and 2050 age-related public spending as a percentage of GDP is expected to increase by 4 percentage points.

The UK has a long history of immigration and 12.6% (in 2007) of the working age population was born outside the UK. Following the EU enlargement of 2004, the UK experienced a high rate of mobility from the eight new Member States which put pressure on public services in some local communities. The employment rate gaps between people born inside and outside the country are slightly above the EU average; however, this has to be seen in the light of the high employment rate — 62.8% for people born outside the EU-25 and 75.4% for people born in another EU-25 country — which is above the EU average. For several groups of ethnic minorities, the employment rate varies greatly with gender. Certain ethnic minorities continue to exhibit higher poverty rates and one third of ethnic minority children live in poverty.

2. OVERALL STRATEGIC APPROACH

The main priorities identified by the National Strategy Report (NSR) remain the same as in 2006-2008 and include facilitating access to the labour market, eradicating child poverty, tackling discrimination and ensuring access to services. Gendered analysis in the NSR could be strengthened regarding employment policies (particularly in relation to employment of older women, women from ethnic minorities and part-time work), child poverty, health and long term care and pension adequacy of current women pensioners.

The UK has a strong tradition of evidence-based policy. There is a clear focus on quantifiable targets and performance measures are transparent and closely monitored. The targets and policies are usually shared and coordinated between several Departments, reflecting the multi-dimensional nature of social inclusion. Good governance is promoted by the involvement of stakeholders in the development of policies. There is an effective interaction between the strategy on social inclusion and the Lisbon strategy. The UK approach to social inclusion is focused on employment as the best route out of poverty and on increasing employment opportunities for the disadvantaged. Improving the skills of the population is seen as a contribution to increased employability and social cohesion, and as the response to the challenges of globalisation. Measures that make work pay have addressed poverty and created incentives to enter employment. The European Social Fund supports the priorities of the NSR by contributing to policies aimed at increasing labour market participation, tackling discrimination and enhancing the skills level of the low skilled. It also contributes to reducing child poverty by improving parents' access to the labour market.

3. SOCIAL INCLUSION

3.1. Key trends

The relative risk of poverty after social transfers (19%) continues to be above the EU average (16%) in 2007. However, in absolute terms the incomes of the poor in the UK greatly exceed the incomes of the poor in most other countries, as the poverty threshold (one person household), at €12 572 per year, is the fourth highest in the EU. According to Eurostat data, old people are at the highest risk of poverty (30% for old people and 23% for children in 2007); however national data show a higher poverty rate for children[95]. The discrepancy is due to different methodologies. Disabled people, certain ethnic minorities, jobless single parents and people living in deprived areas continue to exhibit higher poverty rates.

Income inequalities are above the EU average, with the Gini coefficient standing at 33 (EU-25 average is 30) and s80/s20 income share ratio of 5.5 (EU-27 is 4.8). The increase in Gini coefficient after 2005 followed a fall over the period 2001-2005 and as a result, income inequality remained pretty much unchanged over the last decade. In-work poverty (6% for full-time and 12% for part-time workers) is around the EU average.

Despite high employment rates, the proportion of adults (10.7%) and children (16.7%) living in jobless households is among the highest in the EU in 2007. The rate has remained around

[95] According to national data the poverty rate for children in 2006/07 is 21% before housing costs and 29% after housing cots. Poverty rate for older people is 21% and 18% respectively. National data also indicates that pensioners are less likely to be in poverty- measured after housing costs - than the population as a whole.

11% for adults over the last 7 years. The rate of young people not in education, employment or training has stagnated over the last decade and is particularly high among the low skilled. Unemployment traps are minimised, but inactivity and low wage traps are in most cases higher than in most other EU countries.

3.2. Progress on the priorities set in the 2006-2008 National Strategy Report (NAPIncls) and the challenges identified in the 2007 Joint report

There has been good progress over the last ten years across most areas identified as priorities by the previous NSR, although a number of indicators showed a deterioration over the last period (pensioner poverty, employment rates of several disadvantaged groups, gender pay gap).

According to national data, over the period 1998-2006 the risk of children living in poverty fell from 26% to 22%. The number of children in poverty fell from 3.4 million to 2.9 million (relative poverty) and from 3.4 million to 1.7 million (absolute poverty).

Regarding access to the labour market, several disadvantaged groups (single parents, people with disabilities, older people and ethnic minorities), except for the least skilled, have experienced improvements in their labour market position over the last 10 years. The current economic difficulties may hinder further progress in this area. It is difficult to assess overall progress on the priority of ensuring access to quality services as there are many areas and initiatives and an integrated approach is not explicitly mentioned. There has been a significant increase in investment in education (from 4.6% of GDP in 1999 to 5.5% in 2005). The increased investment in health care has contributed to improved accessibility and quality. Regarding transport, although there have been developments aimed at improving access for disadvantaged groups, further improvements are needed to enhance general access to transport. In England, the number of households living in fuel poverty increased to 3.5 million compared to 3.4 million in 1998. There has been progress in reducing re-offending (by 7.4% compared to 2000), bringing down the number of adults without a bank account (from 2 million to 1.3 million in two years) and increasing the proportion of vulnerable households living in decent homes (from 43% in 1996 to 68% currently).

Progress had been made in some areas regarding equalities. Over the last ten years, the gender pay gap has been reduced, although the latest data show that it has widened over the past year. Overall school attainment for disadvantaged groups has improved. Socio-economic background appears to be the strongest determinant of educational outcome and the attainment gaps between disadvantaged pupils and their peers are large but narrowing. The attainment gaps of most ethnic minorities have narrowed.

3.3. Key challenges and priorities

The key priorities identified by the 2006-2008 National Strategy Report are the same as in the previous reporting period. The selected priorities are appropriate and broadly consistent with the challenges identified by the 2007 Joint Report. Despite the challenges identified in the 2007 Joint Report, the inequalities in terms of income and wealth are largely neglected; a different approach is taken by Scotland, which is committed to increasing the total income and proportion of income earned by the poorest three income deciles by 2017. Income inequality remains a persistent problem and is closely related to inequalities in health, education and life chances.

3.4. Policy measures

The UK set ambitious targets to reduce child poverty by a quarter by 2004 (target narrowly missed), to halve it by 2010 and to eradicate it by 2020. As the child poverty rate has been significantly decreased, it becomes more challenging to reduce it even further and the existing policies might not be sufficient to meet the targets. Child poverty in the UK is tackled though measures to move more parents on low income into work, social transfers, a wide range of local initiatives and measures addressing the wider causes of poverty. In 2008, the government announced new measures to increase social transfers to families with children. A further investment of £125 million over the next three years is aimed to help prepare for the next decade, supported by pilot schemes to develop new and innovative ideas for tackling child poverty.

The government's overall employment rate aspiration of 80% in the long term is very ambitious, especially taken into account the pace of employment growth in recent years. Active labour market policies are undergoing a process of transformation towards more personalised support, increased contracting out of employment services and integration of employment and skills provision. The welfare reform introduces increased conditionality combined with increased support aimed at moving people off benefits and into work. The national minimum wage and working tax credits help provide incentives to enter employment. Regarding people with disabilities, the 'Pathways to Work' programme was rolled out in Great Britain and made compulsory for certain claimants of incapacity benefits considered to be capable of work. The budget for the programme which assists disabled people into work and within the workplace will double (for special equipment, adaptations to work premises, help with transportation). Starting from October 2008, single parents are expected to search for work once their youngest child reaches 12; the age limit is planned to be decreased further. The reform is expected to address the low employment rates of single parents, as part of a package to eradicate child poverty by 2020 and accompanied by pre-work and in-work support measures.

There is a wide range of measures to improve educational attainment, such as school benchmarking, merit pay for teachers, use of targets and plans to provide one-to-one tuition to low-achieving children. Section 5.1.2 provides information on measures regarding access to healthcare. Access to transport is facilitated by the introduction of low-floor vehicles, tailored solutions for specific groups and a wide range of local projects. The main measures to tackle fuel poverty are a package of heating and insulation measures, financial help for older people with heating costs and the requirement for energy companies to achieve 40% of their energy savings by helping vulnerable customers increase their energy efficiency. The government has allocated resources and developed strategies and action plans to promote digital and financial inclusion and improve the well-being and independence of older people.

Concerning action on discrimination, the main policy development is the establishment of an Equality and Human Rights Commission in Great Britain (a separate Commission exists for Northern Ireland) responsible for promoting equality and tackling discrimination in relation to race, gender, disability, sexual orientation, age, religion and belief. Further measures to tackle discrimination were announced in an Equalities Bill. To monitor developments in this area, the government has set quantifiable targets, including a reduction of the gender pay gap and narrowing gaps between disadvantaged groups and the general population in respect of different aspects of active inclusion.

3.5. Governance

Most of the key aspects of social inclusion are devolved to the four countries. The community and voluntary sector are actively engaged in social inclusion processes. In preparing the NSR the government is working together with stakeholder groups consisting of representatives from key government departments, devolved administrations, local government, the voluntary sector and people experiencing poverty. The 12 month project *Bridging the Policy Gap* aimed at increasing awareness of European action in the field of social inclusion and social protection. The first UK conference of people experiencing poverty was held in 2007 and is considered a successful contribution to the enriching experience of policy making. There is some scope for improving effective follow-up strategies of the social inclusion process.

4. PENSIONS

4.1. Key trends

In contrast to many other European countries, the UK state pension system is concerned with preventing poverty and providing a foundation for saving, rather than providing retirement income similar to that in working life. The UK state pension consists of a flat-rate Basic State Pension (BSP) and an additional pension called State Second Pension (S2P) which is earnings-related but following reform will become increasingly a flat-rate addition to the Basic State Pension. This state foundation is supplemented by private pension provision consisting mainly of occupational and personal pensions.

The BSP is based on the number of qualifying years built up through National Insurance Contributions, and its value is currently indexed to prices.[96] Recent reforms will make the BSP more generous and easier to qualify for. Currently, 11 million people in the UK receive the BSP (nearly the entire population above state pension age), but only 85% of men and 35% of women qualify for the full amount. For everyone reaching state pension age (SPA) on or after April 2010, only 30 qualifying years will be needed for a full BSP, down from the 44 years for men and 39 years for women currently required. This is expected to raise entitlement to full BSP to over 90% among both men and women by 2025. Another change will be the removal of the de-minimis rule, under which one does not currently qualify for any BSP if one has fewer than 25% of the required qualifying years. More generous crediting arrangements for periods spent caring for children or the severely disabled will also improve entitlement to BSP and S2P. From 2012 (or later depending on affordability), the BSP will be up-rated in line with earnings.

The SPA for women will be gradually equalised with that of men rising from 60 to 65 between 2010 and 2020. Between 2024 and 2046 it will increase from 65 to 68 years for both men and women. Deferring retirement by working and claiming state pension or delaying claiming a state pension is encouraged. For private provision, the earliest possible age to take a pension will rise from 50 years to 55 from 2010.

Recent reforms also include measures aimed at encouraging private pension provision. Legislation was approved in 2008, stipulating that from 2012 all eligible workers, who are not already in a good quality workplace scheme, will be automatically enrolled into either their

[96] Though in practice since 1997 there has been an increase of more than 7% in real terms in its value, due to above-inflation up-rating of the Basic State Pension.

employers' pension scheme or a new savings vehicle, Personal Accounts. For the first time, all employers will be required to contribute a minimum of 3% (on a band of earnings) to an eligible employee's workplace pension scheme for those who do not actively opt out. Employees will contribute 4%, while government will provide around 1% in the form of tax relief. The self-employed will not be automatically enrolled but will be able to opt in. Further measures to increase private pensions include the reduction of legislative burdens on occupational pension schemes and the simplification of the pension taxation regime. Much of the overall success of the reform will depend on the level of participation in workplace-related schemes, which in turn may be affected by the current deterioration of financial market conditions.

4.2. Key challenges and priorities

The UK, like other European countries, is facing increased longevity which poses long-term challenges for the sustainability of its pension system. In 2006, total pension expenditure in the UK was 10.7% of GDP (EU average: 11.9%). The dependency ratio in the UK is forecast to increase comparatively more slowly than in other Member States. The public pension expenditure as a % of GDP is expected to increase by 2 percentage points and reach 8.6% in 2050. In 2007, the aggregate replacement rate in the UK is 0.41, which is below the EU average of 0.49[97]. Latest Indicators Subgroup projections on net theoretical replacement rates suggest that pensions in relation to earnings at the point of retirement in the UK will drop by 4 percentage points between 2006 and 2046 for an average earner retiring at age 65. Most of this drop takes place in the statutory defined benefit scheme, partly reflecting the increase in the retirement age in the UK to ensure the sustainability of the pension system. The UK has also introduced a number of other measures, including increasing the earliest possible age at which a private pension can be drawn, promoting longer working lives by increasing the deferral rate of the state pension (from 7.4% to 10.4% in 2005) and allowing people to receive their state pension while continuing to work.

The key challenge identified in the last Joint Report is to continue to address the adequacy of pensions. The reform measures outlined in the previous section (increased eligibility for a state pension, pension uprating according to earnings, including periods spent caring in pension entitlements, encouraging private pensions) should increase access to and improve the pension adequacy of future pensioners. Concerning the pension adequacy of today's pensioners, the income of elderly persons has increased significantly over the last decade[98], keeping pace with the strong growth in earnings. Ensuring this trend persists, and continuing to tackle inequality and poverty among pensioners, is the main challenge faced by policymakers.

4.3. More people in work and working longer

In the UK, the employment rates for older workers (66.3% for men and 48.9% for women in 2007) are among the highest in Europe. The average age of exit from the labour market was 62.6 years in 2006 (EU-27 – 61.2 years.) Alongside the initiatives already described (rise in pension age, incentives to defer the state pension, increase in age when the occupational

---

97 It should, however, be kept in mind that the median income from employment for older workers (55-64 years old) in the UK is 40% higher than the EU average (in euros, 2007)

98 Eurostat data indicate that the median income of the 65+ in the UK has risen significantly during the last decade), from being 85% of EU-15 average in 1997 to 109% in 2007, although the largest increases took place in late 90s.

pension can be drawn) the government also emphasises supportive measures to help people to stay in the labour market. The most important tools are the active labour market policy New Deal 50 Plus aimed at older people, legislation to outlaw age discrimination in employment and vocational training and the Age Positive initiative, which promotes the benefits of employing older people. The UK has a comparatively high number of people on incapacity benefits and for a long time they have served as an early exit from the labour market. The government has embarked on welfare reforms with the aim of reducing the number of people on sickness benefits and moving them into work. The main measures include introducing a new medical test to better determine benefit eligibility and increased income conditionality, combined with increased support for those deemed to be able to work.

4.4. Privately managed pension provision

For those retiring today, defined benefit (DB) schemes are predominant, but there is a continuing shift from DB schemes to defined contribution (DC) schemes, where the investment risk is with the pension scheme member. The contribution rates are also significantly higher for open DB schemes than for open DC schemes and typically employers also pay a larger proportion of the total contributions in DB schemes than in DC. Participation in private pension schemes is encouraged by tax incentives. However, the regressive nature of these tax reliefs contributes to increasing inequality. There are concerns that coverage of private pension savings is low (only 56% of working age employees are contributing to a private pension) and has been declining. Participation in private pension schemes varies greatly by earning level and gender. To promote private savings, the government has implemented or will implement several measures described in previous sections (most crucially Personal Accounts but also simplification of legislation and the taxation regime and tax relief). There are also provisions to deal with risks: a Pensions Regulator (regulates work-based pension schemes) and a Pension Protection Fund (pays compensation if the employer becomes insolvent and the pension scheme is under-funded). However, the recent financial crisis poses significant challenges to increased participation in private pensions and adequacy levels.

4.5. Minimum income provision for older people

According to Eurostat data, the risk of poverty for people above 65 is higher (27% for men and 32% for women) than the EU25 average (16% for men and 22% for women). According to national data, pensioner poverty has decreased over the last decade, although during the last year it rose by 2 percentage points. Possible explanations for the last increase are that median earnings grew in excess of inflation and age-related payments were made in 2005/2006 but not repeated the following year.

All those aged 60 or over and living in Great Britain are entitled to claim the Guarantee Credit, which ensures that the weekly income for single persons does not fall below £124.05 and £189.35 for couples. Moreover those aged 65 or over may also be entitled to the Savings Credit, which rewards those who have made some savings towards their retirement. These two elements together make up the Pension Credit. To ensure a better take-up of the Pension Credit, data matching is used to identify those entitled and face-to-face visits are offered to the most vulnerable pensioners. In addition to direct support for pensioners with low incomes, income-related benefits are also provided for additional and varying spending commitments, such as rent and council tax. During cold months, there is also financial support for older people to cover heating costs.

4.6. Information and transparency

The complexity of the UK pension system continues to be problematic. To improve information and transparency, a range of programmes have been launched to focus on improving financial capability, particularly to help those most at risk of taking poor financial decisions. People also have access to personalised pension forecasts and a pension tracing service which helps find lost pension schemes. Generic pension information is available via websites and leaflets. The Pensions Advisory Service provides free information, advice and guidance on the whole spectrum of pensions. The Pensions Education Fund was established to provide impartial and accurate information to employees and self-employed who are at a risk of under-saving.

5. HEALTH AND LONG-TERM CARE

5.1. Healthcare

5.1.1. Health status and description of the system

Healthcare in the UK is delivered through the mainly publicly funded National Health Service (NHS), which provides comprehensive and universal coverage. Primary and secondary care is provided by employees of the NHS or contracted providers. Health care services are free at the point of delivery but there are a limited number of co-payments. Responsibility for health care is devolved to the four constituent countries of the UK. Scotland, Wales and Northern Ireland receive a block grant from HM Treasury and determine its allocation to health and social care and other devolved functions. All four countries in the UK give high priority to improving quality and access, prevention, moving more services out of hospitals into local communities, ensuring more personalised care and tackling health inequalities. During recent years, all four countries have published a number policy documents outlining their vision of health care as well as priorities, challenges and policy responses.

Life expectancy at birth (77.1 for males and 81.1 for females in 2005) is broadly around the EU average. It has increased by about three years for men and two years for women over the last decade. The number of healthy life years is 63.2 for men and 65 for women.

5.1.2. Accessibility

In the UK there is universal access to healthcare for the resident population. Concerning access to health care, the UK is among the most equitable in the EU, as the self-reported unmet need for health care is below the EU average and is fairly evenly distributed across different income groups. Patients who seek private healthcare are still entitled to NHS treatment; however, they cannot benefit from both services for the same episode of treatment. Around 11% of the UK population is covered by private insurance. As a consequence of devolution, there are differences in access to health care between the four countries as there are different regional priorities concerning resource allocation and service development. For example, waiting times in England are significantly shorter than in the rest of the UK. In England there are co-payments for prescription drugs with exemptions for certain groups; in Scotland and Wales drugs are free of charge. Independently of co-payments there are variations in drug accessibility both between and within the countries (availability of cancer drugs being the most noticeable example). The National Institute for Health and Clinical Excellence (NICE) decides which treatments and medicines should be available to NHS

patients and the appraisals are based on weighing up the costs against the benefits. The regions can offer access to drugs on a local basis independently of approval from NICE, resulting in variations in the availability of drugs. Concerning waiting times, all countries have set quantifiable targets and significant progress has been made (especially in England). In the UK, there have been significant absolute improvements in the health of people in disadvantaged groups and areas. Despite these improvements, in England inequalities in health persist and, in some cases have widened. The current strategy on health inequalities focuses on the wider determinants of health, the lives people lead and what the NHS can do. An ongoing evaluation of enacted programmes has been made available with a commitment by the government to continue supporting actions in order to meet the targets, and more action on the factors that drive inequalities. In Scotland, a Ministerial Task Force was established in 2007 to identify priorities and practical actions to tackle health inequalities. In Wales, the government has provided funding for projects to promote awareness and understanding of health inequalities and stimulate action. In Northern Ireland, resources are allocated taking into account the duty to ensure equal access to various groups and demographic factors, and additional resources are targeted to sparsely populated areas. All residents should be able to access treatment within one hour in case of an accident or emergency

5.1.3. Quality

Quality healthcare is a priority for all the constituent countries of the UK, where there are healthcare standards in place along with mechanisms to monitor quality. Health technology assessment programmes have been developed to evaluate the effectiveness and broader impact of healthcare treatments and tests. In England, during the last decade the main challenge was capacity; now the main challenge is to improve the quality of healthcare. There is emphasis on improved delivery and governance and expanding patient choice. Quality is also monitored by using patient surveys. Further plans to improve quality include developing comparable quality indicators and introducing a legal duty for healthcare providers to publish regular reports to the public on the quality of their services. A new system of tariffs will ensure that money follows the patient and that prices reflect the cost of best practice rather than the average cost. In Scotland, policy developments aim to improve the safety of hospital care, support health care staff to drive improvements and share best practices and use patient surveys to improve health care services. In Wales, monitoring patient safety is one of the key issues and the culture of reporting and learning from patient safety incidents is actively promoted. In Northern Ireland there are initiatives to improve clinical and social care governance, promote an informed safety culture and develop new standards.

5.1.4. Sustainability

While still below the EU average (9% of GDP) in relative terms, health expenditure rose from 6.8% of GDP in 1997 to 8.4% of GDP in 2006 and is projected to increase further. The increase in spending is a deliberate policy action with the aim of providing better healthcare services. However, a comprehensive evaluation of increased investment, its effectiveness and overall impact on different parts of the health system would be appropriate. Policies to address sustainability include prevention, promotion of healthy lifestyles and public health and moving more services out of hospitals. Though the UK currently has one of the lowest numbers of practicing clinicians per 1000 population, this number is steadily increasing and is predicted to increase further. The UK also has one of the highest numbers of nurses and midwives. England is the only country within the UK that has adopted a Payment by Results system, whereby a large proportion of hospitals' income is dependent on the volume of activity that they undertake. The price (national tariff) is based on average cost data collected

and submitted by NHS providers. Prices are adjusted to take account of unavoidable regional cost differences. To create incentives for efficiency, Scotland has implemented a national tariff which is the estimated average cost of different procedures. A programme was launched to attack waste, duplication and bureaucracy in the public sector. As part of the programme, the health sector has identified £613 million in savings over the three year period. In Wales, the government allocates resources to local health boards to pay for the costs of hospital treatments provided by NHS Trusts or other independent providers. Northern Ireland is planning to introduce a tariff in shadow form based on the average cost, with an aim of encouraging providers to become more efficient. To make the health sector more streamlined and efficient, 18 former Trusts have been merged into six.

5.2. Long-term care

5.2.1. Description of the system

The responsibility for long-term care is devolved to the four countries of the UK. In England and Wales, long-term services are means-tested. In Scotland, long-term care is free for those in need. Northern Ireland is the only country where healthcare and long-term care services are integrated; the country is currently discussing the possibility of introducing free long-term care.

5.2.2. Accessibility

All four countries have introduced or are planning to introduce measures to support unpaid informal carers. Local authorities determine eligibility and access to care. However, the assessment allows considerable discretion over the decisions. In England, Wales and Northern Ireland, local authorities contribute towards some of the cost of care and it varies between countries and care locations. Co-payments and additional user charges that are not covered for persons above the means-tested threshold can act as barriers to accessibility. England has implemented a pilot scheme under which people can choose to take money from the local council and arrange their own care. In Scotland, there is evidence that free long-term care enjoys broad support, although there are suspicions that need assessment and eligibility rules have been applied inconsistently across the country.

5.2.3. Quality

All four countries have mechanisms in place to monitor the quality of long-term care. In England, responsibility for quality assurance has moved from the local authorities to the central government. The regulatory body inspects the performance of long-term care against National Minimum Standards. The regulatory body can place legal conditions on providers failing to meet requirements to carry out improvements. There are some concerns that the perspectives of users are not well integrated into the standards of the inspection process.

5.2.4. Long-term sustainability

In all the constituent parts of the UK the level of funding for long-term care is increasing. In Scotland, where long-term care is free, it is predicted that the costs will rise substantially over the next 20 years. In England and Northern Ireland there are consultations on the long-term sustainability of long-term care in light of demographic change. In Great Britain, there is a general problem of care coordination between the healthcare services and personal social services, which has implications for the sustainability of the system and future needs

assessment. The countries are seeking ways to ensure integrated health and social care services.

6. CHALLENGES AHEAD

- To continue efforts to reduce persistent inequalities, such as those in income, health, skills, and 'life chances'.

- To tackle levels of economic inactivity by improved engagement with vulnerable groups, whilst adequately supporting the transition to quality and sustainable work and reducing the number of jobless households.

- To pursue the reform process and continue to address pensions adequacy; to implement improved access to quality private pension schemes and to monitor the situation, especially in light of the current financial crisis.

- To build on the progress made and to continue to improve accessibility and quality of healthcare services.

- To look at ways of improving integration of health and long-term care services and addressing discretion in the assessment of needs and eligibility rules.

7. TABLE WITH PRIMARY AND CONTEXTUAL INDICATORS

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,9	119,0	**2000**	71,0	77,7	64,5	55,8	50,4	**2000**	5,6	6,1	4,9	12,0
2005	2,1	121,8	**2005**	71,7	77,7	65,8	54,4	56,8	**2005**	4,8	5,2	4,3	12,8
2008*f*	0,7	115,5	**2007**	71,5	77,5	65,5	52,9	57,4	**2007**	5,3	5,6	4,9	14,3

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU27=100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2005 instead of 2006)		Infant mortality rate	WHO - OECD	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	EU-SILC	Unmet need for health care % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,0	79,2	14,6	18,2	60,6	61,2	6,2	**1995**	6,9	83,9	10,9		-
2000	75,5	80,2	15,7	18,9	61,3	61,2	5,6	**2000**	7,2	80,9	13,3	**2005**	2,3
2006	77,1	81,1	17,0	19,5	63.2b,p	65.0b,p	4,5	**2006**	8,4	87.3d	11.9**	**2006**	1,9

s: Eurostat estimate; p: provisional; b: break in series; d: change in methodology **THE: Tot. Health Expenditure; ** 2005 instead of 2006*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	(2008) Old age dependency ratio Eurostat	Expenditure (% of GDP) Level in **2004** and changes: Total social expend.	Public pensions	Health care	Long-term care
1995	27,7	43,1	24,0	5,6	8,9	7,5	10,9	**2004**	24,3	19,6	6,6	7,0	1,0
2000	26,4	48,8	25,5	3,0	6,9	6,4	9,4	**2010**	24,7	-0,2	0,0	0,2	0,0
2006	26,4	44,7	31,8	2,4	6,1	6,3	8,7	**2030**	33,2	2,2	1,3	1,1	0,3
								2050	38,0	4,0	2,0	1,9	0,8

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate				***Poverty risk gap***				***Income inequalities***	***Anchored at-risk of poverty***	
SILC 2007	Total	Children 0-17	18-64	65+	Total	Children 0-17	18-64	65+	S80/S20		Total - fixed 2005 threshold
Total	19	23	15	30	23	22	25	20	5,5	**2005**	19b
male	18	-	14	27	23	-	26	18	-	**2006**	18
femal	20	-	16	32	23	-	24	21	-	**2007**	16

	People living in jobless households					***Long Term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
2001	17,0	11,2	9,1	13,3	**2000**	1,4	1,9	0,9	**2000**	18,4	18,9	17,9
2004	16,3	10,8	8,8	12,8	**2004**	1,0	1,2	0,6	**2004**	13,6	14,1	13,1
2007	16,7	10,7	8,8	12,7	**2007**	1,3	1,6	0,9	**2007**	17.0b	18.2b	15.8b

**: excluding students; i: change in methodology; b: break in series*

SILC 2007	Total	Male	Female	SILC 2007	Total	Male	Female
Relative income of 65+	0,82	0,91	0,80	***Aggregate replacement ratio***	0,41	0,42	0,44

Change in theoretical replacement rates (2006-2046) - source ISG

Change in TRR in percentage points (2006-2046)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions: Estimate of current (2002)	pensions: Assumption
-4	-2	-3	DB	1	DC	100	53(M)/56(F)	19,85	9	8

** (DB: Defined Benefits; NDC: Notional Defined Contributions; DC: Defined Contributions); ** (DB/DC)*

Annex: Indicators

1. DEFINITION OF THE 14 OVERARCHING INDICATORS

1a. At-risk-of-poverty rate: Share of persons aged 0+ with an equivalised disposable income below 60% of the national equivalised median income[99]. Source: SILC.

+ Illustrative threshold value: Value of the at-risk-of-poverty threshold (60% median national equivalised income) in PPS for an illustrative household type (e.g. single person household). Source: SILC.

1b. Relative median poverty risk gap: Difference between the median equivalised income of persons aged 0+ below the at-risk-of poverty threshold and the threshold itself, expressed as a percentage of the at-risk-of-poverty threshold. Source: SILC.

2. S80/S20: Ratio of total income received by the 20% of the country's population with the highest income (top quintile) to that received by the 20% of the country's population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income. Source: SILC.

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

4. Early school-leavers: Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training is 0, 1 or 2 according to the 1997 International Standard Classification of Education — ISCED 97) and have not received education or training in the four weeks preceding the survey. Source: LFS.

5. People living in jobless households: Proportion of people living in jobless households, expressed as a share of all people in the same age group[100]. This indicator should be analysed in the light of context indicator No 8: jobless households by main household types. Source: LFS.

6. Projected total public social expenditure: Age-related projections of total public social expenditure (e.g. pensions, healthcare, long-term care, education and unemployment transfers), current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-20-30-40-50).
Specific assumptions agreed in the AWG/EPC. See 'The 2005 EPC projections of age-related expenditures (2004-2050) for EU-25: underlying assumptions and projection methodologies' Source: EPC/AWG.

---

99 **Equivalised median income** is defined as the household's total disposable income divided by its 'equivalent size', to take account of the size and composition of the household, and is attributed to each household member (including children). Equivalisation is on the basis of the OECD modified scale.

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

7a. Median relative income of elderly people: Median equivalised income of people aged 65+ as a ratio of income of people aged 0-64. Source: EU-SILC.

7b. Aggregate replacement ratio: Median individual pensions of 65-74 year-olds relative to median individual earnings of 50-59 year-olds, excluding other social benefits. Source: EU-SILC.

8. Self-reported unmet need for medical care: Total self-reported unmet need for medical care for the following three reasons: financial barriers + waiting times + too far to travel.

+ Care utilisation: To be analysed together with care utilisation defined as the number of visits to a doctor (GP or specialist) during the last 12 months. Source: EU-SILC.

9. At-risk-of-poverty rate anchored at a fixed moment in time (2005): Share of persons aged 0+ with an equivalised disposable income below the at-risk-of-poverty threshold calculated in the year 2005 (1st EU-SILC income reference year for all 25 EU countries), adjusted for inflation over the years. Source: SILC.

10. Employment rate of older workers: Persons in employment in the 55–59 and 60–64 age groups as a proportion of the total population in the same age group. Source: LFS.

11. In-work poverty risk: Individuals who are classified as employed[101] (distinguishing between 'wage and salary employment plus self-employment' and 'wage and salary employment' only) and who are at risk of poverty.

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

12. Activity rate: Share of employed and unemployed people in the total population of working age, 15-64. Source: LFS.

13. Regional disparities — coefficient of variation of employment rates: Standard deviation[102] of regional employment rates divided by the weighted national average (15-64 age group). (NUTS II). Source: LFS.

14. Total health expenditure per capita: Total health expenditure per capita in PPP. Source: EUROSTAT based on system of health accounts (SHA) data.

---

[101] Individuals classified as employed according to most frequent activity status. The most frequent activity status is defined as the status that individuals declare having for more than half the number of months in the calendar year.

[102] Standard deviation measures how, on average, the situation in regions differs from the national average. As a complement to the indicator, a graph showing max/min/average per country is presented.
Possible alternative measures:
Regional disparities — underperforming regions. *Source LFS*
1. Share of underperforming regions in terms of employment and unemployment (in relation to all regions and to the working age population/labour force) (NUTS II).
2. Differential between average employment/unemployment in underperforming regions and the national average for employment/unemployment (NUTS II). Thresholds to be applied: 90% and 150% of the national average rates for employment and unemployment, respectively. (An extra column with the national employment and unemployment rates would be included).

2. DATA SOURCES

Indicators of income and living conditions: EU-SILC

For the first time this year, EU-SILC data are available for 25 EU countries. The newly implemented reference source of statistics on income and social exclusion is the Framework Regulation (No 1177/2003) for the European Survey on Income and Living Conditions (EU-SILC). The technical aspects of this instrument are developed by Commission implementing regulations, which are published in the Official Journal. The data for Bulgaria and Romania are still based on the national household budget surveys under the transitional arrangements agreed for the European Statistical System[103].

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

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

It should also be noted that the definition currently used for income excludes non-monetary income components, which include the value of goods produced for own consumption[104] and non-cash employee income. This component will be available for all countries from the SILC (2007) exercise onwards, and will therefore be included in the indicators to be published in January 2009.

The reference year for the data is the year to which the income information refers (i.e. the 'income year'), which in most cases differs from the survey year in which the data were collected. Accordingly, 2006 data refer to the income situation of the population in 2005, even

---

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

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

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

Note on trends

During the transition to EU-SILC, income-based indicators were calculated on the basis of available national sources (household budget survey, micro-censuses, etc) that were not fully compatible with the SILC methodology based on detailed income. Following the implementation of EU-SILC in a given country, the values of all income-based indicators (at-risk-of-poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years. This is why no trends for income-based indicators are presented in this year's report.

Limitations

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

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

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

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

Confidence intervals

Indicators are estimated values based on a sample drawn from the target population and thus are affected by sampling error. Statistical theory provides us with tools for calculating confidence intervals in which the population value lies with a high probability. The confidence intervals are centred around the estimated values reported and their length is a measure of the precision of these estimates. The precision depends on the design of the survey and can thus vary between countries. However, the EU-SILC Regulation provides for national samples to be designed so as to achieve a confidence interval of +/-1% around the estimated value of the total at-risk-of-poverty rate. Eurostat is computing these intervals for a number of indicators and exact values will be reported in EU quality reports. First computations show that the confidence intervals around the total at-risk-of-poverty rate are of the order of +/-0.8%. For the S80/S20 income quintile share ratio, the confidence intervals are of the order of

+/-0.2. For the relative median at-risk-of-poverty gap, they are of the order of +/-1.7. For the Gini coefficient, they are of the order of +/-0.9. These indications of precision must be taken into account when interpreting the data.

LFS: the European Union Labour Force Survey

The European Union Labour Force Survey (LFS) is the EU's harmonised survey on labour market developments. The survey has been carried out since 1983 in the EU Members States, with some states providing quarterly results from a continuous labour force survey, and others conducting a single annual survey in the spring. From 2005, all EU Member States have conducted a quarterly survey. If not mentioned otherwise, the results based on the LFS refer to surveys conducted in the spring ('second quarter' in all countries except for France and Austria, which is 'first quarter') of each year. It also provides data for Bulgaria, Croatia and Romania.

The Annual Averages of Labour Force Data series is a harmonised, consistent series of annual averages of quarterly results on employment statistics based on the LFS, completed through estimates when quarterly data are not available. It covers all the EU-15 (for the period from 1991 to present) and all new Member States and Candidate Countries (since 1996 or later, depending on data availability) except the Former Yugoslav Republic of Macedonia. The Annual Averages of Labour Force Data consist of two series: 1) population, employment and unemployment, and 2) employment by economic activity and employment status. The first series is based mainly on the EU LFS. Data covers the population living in private households only (collective households are excluded) and refers to the place of residence (household residence concept). They are broken down by gender and aggregate age group (15–24, 25–54, 55–64 and 15–64). Unemployment data is also broken down by job search duration (less than 6 months, 6–11, 12–23, 24 months or more). The second series is based on the ESA 1995 national accounts employment data. Data covers all people employed in resident producer units (domestic concept), including people living in collective households. They are broken down by sex, working-time status (full-time/part-time) and contract status (permanent/temporary) using LFS distributions. All key employment indicators presented in this document are based on the Annual Averages of Labour Force Data series. They represent yearly averages unless stated otherwise. Where the Annual Averages of Labour Force Data series does not provide the relevant breakdowns, the original LFS data has been used for this report.

Age-related expenditure projections

Long-term budgetary projections were prepared in 2006 by the Economic Policy Committee and the European Commission (DG ECFIN) — see European Policy Committee and European Commission (2006), 'The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, healthcare, long-term care, education and unemployment transfers (2004-2050)', European Economy, Special Report No 1/2006.

The projections are made on the basis of a common population projection and agreed common underlying economic assumptions that have been endorsed by the EPC. The projections are made on the basis of 'no policy change', i.e. only reflecting enacted legislation but not possible future policy changes (although account is taken of provisions in enacted legislation that enter into force over time). The pension projections are made on the basis of legislation enacted by mid-2005. They are also made on the basis of the current behaviour of economic agents, without assuming any future changes in behaviour over time: for example,

this is reflected in the assumptions for participation rates, which are based on the most recently observed trends by age and gender. While the underlying assumptions have been made by applying a common methodology uniformly to all Member States, for several countries adjustments have been made to avoid an overly mechanical approach that leads to economically unsound outcomes and to take due account of significant country-specific circumstances. The pension projections were made using the models of national authorities, and thus reflect the current institutional features of national pension systems. In contrast, the projections for healthcare, long-term care, education and unemployment transfers were made using common models developed by the European Commission in close cooperation with the EPC and its Working Group on Ageing Populations. The projection results show the combined impact of expected changes in the size and demographic structure of the population, projected macroeconomic developments and assumed neutral evolution in the health status of the population in each Member State of the European Union.

Pension expenditure

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

Replacement rates

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

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

Healthcare expenditure — WHO Health for All database (www.who.int\nha)

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

About 100 countries have either produced full national health accounts or report expenditure on health to the OECD. Standard accounting estimation and extrapolation techniques have been used to provide time series (1998-2004). Ministries of Health have responded to the draft updates sent for their inputs and comments. The principal international references used are: the International Monetary Fund (IMF), Government Finance Statistics and International Financial Statistics; OECD health data; and the United Nations National Accounts Statistics.

National sources include: national health accounts reports, public expenditure reports, statistical yearbooks and other periodicals, budgetary documents, national accounts reports, central bank reports, non-governmental organisation reports, academic studies, reports and data provided by central statistical offices and ministries, and statistical data on official websites.