2003 The social situation in the European Union

- In brief -

European Commission

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Foreword

The Social Situation Report deals with the quality of life of people living in Europe. It provides a holistic view of the population and its social conditions as a background to social policy development and contributes to the monitoring of developments in the social field across Member States.

This publication serves as an executive summary of the Report. It is divided into two main chapters. The first chapter provides an overview of the main social and economic trends in Europe, backed by facts and figures. In the second chapter, there is a synthesis of this year's special theme, which relates to the social dimension of health and, in particular, the questions of how and why the health of European citizens has improved, along with some potential future challenges. The publication then concludes with a brief consideration of the European Social Model.

As in previous years, the annexes of this publication present a set of harmonised social indicators for each Member State, and for the first time the corresponding indicators for the acceding States and candidate countries are also given. The indicators provide an initial overview of the social situation. In addition, they provide a powerful tool for monitoring social developments over time.

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1 Key social developments

1.1 The Social Situation: Opportunities and Challenges

The social situation is largely formed in the cross-field between longer-term developments in population structures and short to medium term changes in the economy.

After five years of strong economic growth, which created 12 million jobs and raised the employment rate by four percentage points to 64.0% of the working age population, the outlook has now become less optimistic. In 2001 the rate of economic growth dropped to 1.5%, or less than half the level it achieved in 2000 and in 2002 recovery has been rather slow. Yet employment continued to grow, albeit slowly.

Meanwhile, the medium term economic and social challenges to society from the ongoing ageing of the European population are becoming clearer. Soon the century long growth in the size of Europe's working age population will come to a halt. And in less than a decade the impact of the retirement of the baby-boomers will begin to be fully felt.

The structural improvements achieved since 1996 and the successful launch of the single currency have resulted in a better economic performance in monetary and financial terms and increased flexibility in the labour market. Beyond the obvious contributions to improvements in living conditions, policy opportunities were enhanced in a number of areas. New possibilities emerged for tackling structural problems in employment, such as youth unemployment and the low activity rates of women and older workers. Higher employment has also eased the pressure on social protection systems and created increased scope for manoeuvre in pension reform. Inequality did not rise during prosperity and rising employment rates and economic growth have produced new possibilities for addressing persistent problems of poverty and social exclusion.

The same period has witnessed significant improvements in the ability of Member States to draw support for their policy efforts from the EU. Collaboration on combating social exclusion and modernising social protection have been added to the processes of macro-economic coordination and employment, creating the potential for a virtuous triangle of mutually reinforcing economic, employment and social policies.

Major challenges persist and with enlargement new ones are emerging. Decisive action is required to maintain the achievements of the last five to seven years and to take advantage of the opportunities created for continuing on a path of sustainable growth and steady improvements in the social situation[1].

1.2 Population dynamics

Developments in the demography of Europe will impact significantly on the social situation and present major challenges for the European economy.

The EU population is ageing....

The EU population is ageing and old age dependency rates will increase. Although fertility increased slightly from 1.45 children per woman in 1999 to 1.47 in 2001, it is still well below the replacement level of 2.1. Life expectancy is growing and mortality is increasingly concentrated in old age. As the baby-boomers reach retirement age there will be growing numbers of people in the elderly age groups. Today, people aged 65 and over represent 16% of the total population while those below 15 represent 17%. By 2010 these ratios will become 18% and 16%. The most dramatic increase will occur in the number of 'very old' people (aged over 80), which will rise by almost 50% over the next 15 years.

...and despite the younger age structure of acceding States, enlargement will not change this trend.

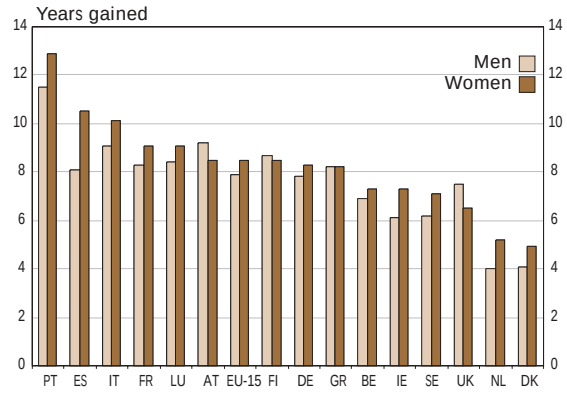
As a consequence of high fertility levels in the 1970s and 1980s the acceding States presently have a younger age structure than EU-15 (population aged 65+ amounts to 13% while children below 15 years constitute 19%). Consequently enlargement will have a rejuvenating effect. However, this effect will be both small and temporary. In the medium to long-term acceding States will tend to reinforce the population decline of the EU. Given the onset and persistence of extremely low fertility levels the proportion of children in the population is rapidly declining and by 2020 the share of older people will approach EU-15 levels.

At the same time families are becoming less stable and households smaller...

The rising old age dependency rates will impact on our ability to cope with caring needs, which may also be exacerbated by developments in family and household structures. There are fewer and later marriages, and also more marital breakdowns. In 2001, there were only 5 marriages per 1,000 inhabitants in EU-15 compared with almost 8 in

1 A full assessment of the overall situation of the European Union in early 2003 is given in "Choosing to grow: Knowledge, innovation and jobs in a cohesive society" Report to the Spring European Council, 21 March 2003 on the Lisbon strategy of economic, social and environmental renewal, COM(2003) 5 final .

Graph 1 Increase in life expectancy between 1960 and 2000



Source: Eurostat. 2000 data: estimated value for EU-15.
1999 data for DE and GR. 1960 data for DE excluding ex-GDR

1970. Furthermore, the estimated divorce rate for marriages entered into in 1960 is 15%, whereas for marriages entered into in 1980 the figure almost doubled to 28%. The trend towards smaller households, with more people living alone at all ages, is continuing. Also there is a striking rise in the number of children living with one adult, and a fall in the number of couples with children. In 2000, 10% of children aged 0-14 years were living with just one adult compared with 6% in 1990. The overwhelming majority of these single parents are women. With the exception of Poland and Cyprus families have also become substantially less stable in the acceding States.

...while migration flows play an increasingly important role in population change.

For more than a decade net immigration has been the main factor in population growth in the Union. Today, all Member States receive significant migratory inflows and in 2001 the annual net migration rate was 3.1 per 1,000 population, representing around 74% of total population growth. In some acceding States emigration has had a noticeable impact on the demographic situation. In particular, the Baltic States have experienced a decrease in population due to emigration.

Policy makers are becoming much more aware of the consequences of ageing...

Awareness of population ageing and its likely impact on employment and social policy has grown significantly in the last couple of years. Member States have committed themselves to work on ageing issues in the context of sound public finances, employment and social protection (i.e. pensions, health and long-term care) and reviewing their national policies accordingly. Acceding States are shadowing these new collaborations on ageing issues in many areas.

...and they are taking steps to address these at the national as well as at EU level.

The general assessment of present policy efforts is that most Member States – and acceding States – plan to take advantage of the window of opportunity before the large cohorts of baby-boomers reach pension age. They intend to enable their pensions[2], health and long term care[3] systems to continue to perform their social objectives and retain their financial sustainability when the pressures from ageing rise. Several major reforms have already been carried out and many are under preparation.

1.3 Recent employment trends

In 2002 unemployment increased slightly for the first time since 1996. Yet, despite the economic downturn labour markets showed remarkable resilience. More jobs were created than lost and the net result was a gain in employment.

This suggests that the development and application of the European Employment Strategy and the new emphasis on promoting social inclusion has helped the Union to move to a path of sustainable and higher employment growth amounting to 1.3% per year since 1996[4]. The employment rate increased to 64.0% in 2001 and is likely to reach to 64.5% in 2002; the unemployment rate declined to 7.4%, the lowest rate for a decade, and although it increased in 2002, the rise to 7.6% was very slight[5].

The employment rate average for all countries in the enlarged Union is somewhat lower than the average for the fifteen current EU Member States. However, certain structural weaknesses exist which, although their scale may differ, are largely common to both existing and future Member States. The outstanding challenges that the future Member States face are to increase labour force participation and employment, to facilitate labour flows from agriculture and industry to services without increasing regional disparities in the medium-term and to upgrade and update skills to the needs of modern knowledge based market economies.

Further progress in meeting the Lisbon agenda including full employment calls for decisive action to raise participation and employment, foster quality and productivity at work and to promote cohesion.

2 Proposal by the Commission for a Joint Commission-Council report on adequate and sustainable pensions, COM(2002) 737 final.
3 Proposal for a joint Commission-Council report on: Health care and care for the elderly: Supporting national strategies for ensuring a high level of social protection, COM(2002) 774 final
4 For a fuller assessment of employment developments in this period see "TAKING STOCK OF FIVE YEARS OF THE EUROPEAN EMPLOYMENT STRATEGY", COM (2002) 416 final.
5 A proposal for a future employment strategy in view of present uncertainties is given in The future of the European Employment Strategy (EES)"A strategy for full employment and better jobs for all" COM(2003) final.

Maintaining labour supply will increasingly depend on raising the activity and employment rates of women...

Between 1996 and 2001, the EU employment rate for men and women increased by almost three and five percentage points respectively, thus narrowing the gap between the sexes to 18 percentage points. As for unemployment the gender gap also declined but remained significant at 2.3 percentage points in 2001. These recent reductions in gender gaps are an encouraging sign that the gap in unemployment rates could be closed in the near future.

There is also a gender gap in the acceding States, however, the proportion of women in the workforce is higher than in EU Member States (46% compared to 42%). The proportion of women employed in managerial occupations is also higher: 38% of managers in acceding States are women, compared to 34% in the EU. Furthermore, in the acceding States, part-time work is less frequent and more equally divided between the sexes: 6% of men (7% in the EU) and 9% of women (32% in the EU) work part-time.

...and older workers...

Overall, 38.5% of the EU population aged between 55 and 64 were in employment in 2001. This is well below the Stockholm target of 50% by 2010. The average age at which people leave the labour market was 59.9 years in 2001. It will be a challenge to increase this by about five years by 2010 as the Barcelona European Council has requested. Recent improvements in the employment of older people in some Member States demonstrate that the trend to declining employment participation can be reversed if efforts are intensified. In the acceding States the employment rates for workers aged 55-64 are even lower, but in the last couple of years they have stabilised and begun to improve.

From a different perspective - i.e. given current and future population dynamics leading to a shrinking population of working age - it is of great importance that most Member States have considerable labour reserves among women and older workers. If existing barriers to participation are removed, these labour reserves could be used to counteract the impact of ageing on the size of the workforce.

...as well as on the size and shape of immigration and the integration of immigrants.

Demographic scenarios - based on the hypothesis of stable immigration inflows and assuming that the Lisbon employment targets are met - tend to show that, beyond 2010, the overall volume of employment in EU-15 would be reduced as a result of a shrinking working-age population. More so than previously, productivity gains will come to play a key part in economic growth. Immigration will also be an important factor in that respect, particularly when present labour reserves among the existing working age population are fully engaged. Obviously the positive economic and social effects of immigration hinge on the ability of Member States to secure the full integration of newcomers and their dependants into employment and the wider social fabric of European societies. Successful integration of immigrants can assist the maintenance of economic growth and reinforce social cohesion.

Growth in employment also entailed the creation of more quality jobs

More than two-thirds of the new jobs created between 1996 and 2001 were high skilled as the knowledge economy became everyday reality. Over 50% of all jobs now require the use of a computer. Indeed, recent Commission work has shown that EU economies with higher shares of jobs of higher quality also perform better in terms of employment and productivity. There are also a considerable number of jobs of lower quality. While for the young and the high skilled such jobs often function as a stepping stone into more stable employment, this is not so for older and unskilled workers. When these groups hold temporary contracts, work involuntarily part-time or in jobs that do not offer training, they remain in cycles of unemployment, inactivity and low skilled employment. Hence effort to promote upward mobility into higher skilled and quality jobs is an important element in promoting higher and more sustainable employment levels.

1.4 Living conditions

Measured by developments in income and consumption, living conditions continue to improve. The average annual increases in income per capita have oscillated around 1.5% during the last decade with the median net annual income in EU-15 at about 11,700 PPS[6] in 1998. Obviously this median covers considerable disparities among Member States and considerable inequalities within the Member States. The northern half of the Union reported higher income levels, and tended to have smaller income inequalities than the southern Member States. Likewise mean consumption has increased markedly in recent years. In Germany, for example, which is fairly typical among Member States in this respect, it grew by about 2.6% per year at the household level.

Living conditions are reflected in citizens' perceptions of their quality of life.

In 2002 Europeans were very or quite happy with their lives in general (78% against 77% two years earlier) and of these some 20% (against 17% in 2000) were very satis-

6 Measured in Purchasing Power Standards to correct for purchasing power disparities between the countries considered.

fied. The most satisfied people live in Sweden (95%) and Denmark (94%) whereas the level of satisfaction is least pronounced in Portugal (50%) and Greece (49%). As in previous years men appear to be happier with their lives than women, and young people more satisfied than the elderly. Of the variations in perceived quality of life across the EU-15, a large amount can be explained by differences in perceived health status.

People with a higher education and those with higher income score higher in terms of perceived health and life quality, reflecting inequalities due to socio-economic status. Additionally, perceived health is generally lower amongst the elderly.

Most respondents to the Eurobarometer 2002 give a higher priority to public spending on health care than other areas such as education or social assistance and consider that the quality of the health care system is one of the three most important issues facing society today.

1.5 Trends in income distribution

Income is one of the main factors in determining the standard of living. The distribution of income is also important in relation to relative poverty and risks of social exclusion. The Welfare State plays an important role in the redistribution of primary income, thereby reducing inequality and poverty. A recent report[7] reveals that large changes in income inequality occurred within many countries between 1980 and 1997 - in most cases income inequality increased. During the economic growth in the second half of the 1990s it is remarkable that inequality on average tended to decrease.

Obviously this may reflect that recent economic growth to a large extent has been employment driven. Employed people are the least likely - and unemployed the most likely (five times more likely) - to be living at risk of poverty[8]. In 1998 retired and self-employed people were twice as likely to be living at risk of poverty than the employed, children three times more likely and the other groups of economically inactive people four times as likely.

Risks of poverty and social exclusion persist...

Despite the important redistributive effects of social protection, combating poverty and promoting social inclusion remain among the key challenges facing the Union. Recent findings from the 2001 Eurobarometer survey reveal that a high proportion of people still consider themselves poor, in the sense that their net income is lower than the amount they judge absolutely necessary. This subjective poverty measure varies widely across Member States - between 9% in Denmark and 66% in Portugal. The survey also shows that, at the individual level, the duration of poverty tends to be longer in southern countries (fourteen or fifteen years) compared to northern countries (two to three years). The Eurobarometer furthermore documents that poverty is closely related to social isolation and that it is strongly affected by poor quality of employment, in particular poor task quality, job precariousness and insufficient training.

Social inclusion is closely linked with employment and/or income. It is noteworthy that in the knowledge society new technologies represent both an opportunity for and a threat to the inclusion of disadvantaged people. Work done by ESDIS (High Level Group on the Economic and Social Dimension of Information Society) has highlighted this and it has been given political prominence with Council Resolutions on e-Inclusion in October 2001 and e-Accessibility for people with disabilities in 2002.

...and differ markedly across the Union...

Poverty rates of households differ considerably between Member States (based on 60% of national median equivalised income as the poverty threshold). In 1998 the difference between the Member States with the highest and the lowest poverty rate amounted to 14 percentage points. Between 1995 and 1998, six out of twelve Member States that have data for both years lowered their poverty rates. Nevertheless, the overall EU-15 poverty rate in 1998 was the same as in 1995.

In general, the southern Member States have the lowest mean equivalised net income in PPS but also the highest level of income inequality according to the 1998 wave of the European Community Household Panel (ECHP). The Scandinavian Member States show the lowest inequality while the highest mean equivalised net income is found in Luxembourg, Belgium and the Netherlands.

...but in EU-15 they would be much higher without the redistributive impact of social benefits.

The redistributive effect[9] of social protection benefits substantially exceeds the redistributive effect of taxes. Social benefits reduce income inequality, measured by the Gini-coefficient[10], by about 30% to 40%. The regressivity of the benefits is relatively large in Germany, the Netherlands, Belgium and the United Kingdom: households with low incomes in these countries receive a relatively higher proportion of social benefits than in Finland, Denmark and Sweden. However, in the case of Germany

7 See "Income on the Move", report on income distribution, poverty and redistribution, Social and Cultural Planning Office of the Netherlands, funded by the European Commission, DG Employment and Social Affairs (E1 Study Series 2002), http://www.europa.eu.int/comm/employment_social/news/2002/dec/income_on_move_en.html

8 With risk of poverty defined as having less than 60 percent of the median equivalised income.

9 The results are taken from "Income on the Move" and refer mainly to the 1997 wave of ECHP.

10 The Gini-coefficient is an index comparing the actual income distribution all across the entire income range with a kind of theoretically ideal distribution where everybody has the same income (gini = 0 percent). A 100 percent gini would mean that only one person has all income.

and the United Kingdom the inequality reduction between the distributions of market and gross income is rather moderate. This is because the share of social security in national income in these countries is relatively low.

Benefits exist in many categories and differ in the number of recipients and in the mean amounts. The poverty reduction of all benefits together, measured simply by comparing 'before' and 'after benefit' income, is 25 percentage points[11]. The main part of poverty reduction is claimed by old age and survivors' benefits (15 points). Unemployment, family related and sickness / invalidity benefits each resulting in equal effects of about three points reduction of poverty.

1.6 Trends in the acceding States

Although most of the acceding States have made gains in closing the income gap in relation to the European Union Member States during the second half of the 1990s, differences are still considerable. In 2000, in eight acceding States the GDP per capita was below half of the EU average, measured in purchasing power standards.

Moreover, the income distribution in the acceding States has tended to become more unequal. This is particularly true for the eight central and eastern European acceding States[12]. Over the last decade Eastern Europe has experienced significant increases in both poverty and inequality. Lately the situation has stabilised. Inequality and poverty are no longer increasing, but the social consequences of the rapid growth in inequality in the early transition period need further attention.

Awareness of these problems has been growing...

Poverty is on the policy agenda in all acceding States, but the wider concept of social exclusion alluding to multi-deprivation less so. Social exclusion has, however, risen in policy prominence in recent years, often as a reflection of EU policy making. The major factors leading to social exclusion are unemployment and family breakdown, and the limited ability of social protection and employment to ensure adequate income and resources in many of the acceding States. In addition inadequate coverage and performance of social assistance schemes often make it very difficult to tackle problems of social exclusion.

...as have the possibilities for drawing support from EU collaboration have grown substantially.

The importance of addressing these problems was recently underlined by the adoption of revised appropriate EU objectives for the fight against poverty and social exclusion by the Council in December 2002. The revisions reinforce the objectives first adopted at the Nice European Council in 2000 and also gave increased emphasis to the gender dimension, the difficulties facing immigrants and the importance of reducing the number of people at risk of poverty and social exclusion. These objectives will underpin the preparation of a second generation of two-year National Action Plans against poverty and social exclusion, which should be drawn up by all Member States by July 2003. The intention is to build on and consolidate the progress made by the Open Method of Co-ordination on poverty and social exclusion which was launched by the Lisbon European Council in 2000.

Enlargement from EU-15 to EU-25 is now on the immediate horizon. With it we can expect to see significant changes in the overall social situation of the Union. Policy challenges in combating social exclusion, poverty and different forms of inequality, including inequalities in health status are set to increase. Regional inequalities and problems with social cohesion will be more important. Thus, as disparities between Member States will increase considerably there will be a great need for instruments of collaboration to bridge such differences in a constructive way.

11 This figure is illustrative of the magnitude, yet since there are other variables which influence the two situations, one cannot attribute the difference between the two Gini coefficient solely to the effect of social benefits.

12 European Commission, "Making a success of enlargement", Strategy Paper and Report of the European Commission on the progress towards accession by each of the acceding States, p. 13.

2 Health and health care in the European Union

2.1 The Health of Europeans and the Current European Agenda

Health is the special theme of this year's report. Health and the quality of health care are very high priority concerns for Europeans (Eurobarometer 2002). This report portrays the health status of Europeans and identifies the main determinants of their health.

While the health sector is key in the treatment of poor health, and also plays a role in the maintenance of good health, the overall health status of citizens is significantly shaped by socio-economic, lifestyle and environmental conditions. The organisation of health and long term care varies greatly across the Union. Amid these differences there are also substantial similarities and - as the report demonstrates - Member States are faced with largely the same current and future challenges in health policy. Among these, two stand out as particularly pertinent. On one hand there is a continuous need to optimise the cost-effectiveness of health care systems in the face of strong drivers of structural change such as ageing and new health technologies. On the other there is great scope for developing better synergies between health policies and other policies that influence the environmental and socio-economic determinants of health.

Health is wealth

The health status of citizens is an important factor in the productive capacity of society and health improvements can improve the potential for growth.[13] This is because better health holds the potential for higher productivity, longer working lives and lower cost (less absence due to illness, less need for treatment, less disability, etc.)[14].

Health care is part of the social protection systems in Member States. As such it is a topic in the new collaboration[15] on the modernisation and improvement of social protection, which form part of the wider Lisbon strategy. Accessibility, quality and sustainability have been pinpointed as the common goals that Member States are striving for in their health care policies. The income maintenance effect of social protection systems clearly also help sustain the health status of citizens. Pension systems, for example, contribute greatly to the maintenance of the health of older citizens by facilitating a sufficiently sound standard of living after retirement.

Obviously, the effect of investments in health depends not just on how much is spent, but on where, when and how resources are committed. The return on investments in better health can – inter alia – be particularly large if efforts are directed at social groups or regions where the average health status is poor or particularly threatened. Inequality in health status is linked to wider inequalities in society. Poor and excluded people are particularly affected by poor health. Member State policies aimed at combating poverty, reducing inequalities and promoting social inclusion and the new European collaboration on these issues impact positively on the health status of poor people and improve the level of social cohesion in society.

In these ways health and health care are located at the intersection between the European Employment Strategy and the Union's efforts to modernise and improve social protection.

Conditions for acquiring good health status and for receiving appropriate and effective treatment for illnesses have improved substantially in the European Union over recent decades. This is due to public and private efforts through direct investments in better health care. However, while health care systems play a crucial role in the combat and prevention of ill health, other policies, which affect the environmental and socio-economic determinants of good health, like employment and working conditions, also impact significantly on the present and future health status of citizens.

13 An assessment of this relation pertaining to the world is given in Report of the Commission on macroeconomics and health - chaired by Jeffrey D. Sachs (2001): Macroeconomics and health: investing in health for economic development. WHO, Geneva.

14 An American review of the scientific literature of the last decade leads to the conclusion that in the US workers with good health earn 15% to 30% more than workers in poor health: Jack Hadley (2002): Sicker and Poorer: the consequences of being uninsured. A review of the research on the relationship between health insurance, health, work, income and education. The Kaiser Commission on Medicaid and the Uninsured.

15 Proposal by the Commission for a Joint Commission-Council report on adequate and sustainable pensions, COM(2002) 737 final. Also, proposal for a joint Commission-Council report on health care and care for the elderly: Supporting national strategies for ensuring a high level of social protection, COM(2002) 774 final.

The European policy agenda on Health

Policy developments during the previous decade brought health issues to the fore of the European agenda.

In the Maastricht Treaty (1993) public health was given a legal base for the first time (Art. 129), encouraging co-operation among Member States, prevention of diseases and incentive measures. No harmonisation of laws and regulations was included. Responding to these new obligations the Commission presented its "Communication on the Framework for Action in the Field of Public Health[16]" based upon the establishment of eight Public Health Programmes. The EU-level added value through support for efforts pursued in Member States and dissemination of "best practice information", with a view to continuously underpin health protection provisions across the Community.

At the end of the 1990s the general framework of health policy changed. The Treaty of Amsterdam expanded the powers of the Community in the public health field. Article 129 was revised through the addition of several new provisions and renamed as Article 152. According to Article 152 actions in the public health area should: contribute towards ensuring the attainment of a high level of health protection; improve health; prevent human illness and disease; prevent sources of danger to health and ensure that all EC policies protect health.

In this overall context, in May 2000 the Commission proposed a new health strategy[17], which promotes an integrated approach to health related-work at Community level. A key element of this was a proposal for a new programme of Community Action in the field of public health[18]. The programme will be focused on three main strands of action:

- Improving health information and knowledge for the development of public health.
- Strengthening the capability for co-ordinated, rapid response to major health threats.
- Targeting actions to promote health and prevent disease.

In addition, the Commission has created an EU Health Forum that brings together relevant European organisations. Furthermore, the sixth Framework Programme for Research provides for policy-orientated research which is relevant to the area of social policy, relating in particular to the implementation of the European Social Agenda[19].

The responsibility for health care provision and funding lies with Member States. However, this responsibility does not prevent basic freedoms - such as freedom of provision of services, circulation of medical products, or of movement of workers - or other Community policies, from applying to this area.

Moreover, health is a crosscutting issue in the European Social Agenda and an important item in the EU strategy for sustainable development, both of which constitute important elements in the Lisbon strategy. In addition health care has become an issue in cross border mobility and in the effort for improving public finances.

The quality and sustainability of health care has been acknowledged as one of the key issues for closer co-operation among the Member States. At the Gothenburg European Council (June 2001) the Social Protection Committee and the Economic Policy Committee was asked to consider the challenges of an ageing society and to prepare an initial report for the Spring 2002[20] European Council on orientations in the field of health care and care for the elderly. The report concluded that the underlying demographic, technological and financial factors present health care and long-term care systems in the European Union with challenges that focus upon: access for all regardless of income or wealth; a high level of quality of care; and financial sustainability of care systems.

These three broad goals were endorsed by the Council in an initial orientation report on health care and care for the elderly to the Barcelona European Council which also stressed that all health systems in the EU are based on the principles of solidarity, equity and universality. The Barcelona European Council asked the Commission and the Council to examine more thoroughly the questions of access, quality and financial sustainability. Based upon a questionnaire submitted to the Member States the Commission proposed a joint report on national strategies to ensure a high level of social protection.[21] Since health care accounts for a large proportion of public spending, the financial sustainability of care systems and their reforms in this regard are important.

Health and Safety at work is one of the most important dimensions in European social policy. Health at work is not only the absence of accidents or occupational illnesses, but involves physical, moral and social wellbeing, which are important for the quality of work and for the productivity of the workforce. A new Community strategy on health and safety at work for the period 2002-2006 has been developed, taking into account changes in society and the world of work[22]. The strategy adopts a global approach to wellbeing at work, based on preventative measures and building partnerships between all players in the areas of employment, health and safety.

16 November 1993.
17 COM (2000) 285 final of 16.5.2000
18 OJ L 271/1 of 9.10.2002, Decision 1786/EC.
19 See the specific programme for research, technological development and demonstration: Integrating and Strengthening the European Research Area (2002-2006).
20 Based upon COM(2001) 723 final: The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability.
21 COM(2002) 774 final.
22 COM(2002) 118 final: Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006.

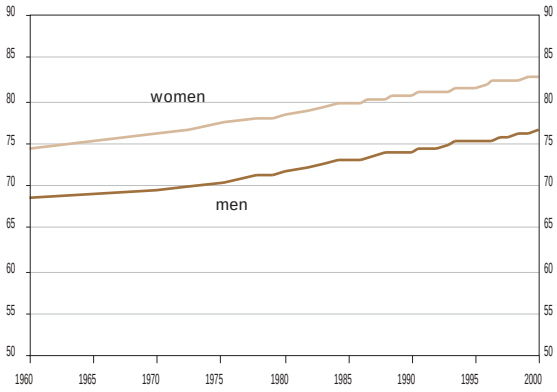
2.2 Population and health

The health status of citizens has improved in all EU Member States over the last decades...

The average health status of EU citizens is improving. In 2000 the average life expectancy at birth for the EU-15 was 78 (75 for men and 81 for women). This is higher than in the USA (74 for men, 80 years for women) but lower than in Japan (78 years for men, 84 for women).

Life expectancy at birth is not only a social indicator. It is also an important economic indicator. Analysis on macroeconomics and health shows that health status explains an important part of the difference in economic growth rates.[23]

Graph 2 Life expectancy, men and women. EU-15, 1960-2000



Source : Eurostat

The figure on life expectancy has increased during the twentieth century: an increase of 25 years was achieved in the first 60 years of the century, while in the last four decades eight more years were gained[24]. Male life expectancy increased from 68 years in 1970 to 75 years in 2000[25]. During the same period female life expectancy increased by 6 years, from 75 years in 1970, to 81 in 2000.

Lower life expectancy for men is caused by male overmortality at all ages, which is a well-known phenomenon in all Member States and also in the majority of other world nations. These inequalities by sex, although conditioned by biological factors, are mainly attributable to social causes and to certain lifestyle patterns. Now that the behaviour of men and women in the EU is becoming more similar, male and female life expectancies are beginning to converge. This has already been observed at EU-15 level (where life expectancy at birth increased 2.5 years for men between 1990 and 2000, compared with 2 years for women) and in all Member States except Greece, Spain, Luxembourg and Portugal.

As a result of increasing life expectancy combined with changes in fertility, the EU population is increasingly older. This demographic ageing means that the number of older people is growing while the share of those in working-age (15 to 64) will decrease. These demographic trends will have economic and social consequences in a number of areas, including health and care systems.

For the provision of health care, one of the most important demographic trend is the increasing size of the very old age group (over 80 years old). It will increase by eight million between 2010 and 2030, an increase of 44%, i.e. a growth even larger than that experienced by the older population in general. Presently the majority of these very old people are in need of assistance and care, which is either provided formally or informally - the latter of these includes care from family members, which is particularly evident in southern Member States. In the future, households will reduce in size and families may be less able to shoulder the increasing care tasks, making the role of both formal and other informal carers of greater importance. The ageing process has a strong gender dimension: the vast majority of these very old people will be women. As the population ages women's health problems will weigh substantially heavier in the pattern of illnesses to be treated and tackled.

...leading to new patterns of mortality and morbidity trends.

As people are living longer, mortality and morbidity are shifting towards increasingly older ages. The main causes of death are diseases of the circulatory system (around 40% of all deaths), cancer (a quarter of all deaths), diseases of the respiratory system, digestive diseases and external causes of injury and poisoning, which includes (car) accidents[26]. One out of every five deaths is caused by a preventable disease. However, this general pattern varies by sex and, especially, by age. Mortality during the first year of life has decreased in recent decades in all Member States, where present levels are among the lowest in the world. However, given the persistence of differences in these existing infant mortality levels among social groups or territories, further improvements can still be achieved.

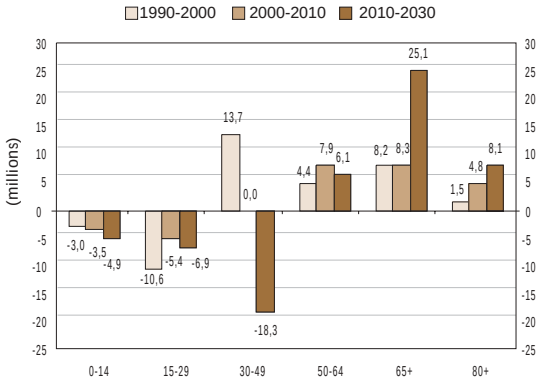
23 Report of the Commission on macroeconomics and health - chaired by Jeffrey D. Sachs (2001): Macroeconomics and health: investing in health for economic development. WHO, Geneva (p 24) : " In particular, each 10 percent improvement in life expectancy at birth is associated with a rise in economic growth of at least 0.3 to 0.4 percentage points per year, holding other growth factors constant".

24 The nature of the indicator partly explains this slow-down. For a given year, life expectancy is the average age that a new-born baby may expect to live to if the mortality rates of this given year were maintained. As the total number of years of life lost by a person who dies in the first year of life is much higher than the years lost by a person who dies, for instance, at 65 years old, life expectancy is more sensitive to the reduction of infant mortality than to increasing longevity at older ages.

25 However, the increase in life expectancy stopped during the second half of the 1980s and early 90s for men in some southern Member States as a consequence of the increase of mortality caused by AIDS and traffic accidents, which affect young men in particular.

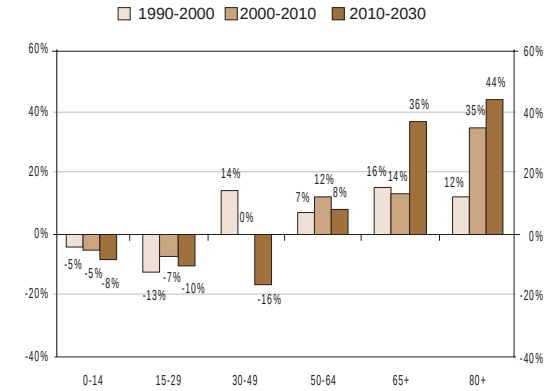
26 Source: Eurostat. Also see the DG Health and Consumer Protection report "The health status of the European Population" EC 2001.

Graph 3 Population change (in millions) by age group. EU-15



Note: B:1995, DK: 1996, EL: 1997, E, F, IRL, I, S,UK, EU: 1998
Source: Eurostat

Graph 4 Population change (in %) by age group. EU-15



Source: Eurostat

However, as infant mortality is currently very low, further increases in life expectancy are now dependent on reducing morbidity and mortality at older ages.

The major causes of morbidity are neuro-degenerative diseases (such as Alzheimer's and dementia), injuries, cardiovascular diseases, musculoskeletal diseases and cancer[27]. As most of these diseases are positively age-related, population ageing will impact on the morbidity pattern and needs for health care. Mental health problems are also increasingly significant. In the EU, about a quarter of new disability benefits are attributed to mental ill-health.

The health situation is also changing in the acceding States and candidate countries

Health status is also improving in the acceding States, but, in most cases, they are generally lower than those in the existing EU Member States. There are large differences among the acceding States and candidate countries, with Malta and Cyprus in the best position (comparable to, or even better than some existing Member States), followed by Slovenia, whereas the Baltic States, Romania, Bulgaria and Turkey have a poorer health situation. This is reflected in higher infant mortality rates and lower life expectancy, as well as higher incidence of non-infectious diseases (especially heart disease, diseases of the circulatory system and cancer), infectious diseases (including in some countries sexually transmitted diseases and tuberculosis) and violent deaths.

Future disability trends will relate more to old-age risks.

It is a feature of human life that the number of functional disabilities of all kinds tends to increase with age. Sickness, risky life styles, accidents and socio-economic factors all combine to create a 'disabling' process, which accumulates over time. It is not surprising, therefore, that young people make up 5% of the people with disabilities, while people of working age constitute 46% and the remaining 49% of the people declaring disability are over 60 years of age (ECHP Data). With increasing life expectancy, prevalence of visual and hearing impairments also increase, as well as neurological disorders such as Alzheimer's disease and dementia. However, future trends in age-specific risks of becoming hampered will be a key factor in the number of elderly people that will be in need of assistance and care.

2.3 Determinants of population health

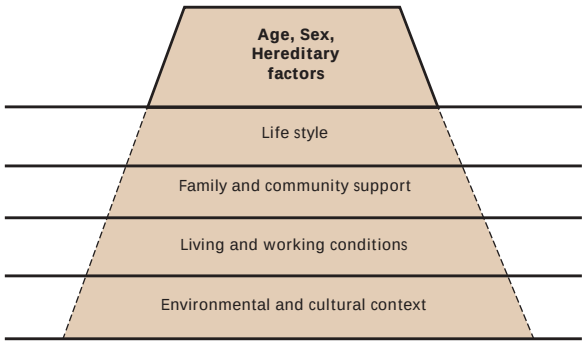
Health developments are to a large extent determined by environmental conditions...

People in Europe are facing health risks from their physical environment, which to a very large extent are due to prevailing patterns of life and inherent use of resources. Human health depends on the availability of quality food, water, air and shelter. It is also affected by noise, traffic congestion and accidents and insufficient sewage systems. Rapid urbanisation has created particular problems in many cities, resulting in air pollution and unacceptable housing conditions. Other health problems relate to water and food contamination, causing communicable diseases. However these adverse effects are being continuously addressed through urban renewal, improved infrastructure, monitoring of pollutants and reinforced food safety measures which have reduced their prevalence.

During the last decade, air pollution in central and eastern European urban areas decreased due to the adoption of several technical measures and of economic sta-

27 Source: Eurostat. Also see the DG Health and Consumer Protection report "The health status of the European Population" EC 2001.

Graph 5 Main determinants of health[28]



gnation. However, housing conditions remain below Western European standards and traffic problems are becoming very important.

...and socio-economic conditions...

Health is clearly related to socio-economic status. This concept is normally defined using a number of inter-related indicators, such as occupational status, gender and levels of education, income and wealth. For the individual the socio-economic status determines the access to social and material resources as well as the exposure to health risks.

At the individual level education appears to enhance social capacities, expand individual opportunities, build self-confidence, increase skills and capabilities and promote a healthier lifestyle, by increasing the awareness of risks. According to the Eurobarometer only 50% of people with less than upper secondary education, against almost 75% of people with tertiary education, perceive their health as "good" or "very good".

Employment and unemployment are both important to health status. High employment rates, or low unemployment, together with high average national wealth, have been shown to reduce mortality rates significantly, within a time lag[29]. Furthermore, many studies at the individual level point to a positive correlation between unemployment and illness or disability, both in physical and mental terms. Unemployed people are far more likely to report bad health and to consult physicians. The mortality risk for people out of employment is higher than that of people in steady employment. There are higher suicide rates among young unemployed people. However, social networks or 'informal jobs' may, to some extent, alleviate the negative impact of job-losses. This 'buffer effect' is stronger in some Member States.

Employment overall has a positive impact on longevity and health, provided that jobs are of high quality. Low quality of work is shown to create specific occupational health problems (accidents, injuries and occupational diseases). The main work-related health problems are musculoskeletal, followed by stress, then pulmonary and cardiovascular disorders. The type of industry and occupation, the type of work contract (temporary) or work time (shift work), age and gender influence the prevalence and incidence of disease. Although women represent 46% of the workforce, the female share in occupational diseases is 18% on average, although this also reflects differences in working hours.

The costs of low quality work are considerable. Costs of preventive or curative health care should be considered in relation to the number of workdays lost due to work related accidents and bad health and the consequent loss of production and income. In total, accidents and work-related health problems resulted in 500 million lost workdays in the EU in 1998/99.

In the acceding States a larger proportion of workers consider their health and safety to be at risk because of work: 40% as compared to 27% in the EU[30]. Work related problems are reported at a higher level in these countries, in particular overall fatigue and musculoskeletal disorders. The health and safety systems in the acceding States will have to adapt to the European legislation. In many of these countries social dialogue is less developed, thus ensuring workers and employers input to improve the system remains a major challenge.

...and the extent and quality of social networks.

Social support is important for health and particularly crucial for good health at both ends of the life cycle. Social networks - consisting of family members, relatives, peers and friends - contribute to protect and enhance the health of individuals. They exert a control on deviant behaviour and on most factors related to lifestyle. They can facilitate access to health and services, provide a large amount of informal care and help attenuate the impact of negative events.

The family remains the bedrock of care and support for both children and adults in all Member States and the role of the family in the provision of care is perceived as important and positive. Currently 6% of Europeans spend a large part of their time providing informal long-term care for older people or working-age adults who are sick or disabled. The future ability of families to provide long-term care will be affected by developments in the activity rates of women and increasing instability of family structures. All Member States see a trend towards a reduction in household size and a

28 Based on the analysis presented in "Policies and strategies to promote social equity in health" Dahlgren and Whitehead. Institute for Future Studies. Stockholm.
29 Prof. H. Brenner: "Unemployment and public health", European Commission, DG Employment and Social Affairs.
30 Survey on working conditions in the candidate countries, 2001 – European Foundation for the Improvement of Living and Working Conditions.

growth in the number of people living alone. Scenarios for EU-15 show that by 2020 46% of people aged 85 and older will be living alone and 80% of these will be women. As a result, an increasing number of elderly people are likely to be in need of formal care provisions even if disability rates at old age continue to drop.

Strategies aimed at promoting healthy behaviour need the strong involvement of a wide range of stakeholders. To increase public awareness and understanding of risks to health, a balance between government, community and individual action is necessary. The potential for community action by non-governmental organisations, local groups and others should be given due attention.

Recent trends in social exclusion pose new challenges for reducing health inequalities

In poor countries there appears to be a clear association between the level of income and mortality. Higher income is often related to better health. This relationship becomes less obvious in more wealthy countries, where mortality patterns appear to be associated to the degree of income inequality. This is primarily because low income and poverty are associated with poor living and working conditions and poor lifestyle. Poor people are much more likely to describe their health as bad or very bad in most Member States and report a higher level of social isolation, less potential support and lower availability of informal care.

Low income and poverty may imply poorer access to preventive (e.g. consultation) and curative (for example medication and hospitalisation) health care of sufficient quality – for example treatment, communication and follow-up. Individuals with higher income are more likely to receive specialist services whereas those with lower income tend to use general practitioner care[31]. Incremental health benefits resulting from reduced income inequality are particularly important when poverty is also present within the society. In policy terms this means that fighting poverty and removing barriers to access to health care systems are major health issues.

New challenges also relate to the health impact of various lifestyles...

Life style has an important impact on health status. A number of serious and growing health problems of epidemic proportions relate to poor life styles in relation to nutrition, exercise and abuse of alcohol, tobacco and illegal drugs, which may be changed through awareness raising public health campaigns and preventive actions. Tobacco use is the leading risk factor, accounting for about 12% of the total disease and injury burden, according to the latest WHO report[32]. Tobacco smoking is associated with a vast array of, sometimes fatal, diseases that may otherwise have been avoided (cardiovascular diseases, cancers and pulmonary diseases). Overall, one third of the EU-15 population declare to smoke regularly. The smoking prevalence among men is higher than for women in the EU-15 (40% for men and 28% for women) and it is on the increase, for young women particularly. Evidence found for Denmark shows that lung cancer, linked with high female tobacco consumption, is one of the causes of relatively low life expectancy of Danish women[33].

Alcohol and blood pressure account for 9-10% of DALYs[34], and cholesterol and body mass for 6-7% of DALYs for both sexes. Inadequate nutrition – i.e. a poor overall dietary pattern – has important consequences in socio-economic terms, contributing to health deficiencies or resulting in economic and social costs. Eurostat data suggests that around 17% of EU adults are overweight and around 6.5% are obese. Being overweight or obese increases the risk of some chronic diseases, such as cardiovascular diseases, certain cancers and diabetes type two. Obesity is on the increase, particularly among children.

...particularly for the young people...

Health improvement for the youth has not followed the same pace as society in general and young people -young men in particular - presently face relatively high death rates that are linked with behaviour and lifestyles. Drug abuse, including alcohol, is frequently behind the excessive number of deaths of young people from external causes: mainly car accidents for young men between 15 and 30, but also other types of violent deaths, such as suicides, the second most common cause of death for young men. Furthermore, use of illegal substances is concentrated amongst young adults, especially men in urban settings: the prevalence rate among young adults is roughly twice that of all adults. In addition, sexual behaviour – for example unintended pregnancies and the risk of infection from sexually transmitted infections – is a significant issue in young people's health.

...and in the acceding States.

Problems with tobacco consumption are significant, with rising numbers of smokers among young people and women. Alcohol consumption is another lifestyle factor that plays a role in many causes of mortality. It is likely that alcohol is a more significant factor in higher rates of sudden cardiac death[35] and cirrhosis in central and eastern European acceding States than in the EU.

31 The issue of access to high quality healthcare also for all vulnerable groups was discussed in the Joint Report on Social Inclusion agreed at Laeken in December 2001.
32 World Health Report – 2002: Reducing risks, promoting healthy life.
33 See the DG Health and Consumer Protection report "The health status of the European Population" EC 2001.
34 The DALY or Disability-Adjusted Life Year is a measure to quantify the burden of disease, which takes into account years of life lost due to premature mortality and years lived with a disability of specified severity and duration. One DALY (lost) is thus one lost year of healthy life.

Generally speaking, mortality rates from injuries, especially road traffic accidents, drowning and fires, and from homicides and suicides, are also higher in these countries, which may in part be attributed to patterns of alcohol consumption.

2.4 Health care systems

Health care systems are important for health outcomes and the economy in all Member States...

Health care systems are important for combating ill health and contribute significantly to health outcome. Moreover, the weight of the health and long-term care sector in the economy and employment is considerable. On average, employment in the health and social services sector of the fifteen Member States is almost 10% of overall employment. The health sector is also a very dynamic and quickly developing sector of the economy with a substantial potential for contributing further to economic growth and employment opportunities. The health and social work sector contributed to 18% of net employment creation in the EU between 1995-2001[36].

...which despite great differences in the organisation of health care face similar challenges.

There is a large diversity among Member States in the way health care systems are organised, regulated, financed, delivered and utilised. Nevertheless, there are many similarities in the problems health care systems have to tackle. Population ageing constitutes one particularly important common challenge. Securing access for all to high quality sustainable health and long term care even at the height of population ageing is generally perceived as the common goal that Member States are striving for in their health care policies.

Member States spend substantial amounts on health care...

In 1999 the share of total health expenditures in GDP varied between 10.3% in Germany and 6.1% in Luxembourg, with a weighted average of 8.4%. Total health care expenditure as a proportion of Gross Domestic Product is presently highest in Germany, followed by France and Belgium. In the USA, total expenditure on health reaches 13% of GDP in 2000, with a public share of 44%[37]. In Canada the figures are more similar to the EU average, with health expenditure 9.1% of GDP, and a public share of 71%.

Health care systems in Europe rely on a mix of funding sources. Most funding in all Member States is public expenditure (on average 75%) raised through taxation and social health insurance contributions. Private expenditure (from out-of-pocket payments and private health insurance) accounts for less than 30% of total health expenditure, except in Greece, Italy and Portugal. The share of out-of-pocket payments within the overall EU health expenditure increased slightly during the 1990s and in 1998 the EU average was 16%. In Italy and Portugal the share of out-of-pocket payments in total health expenditure is higher than 30%. It seems that, contrary to expectations, cost shifting to private sources of funding has not restrained the growth of overall health expenditure.

...and for long term care.

It is difficult to establish both costs and national trends for long-term (or tertiary) care because these services are often divided between different public structures and budgets – normally between the health budget and the budget for social services. The best available estimates of public expenditure on long term care point to an EU weighted average of 1.3% of GDP in 2000 and a span from 0.7% in France, Ireland, Austria up to 3% in Denmark and 2.8% in Sweden[38].

The organisation of long-term care for the elderly shows considerable variations between Member States. Denmark has a high number of beds devoted to long term nursing care whereas the Mediterranean Member States are considerably below the EU average; this is related to the differing role played by family networks providing informal care. The sector is undergoing rapid changes as services are being reorganised or innovated in northern and central Member States and expanded in the south, partly because of the changes in family patterns. Non-profit organisations play an increasing role in the health and social services sectors.

Within health care services the balance between primary, secondary and tertiary[39] care has progressively changed. Secondary (mainly hospital in-patient) care has declined in importance mainly due to progress in therapeutic treatments and improvements in primary care and day care. This raised the need for a greater decentralisation of health care provision and for new co-ordination between the stakeholders at national, regional and local levels. The changing relationships between the state, the market and the non-profit sector in health care, with a growing share for the private sector, raises new challenges in terms of regulating and managing health care provision and achieving equity objectives.

35 Britton, A. & McKee, M. 2000 'The relationship between alcohol and cardiovascular disease in Eastern Europe' Journal of Epidemiological Community Health 2000, 54: 328-332.
36 Employment in Europe, 2002.
37 OECD Health Data - 2002.
38 Budgetary Challenges posed by ageing populations - Economic Policy Committee (2001).
39 Secondary care covers the hospital in-patients services; tertiary care covers long term care.

Most Member States are ensuring universality of access...

Universal or near universal rights to health care are found in every Member State. This has been a major achievement within the EU in recent decades. With the introduction of universal coverage in January 2000, France now joins Denmark, Finland, Greece, Ireland, Italy, Luxembourg, Portugal, Sweden and the UK in providing universal statutory health coverage significantly reducing the risk of social exclusion from health services. In comparison, in the USA it is estimated that 40 million Americans or 14% of the population have no health insurance[40].

However, in spite of the universal or near universal character of statutory health insurance coverage, problems of access associated with various gaps in coverage persist across Member States. These problems arise in two ways: as a consequence of the exclusion of particular treatments from statutory health insurance coverage, or as a consequence of increasing reliance on user charges.

...and developing quality standards.

Most Member States have made progress in establishing quality standards for health care[41]. However, this has proved to be difficult in some areas, for example with outpatients, and in relation to the introduction of outcome related standards. Pressures to improve the quality of care experienced by patients have continued to grow, as have pressures to contain costs. Increasing awareness that spending on inefficient technologies imposes opportunity costs on other patients has contributed to an increase in the demand for evidence on the budgetary impact and cost-effectiveness of interventions as part of health technology assessment. Quality evaluation of health care delivery can be found in one form or another in all EU countries[42].

The acceding States and candidate countries show different patterns.

Most acceding States and applicant countries spend a lower proportion of Gross Domestic Product on health care than the EU average. It ranges from 2.6% in Romania to more than 8% in Malta. There is a relatively high propensity to hospitalise people in the acceding States mainly due to underdeveloped primary care systems[43]. However, in many of these countries there are fewer medical staff per inhabitant and the hospital infrastructure and other health care facilities are relatively poor. In theory, entitlements to healthcare benefits have remained universal with comprehensive coverage in most countries. In practice however, services are rationed and informal payments are not uncommon[44]. There is a certain trend towards the privatisation of health care provision in a number of the acceding States. This is accompanied by more private resources being devoted to health both through out-of-pocket payments and through risk coverage by private health insurance.

2.5 Future challenges to health care systems

Health care systems face new challenges to their financial sustainability, quality and accessibility...

Demand for health and long-term care have grown over recent decades, mainly as a result of the progress in medical technologies and treatments and the growing expectations of our wealthier societies. Policy makers will also have to address the new structural trend of rising expectations from health care consumers. Changes in lifestyles, patterns of work, incomes, educational levels and family structures are altering people's attitudes towards health care. The information society also brings instant access to knowledge about the latest possible treatments to anyone with access to the Internet: health-related websites are among the most visited on the Internet. Changing attitudes include increased awareness of patients' rights and responsibilities, less tolerance of discrimination and a reduced deference towards health care professionals. There is widespread evidence of a desire for greater choice and more individualised services, along with access to a wider range of medical treatments – including those beyond the traditional boundaries of health care systems. As a consequence, it is important to correctly assess and address the underlying health needs of the population, as this can contribute to the elimination of ineffective, or even detrimental, health services from being administered.

...developments in technologies and therapies...

Progress in medical technologies and treatments have contributed to rising costs over past decades. New technologies can also reduce the costs of treating certain diseases, but they may raise expenditure if they treat conditions for which no treatments or only less effective treatments were previously available, or if they are prescribed for conditions for which cheaper treatment alternatives exist. The impact of new technologies on future health care expenditure is difficult to predict, but a more syste-

40 Jack Hadley (2002): Sicker and Poorer: the consequences of being uninsured. A review of the research on the relationship between health insurance, health, work, income and education. The Kaiser Commission on Medicaid and the Uninsured.

41 For a discussion on quality standards please see the European Commission Communication "Health care and care for the elderly: Supporting national strategies for ensuring a high level of social participation" (2003).

42 A detailed discussion on Health Technology Assessment is contained in Section 2.3 of the DG Employment and Social Affairs publication "The social situation in the European Union 2003".

43 See Wallace, C., Haerpfer, C., Mateeva, L. (Institute for Advanced Studies, Vienna) "Health and Health Care Systems in the Applicant Countries", August 2002, p. 8.

44 Social Protection System in the 13 candidate countries – A Report to the European Commission, DG Employment and Social Affairs – november 2002.

matic assessment of medical technologies and treatments would help to ensure that increased expenditure is only a result of genuine progress and that opportunities for savings are not missed. Such assessment – and dissemination and implementation of the results – is crucial for the three goals of access, quality and viability. However, monitoring progress at present is very dependent on the quality of the data related to health. Important weaknesses can still be observed at EU level, both in terms of data availability and standardisation of definitions and data collection methods.

Information and communication technologies (ICT) have been introduced into health systems as with most of the other parts of the economy. They can substantially improve the organisation of health care delivery. Some health care authorities indicate that they are currently spending 20% of their capital equipment budget on ICT. Generalisation of ICT may create new barriers for disadvantaged groups to get access to high quality health care if it requires patients to have certain digital skills.

...population ageing...

As a result of sustained low birth rates and increasing life expectancy, Europe's population is ageing. The first baby-boomer cohorts will be retiring in the next ten to fifteen years, leading initially to increased expenditure on pensions. Ten years later as these cohorts begin to move into the fourth age, their sheer numbers are likely to result in a higher need for health and – in particular – long-term care provisions. However, the need for care will, to a certain extent, depend on the effectiveness of previous and future health promotion strategies.

The impact of demographic ageing on future health costs is difficult to predict[45]. It relates to both the demand for, and supply of, health care and it is clearly linked to living conditions, lifestyles, family support and the socio-economic situation. For health care, the most important demographic trend is the growing number of very old people (over 80 years old), in a context where households are reducing in size and families may be less able or willing to respond to care needs. On the one hand health care systems will have to adjust to the changes in the pattern of illness and care needs, with geriatric medicine and care for chronicle diseases being expanded and upgraded in importance. On the other hand formal health care systems will have to prepare for a situation where they may have to handle a substantially larger share of care needs as in many Member States the role of families in care provision shrinks. Moreover, while the share of the very old in need of long term care may fall as a consequence of better health and less disability the absolute number is still likely to increase.

...and the ageing of medical personnel.

The problems with recruitment and retention of medical personnel, which are already being felt in some Member States, are likely to be accentuated by the overall trend towards an ageing and shrinking workforce in this sector, resulting in the competition for manpower becoming tougher. Both trends could increase costs. Thus, the health sector will have to adjust to the impact of ageing on its personnel as well as on its clientele. This is particularly true for nurses: In seven Member States 40% of nurses are already more than 45 years of age and in another five Member States almost one in two nurses have reached this age. Two other factors contribute markedly to the shortages of nurses: 'Stop-go' trends in recruiting policies and most importantly: demanding working conditions in combination with moderate pay leading to a high staff turnover. The recruitment of immigrants to fill shortages in this sector is likely to grow in importance.

Enlargement may raise new challenges in relation to personnel. When the freedom of movement applies fully to the acceding States it may impose further challenges to the provision of treatment and services in these countries. This may be from people seeking medical treatment in other Member States and also from medical staff being attracted by higher wages in the current EU countries.

In response the health care sector will need to undergo a process of perpetual transformation and develop better synergies with other policy areas.

The combined effect of technological progress, rising incomes and expectations and population ageing will create a structural trend towards rising health expenditure. Hence, a key challenge in future health policy will be to make health services so effective and cost-efficient that wide access to high quality health and long term care becomes fully sustainable, even when faced with these trends. This calls for determined efforts towards better governance and impact assessment in relation to health interventions, treatments and technologies.

Ageing will lead to greater pressures on health care services and long term care provision. Adapting to sudden changes in the pattern of pathologies and while meeting manpower needs and ensuring sustainability, quality and accessibility in the long term present policy makers and administrators with a complex mix of challenges.

As previously discussed, strong links between socio-economic factors (namely education level, family patterns, gender inequalities, income and employment)

45 Projections based on the Eurostat baseline demographic scenario suggest that, on average within the EU, the volume of total health expenses could increase ceteris paribus by almost 0.6% per year in real terms as a result of the changes in population age structure over the next quarter of century. Moreover the Economic Policy Committee has estimated that the ageing induced growth in public expenditure on health and long-term care from 2000-2050 could amount to 2-3 percentage points of GDP. However these projections should be treated with caution since they refer to very long periods and rely on several assumptions about future economic and behavioural trends.

and health are found in all Member-States and inequalities in health status are still substantial. While not wholly unrelated to the character of health care systems these inequalities are primarily linked to the wider societal inequalities reflected in the socio-economic determinants of health. On that basis it could be argued that policies, which promote employment, improve the quality of jobs or lower inequalities, could lead to significant improvements in the health situation of the population. Indeed, one of the findings of this report is that, in addition to health policy, social and employment policies in combination with economic policies can make significant contributions to the creation and maintenance of good health. Hence, another major challenge will be to better exploit the synergies between health policies and those policies affecting the socio-economic and environmental determinants of health in order to ensure good healthy living conditions for all Europeans throughout all the stages of their lifecycle[46].

46 The Commission Communication on Impact Assessment (COM(2002) 276 final) is relevant to this discussion.

3 The resilience of the European Social Model

In 1993 when the European Council in Copenhagen asked why the Union's growth potential, competitiveness and employment was lagging behind other major economic areas several voices suggested that the poorer performance resulted from fundamental weaknesses in the existing European model of society. Others contended that the basic tenets of the European model of society would be fully compatible with efforts to substantially improve the Union's overall performance. A decade later, indicators collected for the Report on "The Social Situation in the European Union" seem to validate that the Union and its Member States decided to continue an approach aimed at preserving solidarity and social cohesion[47].

Indicators for employment, education, health and general well-being found across this report generally confirm that substantial progress has been achieved and that Europe is as capable of delivering good living conditions for the wide majority of its citizens as other major economies.

Over the last decade employment promotion and modernisation of social protection have increasingly become key priorities at the heart of the overall strategy of the Union. Employment and social policies have undergone rapid development in Member States and a process of catching up and convergence has taken place. As a result we have witnessed not the withering away of European approaches built on a combination of market dynamics and public efforts, but a strengthening and further development of the European Social Model.

It is now generally recognised that quality social policies geared to support employment can enhance economic performance. The health sector is a good example of this synergy between the social and the economic dimension. On the one hand the sector contributes to the quality of life and better health translates into better economic performance (higher productivity, less absence, lower need for health care etc.). On the other its development is a driver for employment growth. More than 2 million jobs or 18% of the total job-creation between 1995-2001 happened in the health and social work sector, which now accounts for almost 10% of total employment.

As highlighted in this year's synthesis report[48] those Member States that perform best on all crucial indicators are those where the principles of active welfare states are applied with the greatest consistence and commitment. The performance of these Member States demonstrate that there is a potential for further progress which needs to be better tapped in coming years. The European Employment Strategy and the new processes on modernisation of social protection and promotion of social inclusion are organised to enable all Member States to draw on the common fund of knowledge about how Europe can move further towards economic and social sustainability.

Of course considerable problems persist and the challenges for the Union are likely to be even greater in the coming decade than they were in the previous one. For example, there are still concerns about the trends regarding the young generation as underlined in several parts of the Social Situation Report: persistent unemployment, specific mortality and work related accident rates and lack of professional education. The persistence of poverty-traps is another matter for concern. However the way forward, as shown by the best performing Member States, still lies in the improvement and modernisation of the functioning of the European Social Model.

47 Growth, competitiveness, employment, - The challenges and ways forward into the 21st Century; Commission, 1993.
48 "Choosing to grow: Knowledge, innovation and jobs in a cohesive society" Report to the Spring European Council, 21 March 2003 on the Lisbon strategy of economic, social and environmental renewal, COM(2003) 5 final.

Annexes

Ageing of the population

In 2001, there were 62 million elderly people aged 65 and over in the EU compared with only 34 million in 1960. Today, elderly people represent 16% of the total population or 24% of what is considered to be the working age population (15-64 year olds). By 2010, the latter ratio is expected to rise to 27%. Over the next fifteen years, the number of 'very old' people aged 80 and over will rise by almost 50%.

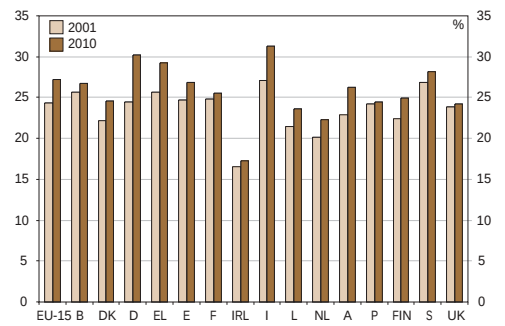
Key indicator

Old age dependency ratio (Population aged 65 and over as a percentage of the working age population (15-64) on 1st January)

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1990	21.6	22.1	23.2	21.6	20.4	20.2	21.1	18.6	21.5	19.3	18.6	22.1	20.0	19.8	27.7	24.0
1995	23.0	23.8	22.7	22.5	22.8	22.3	23.0	17.8	24.1	20.6	19.3	22.4	21.6	21.1	27.4	24.3
2000	24.3	25.5	22.2	23.9	25.6	24.6	24.6	16.8	26.6	21.4	20.0	22.9	23.8	22.2	26.9	23.9
2001	:	25.7	22.2	24.5	:	24.7	24.8	16.6	27.1	21.5	20.1	22.9	24.2	22.4	26.8	:
2010	27.3	26.7	24.6	30.3	29.2	26.8	25.5	17.3	31.3	23.6	22.3	26.3	24.5	24.9	28.1	24.2

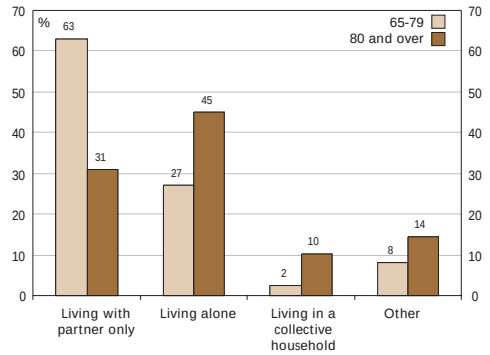
Source: Eurostat - Demographic Statistics.

Graph 6 Old age dependency ratio 2001 and 2010



Source:Eurostat - Demographic Statistics. EU-15, EL and UK 2000 data.

Graph 7 Elderly population by household situation and age, EU-15, 2010



Source: Eurostat - 1995-based (baseline) household projections

Migration and asylum

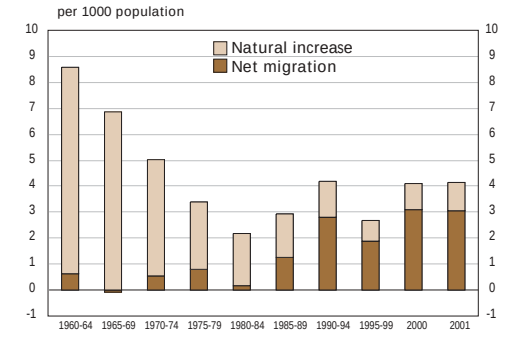
Since 1989, net migration has been the main component of annual population change in the Union. In 2001, the annual net migration rate was 3.1 per 1 000 population, representing around 74% of total population growth. In 2000, around 5% of the EU population were non-nationals (3.4% were non-EU nationals and 1.5% EU nationals), and there were just over 363,000 asylum applications in the fifteen Member States.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Net migration rate (per 1 000 population)																
2001	3.1	3.2	2.3	3.2	3.3	5.8	1.0	7.8	2.9	7.5	3.1	2.2	6.3	1.2	3.2	2.6
2000	3.1	1.3	1.9	2.0	1.2	8.8	0.8	7.0	3.1	8.3	3.6	2.1	4.9	0.5	2.7	3.3
Average annual net migration rate																
1995-99	1.9	1.1	3.0	2.5	1.9	1.1	0.7	4.3	2.1	10.0	2.0	1.0	1.1	0.8	1.1	2.0
1990-94	2.8	1.9	2.0	7.0	5.7	0.4	1.3	-0.4	1.9	10.5	2.7	7.5	-1.3	1.8	3.7	1.3

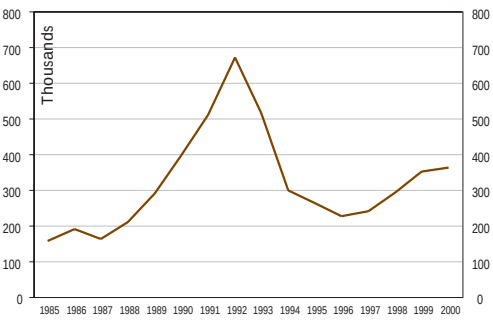
Source: Eurostat - Demographic Statistics

Graph 8 Average annual rate of population change by component, EU-15, 1960-2001



Source: Eurostat - Demographic Statistics

Graph 9 Asylum applications, EU-15, 1985-2000



Source: Eurostat - Migration Statistics

Education and its outcomes

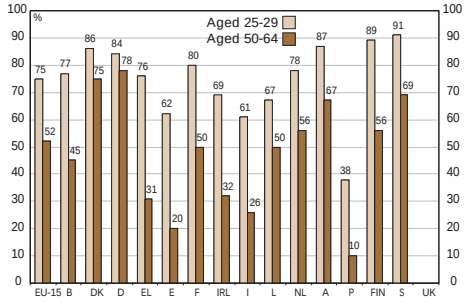
Attainment levels of the population have improved significantly over the last thirty years, particularly among women. Today 75% of young people aged 25-29 in the Union have a upper secondary qualification. At the same time, however, 19% of people aged 18-24 leave the education system with only lower secondary education at best.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Early school-leavers not in further education or training (Share of the population aged 18-24 with less than upper secondary education (ISCED 0-2) and not in education or training)																
2001	19	14	17	13	17	29	14	19	26	18	15	10	45	10	11	:
Population aged 18-24 by activity status (%), 2001																
In education and employment	16	6	37	27	2	7	9	11	3	8	44	15	7	28	19	30
In education and not in employment	36	49	25	29	45	45	47	32	45	49	18	30	36	30	31	19
Not in education and in employment	34	33	32	33	32	36	31	42	31	36	33	46	48	31	40	38
Not in education and not in employment	14	12	6	11	21	13	13	14	22	7	5	8	10	12	9	13

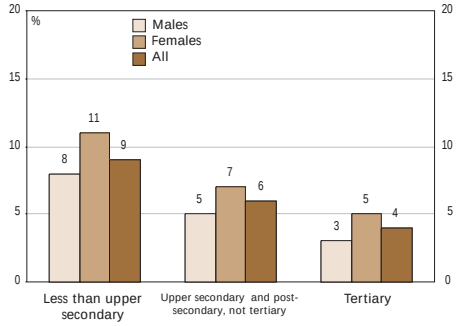
Notes: IRL 1997 data. UK - Data not shown for early school leavers. A definition of 'upper secondary attainment' has still to be agreed.
Source: Eurostat - European Union Labour Force Survey

Graph 10 Percentage of population that has completed at least upper secondary education, by age-group, 2001



Source: Eurostat - European Union Labour Force Survey.
IRL: 1997 data. UK - Data not shown. A definition of upper secondary attainment has still to be agreed.

Graph 11 Unemployment rates of the population aged 25-64 by sex and level of education, EU-15, 2001



Source: Eurostat - European Union Labour Force Survey
Note: UK - GCSE 'O' levels are included under upper secondary (ISCED 3).

Lifelong learning

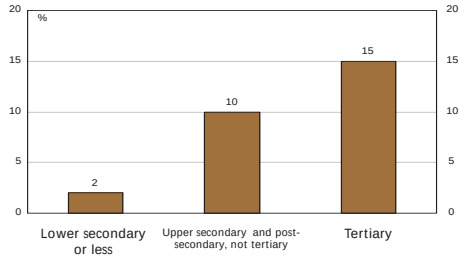
EU-wide, 8% of the population aged 25-64 participated in education/training (in the last four weeks) in 2001. Such training activities seem to be more prevalent in the Nordic countries, the Netherlands and the United Kingdom. Older people are less likely to receive training than younger people. Higher qualified people are more likely than the low-qualified to participate in such training.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Lifelong learning (Percentage of population aged 25-64, participating in education and training in the 4 weeks prior to the survey), **2001**																
Total, 25-64	8	7	18	5	1	5	3	5	5	5	16	8	3	19	17	22
25-34	14	12	27	13	4	11	6	9	12	9	25	14	8	28	25	26
35-44	8	8	19	5	1	3	2	5	3	6	18	8	2	21	18	24
45-54	6	5	14	3	0	2	1	3	2	3	13	7	1	18	15	20
55-64	3	2	8	1	0	1	0	1	1	1	7	2	0	8	10	13

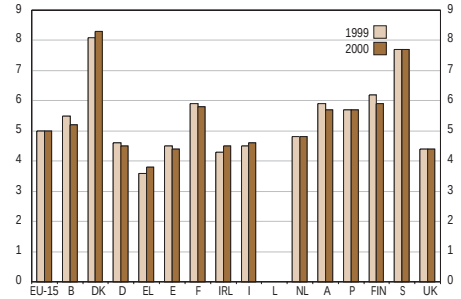
Notes: F - training must occur at the time of the interview for it to be counted. IRL: 1997 Data.
Source: Eurostat - European Union Labour Force Survey

Graph 12 Lifelong learning (Percentage of population aged 25-64, participating in education and training in the 4 weeks prior to the survey) **by level of education, EU-15, 2001**



Notes: F - training must occur at the time of the interview for it to be counted
IRL 1997 data. UK - GCSE 'O' levels are included under upper secondary (ISCED 3).
Source: Eurostat - European Union Labour Force Survey

Graph 13 Spending on human resources (Total public expenditure on education as a percentage of GDP)**, 1999 and 2000**



Source: Eurostat - Education Statistics

Employment

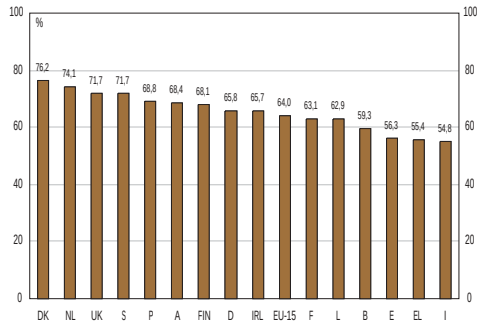
In 2001, an estimated 168 million people were in employment in the Union, a rise of more than 12 million since 1996. This represents annual employment volume growth of around 1.5% per annum. In 2001, employment increased by 1.2%. The employment rate for the population aged 15-64 stood at 64% in 2001.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Employment rate, 15-64 years																
2001	64.0	59.3	76.2	65.8	55.4	56.3	63.1	65.7	54.8	62.9	74.1	68.4	68.8	68.1	71.7	71.7
2000	63.2	60.5	76.3	65.4	55.7	54.8	62.0	65.2	53.7	62.7	72.9	68.4	68.3	67.3	70.8	71.5
Trend in employment																
Total employment 2001 (millions)	167.9	4.0	2.8	38.8	3.9	16.0	24.8	1.7	23.5	0.3	8.3	4.0	5.0	2.3	4.3	28.2
Total employment 2000 (millions)	165.8	3.9	2.8	38.7	3.9	15.6	24.3	1.7	23.1	0.3	8.1	4.0	4.9	2.3	4.2	27.9
Total employment 1996 (millions)	156.1	3.7	2.6	37.3	3.8	13.7	22.8	1.3	22.1	0.2	7.3	3.9	4.5	2.1	4.1	26.5
2001/1996 (% aver. annual empl. growth)	1.5	1.2	1.1	0.8	0.7	3.1	1.7	5.5	1.2	2.1	2.6	0.6	1.9	2.2	1.2	1.2
2001/2000 (% annual empl. growth)	1.2	1.2	0.2	0.2	0.2	2.5	2.0	2.9	1.6	2.2	2.1	0.2	1.6	1.2	1.9	0.9

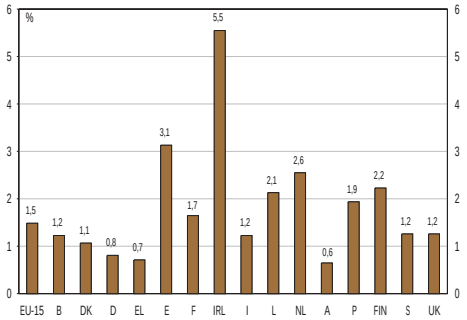
Source: Eurostat - Quarterly Labour Force Data (QLFD).

Graph 14 Employment rates (15-64 years), 2001



Source: Eurostat - Quarterly Labour Force Data (QLFD).

Graph 15 Average annual employment growth, 1996-2001



Source: Eurostat - National Accounts (ESA 95)

Employment of older workers

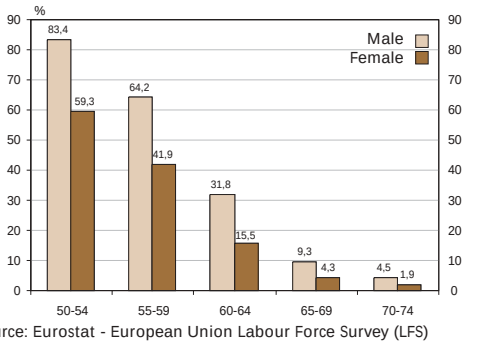
Although in the past four years, the EU employment rate of 55-64 year-old men rose by 1.5 percentage points to stand at 48.7% in 2001, it is still below the 1991 rate (51.2%). In contrast, the comparable female rate increased steadily to reach 29% in 2001. Overall, 38.6% of the population aged 55-64 were in employment in 2001. In 2001, men exit the labour force on average at the age of 60.5 while women did so about 1.5 year earlier. The overall exit age was 60 years.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Employment rate of older workers (employed person aged 55-64 as a share of the total population of the same age group), **2001**																
Total	38.6	26.5	58.0	37.7	38.0	38.9	31.0	46.8	28.0	24.4	39.6	28.6	50.3	45.7	66.5	52.3
Men	48.7	36.5	65.5	46.1	55.0	57.4	35.4	64.7	40.4	34.8	51.1	40.0	61.6	46.7	69.1	61.7
Women	28.9	16.9	49.8	29.5	22.5	21.8	26.7	28.8	16.2	14.0	28.0	17.9	40.6	44.8	63.8	43.1
Effective average exit age (average exit age, weighted by the probability of withdrawal from the labour market), **2001**																
Total	59.9	57.0	61.9	60.7	59.6	60.6	58.1	63.1	59.4	56.8	60.9	59.6	62.0	61.6	62.0	62.1
Men	60.5	57.8	62.2	60.9	61.2	60.7	58.2	63.2	59.6	57.5	61.1	60.0	62.0	61.6	62.1	63.1
Women	59.1	55.9	61.1	60.4	57.7	60.2	58.0	62.2	59.2	55.3	60.3	58.6	61.5	61.4	61.9	61.0
Persons in employment aged 55-64, 2001 (1000)	16662	259	352	4398	489	1578	1754	158	2002	16	654	270	542	254	695	3240

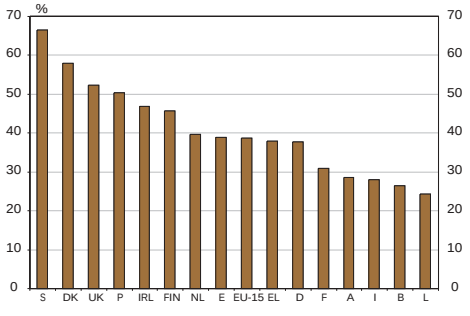
Source: Eurostat - European Union Labour Force Survey (LFS) and Quarterly Labour Force Data (QLFD)

Graph 16 Employment rates by age-group and sex, EU-15, 2001



Source: Eurostat - European Union Labour Force Survey (LFS)

Graph 17 Employment rates of older (aged 55-64) workers, 2001



Source: Eurostat - Quarterly Labour Force Data (QLFD)

Unemployment

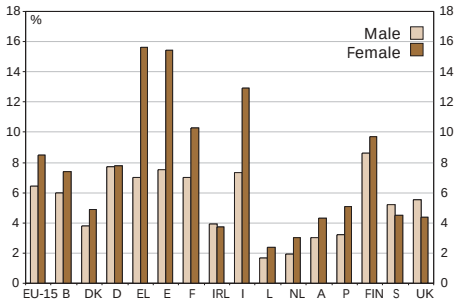
In 2001, the total number of unemployed in the European Union dropped to 12.8 million. This represents 7.4% of the labour force. This is the lowest rate since 1992. Between 2000 and 2001, Spain, France, Finland and Sweden recorded the largest fall in their unemployment rate although Spain continues to have the highest figure (10.6%), slightly above Greece (10.5%). It decreased in all Member States, except in Portugal where it remained at a low 4.1%.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Unemployment rate (total unemployed individuals as a share of total active population. Harmonised series)																
2001 Total	7.4	6.6	4.3	7.7	10.5	10.6	8.6	3.8	9.4	2.0	2.4	3.6	4.1	9.1	4.9	5.0
2001 Men	6.4	6.0	3.8	7.7	7.0	7.5	7.0	3.9	7.3	1.7	1.9	3.0	3.2	8.6	5.2	5.5
2001 Women	8.5	7.4	4.9	7.8	15.6	15.4	10.3	3.7	12.9	2.4	3.0	4.3	5.1	9.7	4.5	4.4
2000 Total	7.8	6.9	4.4	7.8	11.1	11.3	9.3	4.2	10.4	2.3	2.8	3.7	4.1	9.8	5.8	5.4
1994 Total	10.5	9.8	7.7	8.2	8.9	19.8	11.8	14.3	11.0	3.2	6.8	3.8	6.9	16.6	9.4	9.4
Unemployment, 2001 (1000)	12861	286	123	3073	457	1892	2221	68	2248	4	198	137	212	238	225	1485

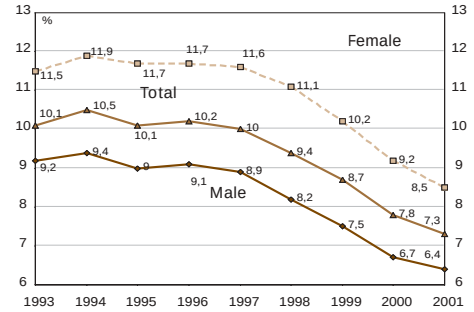
Source: Eurostat - Unemployment rates (ILO definiton).

Graph 18 Unemployment rates by sex, 2001



Source: Eurostat - Unemployment rates (ILO definition).

Graph 19 Trend in the unemployment rate by sex, EU-15, 1993-2001



Source: Eurostat - Unemployment rates (ILO definition).

Youth unemployment

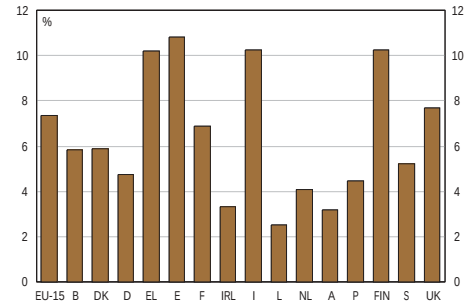
EU-wide, 7.3% of young people (aged 15-24) were unemployed in 2001. The unemployment rate (as a percentage of the labour force) among young people was 14.7%. The differences between these two percentages vary significantly between countries, and may, in part be explained by the fact that a significant number of people in this age group remain in education. Youth unemployment/population ratio between 2000 and 2001 has not followed the overall, declining trend in unemployment: in five Member States it increased, in five remained the same, and in five decreased.

Key indicator

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Youth unemployment/population ratio																
2001	7.3	5.8	5.9	4.7	10.2	10.8	6.9	3.3	10.2	2.5	4.1	3.2	4.5	10.3	5.2	7.7
2000	7.6	6.1	5.0	4.6	11.1	11.3	6.9	3.3	11.6	2.5	4.1	2.9	4.1	11.1	5.1	8.0
1994	10.4	8.2	7.0	4.8	10.3	19.3	10.1	10.7	12.4	3.3	6.6	3.5	6.5	14.8	10.6	10.9
Source: Eurostat - Quarterly Labour Force Data (QLFD)																
Youth unemployment rate																
2001 total	14.7	17.6	8.5	8.2	28.1	21.5	19.3	6.6	28.1	7.5	5.5	5.8	9.3	19.7	11.0	11.9
2001 male	13.8	16.5	7.6	9.2	21.7	16.6	17.2	6.8	24.9	8.5	4.7	5.1	7.3	19.5	12.2	13.2
2001 female	15.7	19.1	9.5	7.1	35.1	27.9	21.9	6.3	32.0	6.3	6.3	6.7	11.8	20.0	9.8	10.3
2000 total	15.4	17.0	7.0	8.5	29.5	22.6	19.7	6.5	30.7	7.2	5.6	5.3	8.8	21.3	11.2	12.3
1994 total	20.9	23.2	10.2	8.4	27.7	40.2	28.7	23.0	31.9	7.1	10.9	5.7	15.0	34.0	22.0	16.4

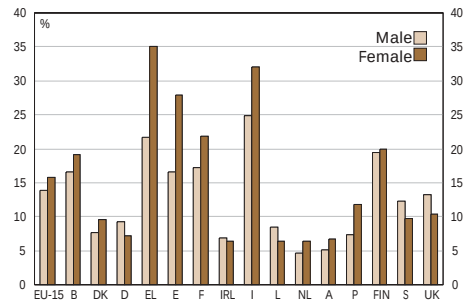
Source: Eurostat - Unemployment Rates (ILO definition).

Graph 20 Youth unemployment/population ratio (15-24 years), 2001



Source: Eurostat - Quarterly Labour Force Data (QLFD).

Graph 21 Youth unemployment rates (15-24 years) by sex, 2001



Source: Eurostat - Unemployment Rates (ILO definition).

Long-term unemployment

In 2001 3.3% of the EU-15 labour force were affected by long-term unemployment. Put another way, 44% of unemployed people were jobless for at least one year. The long-term unemployment rate has fallen in recent years but remains 5% and over in Greece, Spain and Italy. For young people between 15 and 24 years old, 6.9% (as a percentage of the labour force) were unemployed for at least six months.

Key indicator

Long-term unemployment rate	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
(Total long-term unemployed (over 12 months) as a percentage of total active population - harmonised series.)																
2001 - total	3.2	3.3	0.9	3.9	5.4	5.1	2.9	1.3	5.9	0.5	0.8	0.9	1.5	2.5	1.2	1.3
2001 - males	2.8	:	0.8	:	3.2	3.0	:	1.6	4.5	:	0.7	0.9	1.2	2.7	1.4	1.7
2001 -females	3.9	:	1.0	:	8.7	8.1	:	0.8	8.0	:	1.0	1.0	1.9	2.3	1.0	0.8
2000	3.7	3.8	1.0	4.0	6.1	5.9	3.7	1.6	6.4	0.5	1.1	1.0	1.6	2.8	1.7	1.5
1994	5.2	5.6	2.9	3.8	4.4	12.9	4.7	9.4	6.7	0.9	3.1	1.0	2.6	6.1	2.5	4.2

Source: Eurostat - Quarterly Labour Force Data (QLFD)

Persons unemployed for 12 months or more as a percentage of total unemployed																
2001	43.8	49.5	21.0	50.2	51.5	47.9	33.7	32.9	62.5	26.3	35.3	26.2	36.5	27.6	24.5	25.4
2000	47.0	55.1	22.8	51.2	54.9	52.4	40.1	39.1	61.8	23.4	39.6	26.5	39.1	28.8	28.5	27.6
1994	49.7	56.8	37.7	46.4	49.1	65.1	40.1	65.6	61.0	29.0	46.1	25.2	37.5	36.8	26.3	44.8

Source: Eurostat - European Union Labour Force Survey (LFS) and Quarterly Labour Force Data (QLFD)

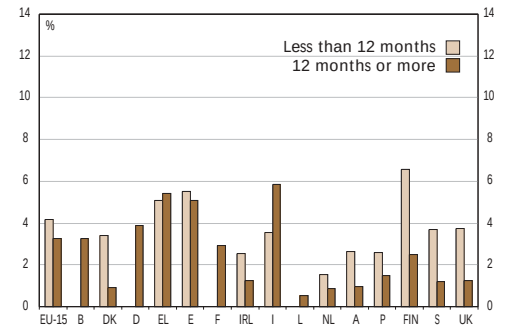
Youth long-term unemployment rate (6 months or more)																
2001	6.9	:	1.1	:	17.9	11.9	:	:	21.0	:	2.5	2.0	3.7	3.1	2.3	3.0
2000	7.7	7.8	0.5	3.7	20.3	12.9	8.3	0.5	22.5	1.8	3.1	1.6	3.2	3.8	2.5	3.3
1994	13.1	12.8	3.4	4.4	19.3	30.2	13.9	17.0	25.1	4.1	10.0	1.7	7.1	7.6	10.0	8.0

Source: Eurostat - European Union Labour Force Survey (LFS)

Young persons unemployed for 6 months or more as a percentage of total number of young unemployed persons																
2001	47.3	:	12.6	:	63.5	48.2	:	:	74.3	:	54.0	34.5	40.0	15.9	27.5	25.1
2000	48.5	44.7	7.6	44.0	68.7	49.1	42.6	7.4	72.4	27.3	54.0	31.4	37.5	17.9	28.4	27.0

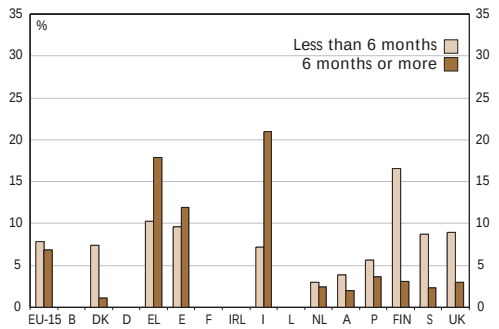
Source: Eurostat - European Union Labour Force Survey (LFS)

Graph 22 Unemployment rates by duration, 2001



Source: Eurostat - Quarterly Labour Force Data (QLFD)

Graph 23 Youth unemployment rates by duration, 2001



Source: Eurostat - European Union Labour Force Survey (LFS)

Social protection expenditure and receipts

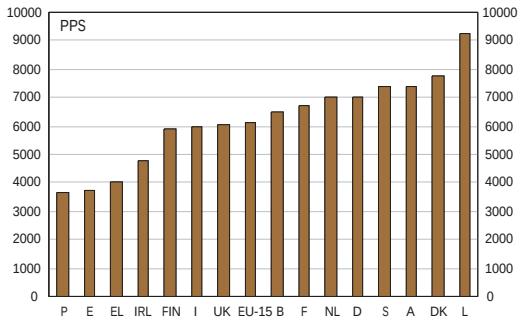
In 2000, social protection expenditure in the European Union dropped back in real terms and amounted to 27.3% of GDP, down by nearly a whole percentage point compared with 1996. There are considerable differences between Member States : in terms of per-capita PPSs the ratio of the expenditure between the countries that spent most and least within EU-15 in 2000 was thus 2.5. Different countries have markedly different systems for financing social protection, depending on whether they favour social security contributions or general government contribution.

Key indicator

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Expenditure on social protection as a percentage of GDP																
2000	27.3	26.7	28.8	29.5	26.4	20.1	29.7	14.1	25.2	21.0	27.4	28.7	22.7	25.2	32.3	26.8
1996	28.4	28.6	31.4	29.9	22.9	21.9	31.0	17.8	24.8	24.0	30.1	29.5	21.2	31.6	34.7	28.1
1991	26.4	27.1	29.7	26.1	21.6	21.2	28.4	19.6	25.2	22.5	32.6	27.0	17.2	29.8	34.3	25.7

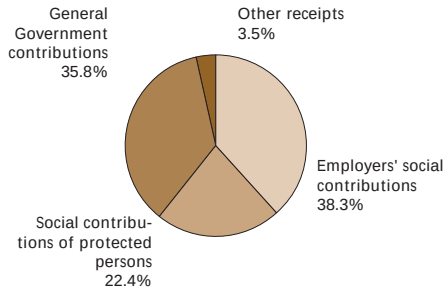
Source: Eurostat - European System of integrated Social Protection Statistics (ESSPROS)

Graph 24 Expenditure on social protection per head of population, 2000



Source: Eurostat - European System of integrated Social Protection Statistics (ESSPROS)

Graph 25 Social protection receipts by type as a percentage of total receipts, EU-15, 2000



Source: Eurostat - European System of integrated Social Protection Statistics (ESSPROS)

Social benefits

In most Member States in 2000, the largest share of social protection expenditure was assigned to the old age and survivors functions. This was especially true of Italy (63.4% of total benefits against the EU average of 46.4%). EU-wide, benefits paid under the old-age and survivors functions rose by 12% in real terms per capita during the period 1995-2000 against +9% for all benefits. This growth is primarily explained by demography. Furthermore the retirement policy also influences the development of these benefits.

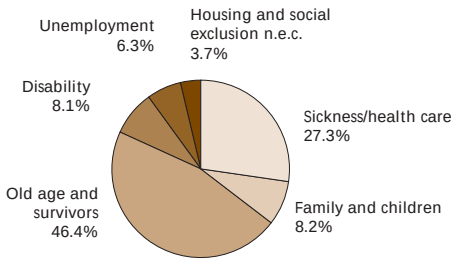
Key indicator

Old age and survivors benefits as a percentage of total social benefits

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
2000	46.4	43.8	38.1	42.2	49.4	46.3	44.1	25.4	63.4	40.0	42.4	48.3	45.6	35.8	39.1	47.7
1991	44.6	41.8	35.8	42.9	52.9	41.4	42.8	29.6	58.7	47.5	37.3	49.9	40.8	32.8	:	43.7

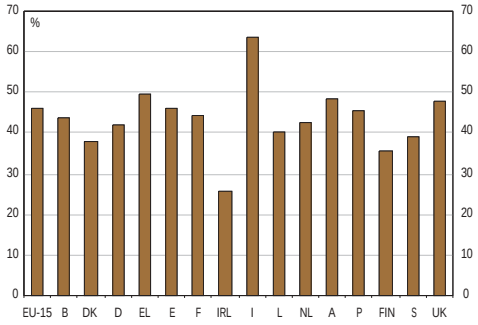
Source: Eurostat - European System of integrated Social Protection Statistics (ESSPROS).

Graph 26 Social benefits by groups of functions as a percentage of total benefits, EU-15, 2000



Source: Eurostat - European System of integrated Social Protection Statistics (ESSPROS)

Graph 27 Old age and survivors benefits as a percentage of total social benefits, 2000



Source: Eurostat - European System of integrated Social Protection Statistics (ESSPROS)

Labour Market Policy expenditure

In 2000, total Labour Market Policy expenditure represented 2.04% of GDP, out of which 0.68% was dedicated to active labour market policy measures. There are considerable differences between Member States that are not a clear north/south divide. Two countries spent more than 3% of GDP (Belgium and Denmark), six countries spent between 2% and 3% (Germany, Spain, France, the Netherlands, Finland and Sweden), and six countries spent less than 2% (Greece, Ireland, Italy, Austria, Portugal and the United Kingdom).

Key indicator

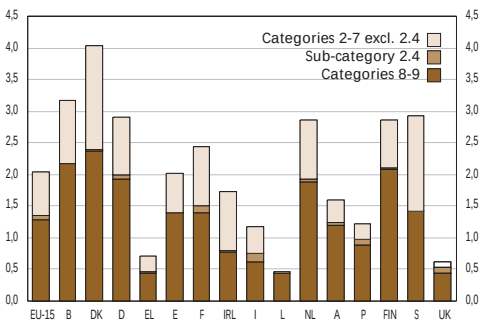
Public expenditure on active LMP measures as a percentage of GDP, 2000

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Categories 2-7 excl. 2.4	0.681	1.000	1.641	0.917	0.253	0.632	0.931	0.929	0.436	:	0.920	0.365	0.254	0.742	1.507	0.089
Sub-category 2.4	0.075	-	0.026	0.061	0.016	-	0.109	0.018	0.135	0.036	0.040	0.033	0.098	0.023	-	0.104
Categories 8-9	1.282	2.178	2.378	1.924	0.449	1.393	1.401	0.786	0.611	0.439	1.890	1.204	0.876	2.093	1.409	0.434
Total	2.037	3.177	4.045	2.901	0.718	2.025	2.441	1.733	1.182	:	2.850	1.602	1.228	2.859	2.916	0.627

Categories 2-7: Training - Job rotation and job sharing - Employment incentives - Integration of the disabled - Direct job creation - Start-up incentives
Sub-category 2.4: Special support for apprenticeship. Categories 8-9: Out of work income maintenance and support - Early retirement

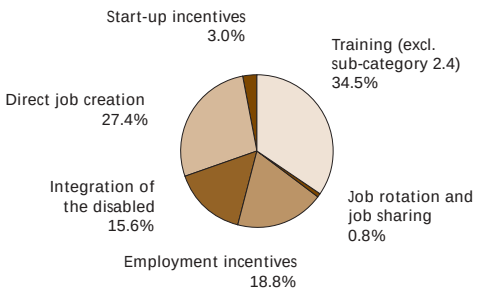
Source: Eurostat - Labour Market Policy Database (LMP)

Graph 28 Total public expenditure on LMP measures as a percentage of GDP, 2000



Source: Eurostat - Labour Market Policy Database (LMP)

Graph 29 Labour Market Policy expenditure by type of action (categories 2-7), EU-15, 2000



Source: Eurostat - Labour Market Policy Database (LMP)

Income distribution

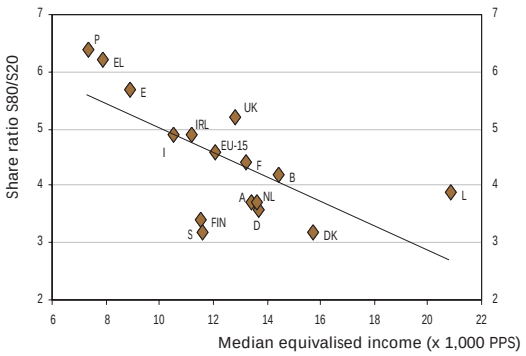
As a population-weighted average in EU Member States in 1999, the top (highest income) 20% of the population received 4.6 times as much of the total income as the bottom (lowest income) 20% of the population. This gap between the most and least well-off people is smallest in Denmark and Sweden (3.2), followed by Finland, Germany, Netherlands and Austria. It is widest in the southern Member States, Ireland and the United Kingdom.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Inequality of income distribution (income quintile share ratio) - The ratio of total income received by the 20% of the population with the highest income (top quintile) to that received by the 20% of the population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income.																
1999	4.6*	4.2	3.2	3.6	6.2	5.7*	4.4	4.9	4.9	3.9	3.7	3.7	6.4	3.4	3.2	5.2

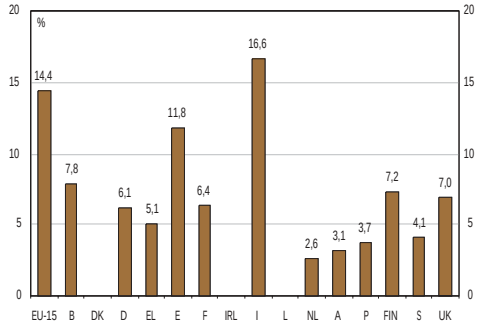
Source: Eurostat - European Community Household Panel - UDB version December 2002

Graph 30 Level of income and income inequality, 1999



Source: Eurostat - European Community Household Panel - UDB, version December 2002

Graph 31 Dispersion of regional employment rates, 2001



Source: Eurostat - European Union Labour Force Survey 2001.

Low-income households

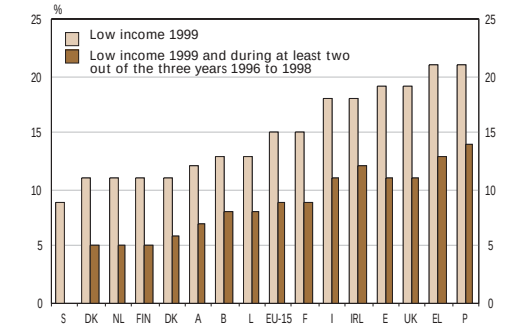
When looking at the total population, around 15% of EU citizens had an equivalised income that was less than 60% of their respective national median in 1999. This figure represents around 56 million people. Using 60% of the national median as a cut-off threshold, the proportion of people at risk of poverty was relatively higher in Greece and Portugal (21%), followed by Spain and United Kingdom (19%) - and was relatively lower in Belgium, Denmark, Germany, Luxembourg, the Netherlands, Austria and Finland (11 to 13%). It was particularly low in Sweden (9%). Social benefits reduce the proportion of people at risk of poverty in all Member States but to very differing degrees: the reduction ranging from around 5% in Greece to almost 70% in Sweden.

Key indicator

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
At-risk-of-poverty rate - before social transfers. The share of persons with an equivalised disposable income, before social transfers, below the risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income (after social transfers). Retirement and survivor's pensions are counted as income before transfers and not as social transfers, **1999**	24*	25	24	21	22	23*	24	30	21	24	21	23	27	21	28	30
At-risk-of-poverty rate - after social transfers. The share of persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income, **1999**	15*	13	11	11	21	19*	15	18	18	13	11	12	21	11	9	19
60% of median annual income (€)	7334*	8 531	11 649	8 754	3 810	4491*	8 289	6 656	5 557	12 716	7 668	8 621	3 168	8 154	8 503	8 289
60% of median annual income (PPS)	7263*	8 659	9 414	8 236	4 753	5347*	7 944	6 721	6 305	12 532	8 067	8 158	4 400	6 921	6 942	7 694

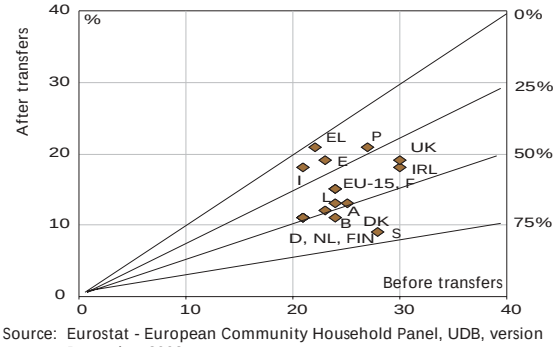
Source: Eurostat - European Community Household Panel UDB, version December 2002.

Graph 32 At-risk-of-poverty rate (after social transfers) and At-persistent-risk-of-poverty rate, 1999



Source: Eurostat - European Community Household Panel, UDB, version December 2002

Graph 33 At-risk-of-poverty rate after and before social transfers, 1999



Source: Eurostat - European Community Household Panel, UDB, version December 2002

Jobless households and low wages

An important cause of poverty and social exclusion is the lack of a job or low wages from employment. In 1999, the 'at-risk-of-poverty' rate for people living in households where no people of working age are in employment was 51% - almost 3 times as high as the rate where at least one person is working.

Key indicator

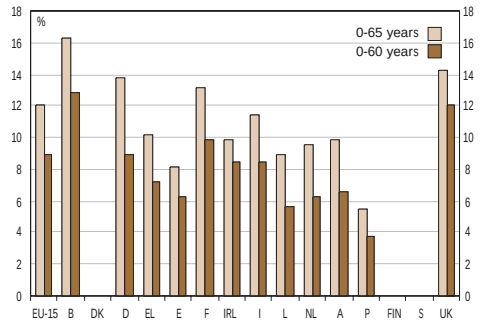
	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Population in jobless households - persons aged 0-65 (Percentage of people living in households with no member in employment as a share of total population (excluding persons in households where all members are aged less than 18 years, or 18-24 years and in education, or 65 years and more and not working))																
2002	12.1	16.3	:	13.8	10.1	8.1	13.1	9.8	11.5	8.9*	9.5*	9.9*	5.4	:	:	14.3
Population in jobless households - persons aged 0-60 (Percentage of people living in households with no member in employment as a share of total population (excluding persons in households where all members are aged less than 18 years, or 18-24 years and in education, or 60 years and more and not working))																
2002	8.9	12.9	:	8.9	7.2	6.2	9.8	8.5	8.5	5.6*	6.3*	6.5*	3.7	:	:	12.0

Source: Eurostat - European Union Labour Force Survey 2002.

At-risk-of-poverty rates (%) among people living in households where ... of the working age people are in employment, 1999																
... none ...	51.0	43.0	45.0	54.0	42.0	54.0	47.0	79.0	51.0	24.0	:	26.0	41.0	47.0	:	57.0
... some -but not all- ...	18.0	11.0	5.0	10.0	20.0	18.0	21.0	12.0	24.0	16.0	:	13.0	24.0	9.0	:	22.0
... all ...	5.0	3.0	3.0	4.0	11.0	5.0	5.0	3.0	4.0	7.0	:	7.0	13.0	5.0	:	7.0

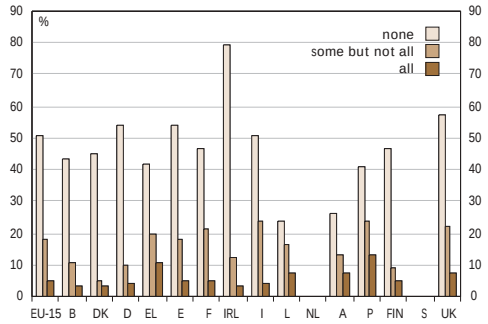
Source: Eurostat - European Community Household Panel UDB, version December 2002.

Graph 34 Population in jobless households, 2002



Source: Eurostat - European Union Labour Force Survey

Graph 35 At-risk-of-poverty rates among people living in households where ... of the working persons are in employment, 1999



Source: Eurostat - European Community Household Panel UDB, version December 2002

Women and men in decision making

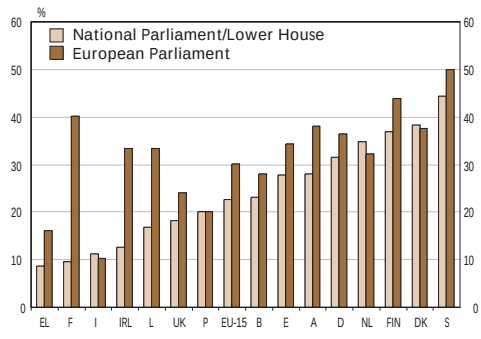
At the EU level, women's representation in the European Parliament has increased steadily with each election since 1984 and now reaches 30%. In national Parliaments women continue to be under-represented in all Member States as the percentages of seats occupied by women in these bodies range from 9% in Greece to 44% in Sweden.

Key indicator

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Female share in national parliaments (Percentage of seats occupied by women in the national Parliaments (or Lower House)), **spring 2001**	23	23	38	32	9	28	10	13	11	17	35	28	20	37	44	18
Percentage of seats occupied by women in the European Parliament, election June 1999	30	28	38	36	16	34	40	33	10	33	32	38	20	44	50	24
Percentage of women in the national governments, spring 2001	25	22	43	39	13	18	29	22	14	29	36	31	10	39	50	33

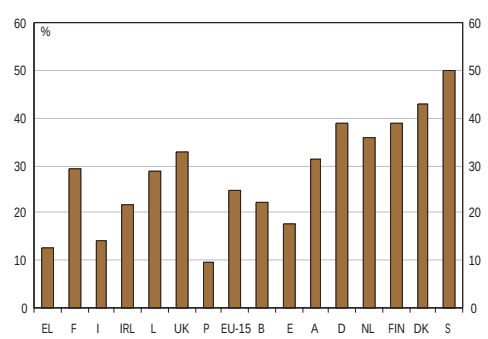
Source: European database - Women in decision making

Graph 36 Percentage of seats occupied by women in Parliaments, 2001



Source: European database - Women in decision making

Graph 37 Percentage of women in the national governments, spring 2001



Source: European database - Women in decision making

Employment of women and men

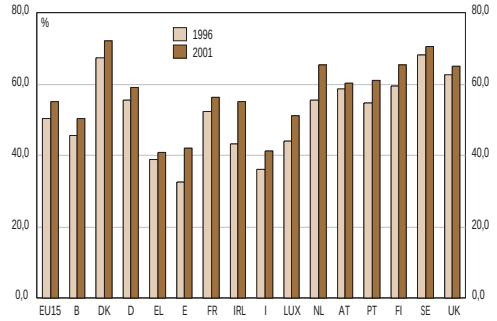
Between 1996 and 2001, the EU employment rate for men rose by almost 3 points. Over the same period, the rate for women however rose by almost 5 points, thereby narrowing the gap between the sexes. Nevertheless, the rate for men (73.0%) remains considerably higher than that of women (54.9%). Female employment rates are highest in the three Nordic countries, the United Kingdom and the Netherlands.

Key indicator

	EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Employment rate. 15-64 years. 2001																
Females	54.9	50.3	72.0	58.8	40.9	41.9	56.1	55.0	41.1	50.9	65.2	60.1	61.1	65.4	70.4	65.1
Males	73.0	68.2	80.2	72.6	70.8	70.9	70.3	76.4	68.5	74.8	82.8	76.7	76.9	70.9	73.0	78.3

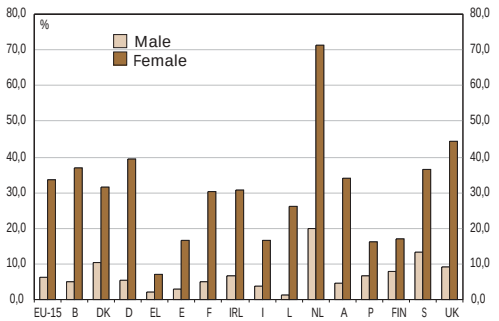
Source: Eurostat - QLFD (Quarterly Labour Force Data)

Graph 38 Female employment rates (15-64 years), 1996 and 2001



Source: Eurostat - QLFD (Quarterly Labour Force Data)

Graph 39 Percentage of persons in employment working part-time, by sex, 2001



Source: Eurostat - QLFD (Quarterly Labour Force Data)

Earnings of women and men

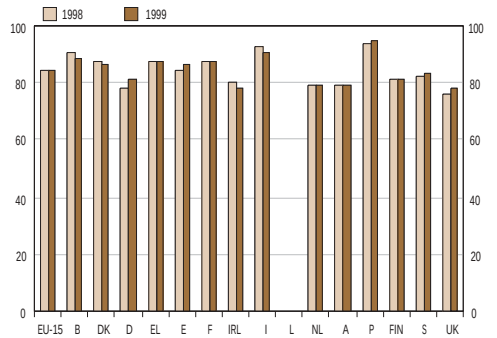
EU-wide, the average gross hourly earnings of women in 1999 were estimated at 16% less than the gross hourly earnings of men. The smallest differences are found in Portugal, Italy, Belgium and France, the biggest in the United Kingdom and Ireland. At EU level the difference remains the same as in 1998, 1997 and 1996. To reduce gender pay differences both direct pay-related discrimination and indirect discrimination related to labour market participation, occupational choice and career progression have to be addressed.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Gender pay gap in unadjusted form (Average gross hourly earnings of females as % of average gross hourly earnings of males. The population consists of all paid employees aged 16-64 that are 'at work 15+ hours per week'.)																
1999	84*	89	86	81	87	86*	88	78	91	:	79	79	95	81	83	78
1998	84*	91	88	78	88	84*	88	80	93	:	79	79	94	81	82	76
1997	84*	90	87	79	87	86*	88	81	93	:	78	78	93	82	83	79
1996	84*	90	85	79	85	86*	87	79	92	82	77	80	94	83	83	76
1995	83*	88	85	79	83	87*	87	80	92	81	77	78	95	:	85	74
1994	84*	87	89	79	87	90	87	81	92	83	77	:	90	:	84	72

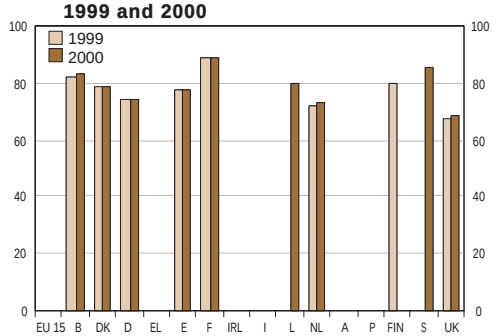
Source: Eurostat - European Community Household Panel UDB version December 2002 (except F: National Labour Force Survey, NL and S: Earnings Surveys.)

Graph 40 Gender pay gap in unadjusted form 1998 and 1999



Source: Eurostat - European Community Household Panel UDB version December 2002 (except F: National Labour Force Survey, NL and S: Earnings Surveys.)

Graph 41 Average gross annual earnings of females as % of average gross annual earnings of males (full-time employees, NACE Rev. 1 sections C-K), **1999 and 2000**



Source: Eurostat - Harmonised statistics on earnings

Life and health expectancies

Life expectancy continues to rise and now it's more than 81 years for women and 75 for men. In all Member States, women live longer then men. EU-wide, women can expect to live to 66 and men to 63 years of age without any disability.

Key indicator

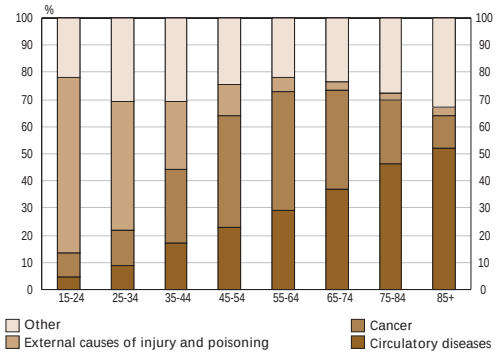
	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Life expectancy at birth. 2000																
Males	75.3	74.6	74.5	74.7	75.5	75.5	75.2	74.2	76.3	74.9	75.5	75.4	72.7	74.2	77.4	75.4
Females	81.4	80.8	79.3	80.7	80.6	82.7	82.7	79.2	82.4	81.3	80.5	81.2	79.7	81.0	82.0	80.2

Note: D. EL: 1999.
Source: Eurostat - Demographic statistics

Healthy life years (Disability-free life expectancy at birth), 1996																
Males	63	65	62	63	67	65	60	64	67	61	63	62	59	56	:	61
Females	66	69	62	69	70	68	63	67	70	64	63	66	61	59	:	62

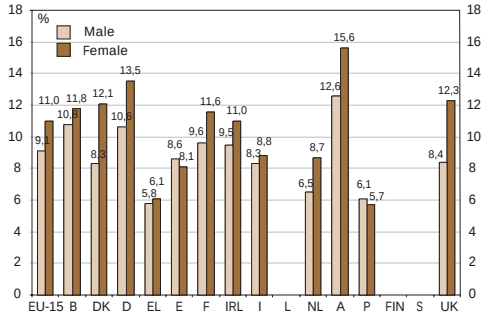
Source: Eurostat - Mortality Statistics and European Community Household Panel

Graph 42 Major causes of death by age-group, EU-15, 1998



Source: Eurostat - Mortality Statistics

Graph 43 Percentage of population hospitalised during the last 12 months, 1998



Source: Eurostat - European Community Household Panel UDB, version December 2001

Accidents and work-related health problems

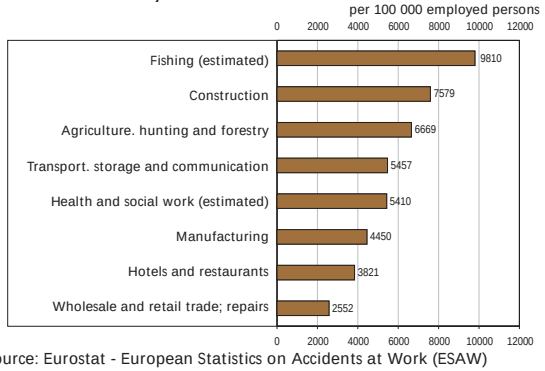
In 2000, around 4.0% of EU workers were victims of a working accident resulting in more than three days' absence, 6.3% including accidents with no absence from work or an absence up to 3 days. From 1994, the number of accidents at work with more than three days' absence decreased by 11% (the value of the index 1998 = 100 was 99 in 2000 and 111 in 1994). During 1998-99 5.4% of employees per year suffered from work-related health problems. A total of around 510 million working days were lost in 1999 as a result of accidents at work (160 million days lost) and work-related health problems (350 million days lost). Road transport fatalities have fallen by around 46% since 1970 but there were still around 40 000 deaths on EU roads recorded in 2001.

Key indicator

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Serious accidents at work (Index of the number of serious accidents at work per 100 thousand persons in employment (1998=100)), **2000**																
Total	99*	82~b	89	96	88	108	102	72	99	104	105	92	94*	89	111	111
Men	98*	80~b	88	96	92	109	101	69	98	105	:	92	96*	89	113	109
Women	104*	101	99	99	76	113	111	88	104	100	:	93	93*	88	106	118
Fatal accidents at work (Index of the number of fatal accidents at work per 100 thousand persons in employment (1998=100)), **2000**																
Total	79*	100	61	70	73	85	85	39	66	149*	115	100	79*	88	85	88

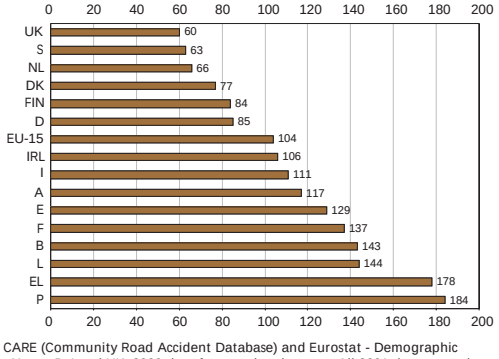
Source: Eurostat - European Statistics on Accidents at Work (ESAW)

Graph 44 Accidents at work by type of activity, EU-15, 2000



Source: Eurostat - European Statistics on Accidents at Work (ESAW)

Graph 45 Number of road traffic deaths per million population, 2001



Source: CARE (Community Road Accident Database) and Eurostat - Demographic Statistics.Notes: B, I and UK: 2000 data from national sources.All 2001 data are estimates.

Key social indicators per Member State

Nr.	Key indicator	Unit	Year	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
3	Old age dependency ratio	%	2001	24.3°	25.7	22.2	24.5	25.6°	24.7	24.8	16.6	27.1	21.5	20.1	22.9	24.2	22.4	26.8	23.9°
4	Net migration rate	per 1000 inhab.	2001	3.1	3.2	2.3	3.2	3.3	5.8	1.0	7.8	2.9	7.5	3.1	2.2	6.3	1.2	3.2	2.6
5t	Early school-leavers not in further education or training - total	%	2001	19.4	13.6	16.8	12.5	16.5	28.6	13.5	18.9	26.4	18.1	15.3	10.2	45.2	10.3	10.5	:
5m	Early school-leavers not in further education or training - males	%	2001	21.9	15.0	16.9	12.2	20.4	34.9	15.0	22.6	30.2	19.0	16.5	9.7	52.3	13.0	11.3	:
5f	Early school-leavers not in further education or training - females	%	2001	16.8	12.3	16.7	12.8	13.0	22.2	12.0	15.1	22.6	17.2	14.1	10.7	38.0	7.7	9.7	:
6t	Lifelong learning - total	%	2001	8.4	7.3	17.8	5.2	1.4	4.9	2.7	5.2	5.1	5.3	16.3	8.2	3.3	19.3	17.5	21.7
6m	Lifelong learning - males	%	2001	7.9	7.7	16.4	5.7	1.5	4.3	2.5	5.2	4.9	5.9	17.0	8.7	3.0	17.1	15.4	18.0
6f	Lifelong learning - females	%	2001	8.9	6.9	19.1	4.8	1.2	5.5	3.0	5.3	5.2	4.7	15.5	7.7	3.7	21.4	19.7	25.7
7	Employment rate (cf. nrs 19m & 19f)	%	2001	64.0	59.3	76.2	65.8	55.4	56.3	63.1	65.7	54.8	62.9	74.1	68.4	68.8	68.1	71.7	71.7
8at	Employment rate of older workers - total	%	2001	38.6	26.5	58.0	37.7	38.0	38.9	31.0	46.8	28.0	24.4	39.6	28.6	50.3	45.7	66.5	52.3
8am	Employment rate of older workers - males	%	2001	48.7	36.5	65.5	46.1	55.0	57.4	35.4	64.7	40.4	34.8	51.1	40.0	61.6	46.7	69.1	61.7
8af	Employment rate of older workers - females	%	2001	28.9	16.9	49.8	29.5	22.5	21.8	26.7	28.8	16.2	14.0	28.0	17.9	40.6	44.8	63.8	43.1
8bt	Effective average exit age - total	years	2001	59.9	57.0	61.9	60.7	59.6	60.6	58.1	63.1	59.4	56.8	60.9	59.6	62.0	61.6	62.0	62.1
8bm	Effective average exit age - males	years	2001	60.5	57.8	62.2	60.9	61.2	60.7	58.2	63.2	59.6	57.5	61.1	60.0	62.0	61.6	62.1	63.1
8bf	Effective average exit age - females	years	2001	59.1	55.9	61.1	60.4	57.7	60.2	58.0	62.2	59.2	55.3	60.3	58.6	61.5	61.4	61.9	61.0
9t	Unemployment rate - total	%	2001	7.4	6.6	4.3	7.7	10.5	10.6	8.6	3.8	9.4	2.0	2.4	3.6	4.1	9.1	4.9	5.0
9m	Unemployment rate - males	%	2001	6.4	6.0	3.8	7.7	7.0	7.5	7.0	3.9	7.3	1.7	1.9	3.0	3.2	8.6	5.2	5.5
9f	Unemployment rate - females	%	2001	8.5	7.4	4.9	7.8	15.6	15.4	10.3	3.7	12.9	2.4	3.0	4.3	5.1	9.7	4.5	4.4
10	Youth unemployment/population ratio	%	2001	7.3	5.8	5.9	4.7	10.2	10.8	6.9	3.3	10.2	2.5	4.1	3.2	4.5	10.3	5.2	7.7
11t	Long-term unemployment rate - total	%	2001	3.2	3.3	0.9	3.9	5.4	5.1	2.9	1.3	5.9	0.5	0.8	0.9	1.5	2.5	1.2	1.3
11m	Long-term unemployment rate - males	%	2001	2.8	:	0.8	:	3.2	3	:	1.6	4.5	:	0.7	0.9	1.2	2.7	1.4	1.7
11f	Long-term unemployment rate -females	%	2001	3.9	:	1.0	:	8.7	8.1	:	0.8	8.0	:	1.0	1.0	1.9	2.3	1.0	0.8
12	Expenditure on social protection as a percentage of GDP	%	2000	27.3	26.7	28.8	29.5	26.4	20.1	29.7	14.1	25.2	21.0	27.4	28.7	22.7	25.2	32.3	26.8
13	Old age and survivors benefits as a percentage of total social benefits	%	2000	46.4	43.8	38.1	42.2	49.4	46.3	44.1	25.4	63.4	40.0	42.4	48.3	45.6	35.8	39.1	47.7
14	Public expenditure in active LMP measures as a percentage of GDP	%	2000	0.681	1.000	1.641	0.917	0.253	0.632	0.931	0.929	0.436	:	0.920	0.365	0.254	0.742	1.507	0.089
15	Inequality of income distribution	Ratio	1999	4.6	4.2	3.2	3.6	6.2	5.7	4.4	4.9	4.9	3.9	3.7	3.7	6.4	3.4	3.2	5.2
16a	At-risk-of-poverty rate before social transfers	%	1999	24*	25	24	21	22	23*	24	30	21	24	21	23	27	21	28	30
16b	At-risk-of-poverty rate after social transfers	%	1999	15*	13	11	11	21	19*	15	18	18	13	11	12	21	11	9	19
17a	Population in jobless households, persons aged 0-65	%	2002	12.1	16.3	:	13.8	10.1	8.1	13.1	9.8	11.5	8.9*	9.5*	9.9*	5.4	:	:	14.3
17b	Population in jobless households, persons aged 0-60	%	2002	8.9	12.9	:	8.9	7.2	6.2	9.8	8.5	8;5	5.6*	6.3*	6.5*	3.7	:	:	12.0
18	Female share in national Parliaments	%	2001	23	23	38	32	9	28	10	13	11	17	35	28	20	37	44	18
19m	Employment rate - males (cf. nr. 7)	%	2001	73.0	68.2	80.2	72.6	70.8	70.9	70.3	76.4	68.5	74.8	82.8	76.7	76.9	70.9	73.0	78.3
19f	Employment rate - females (cf. nr. 7)	%	2001	54.9	50.3	72.0	58.8	40.9	41.9	56.1	55.0	41.1	50.9	65.2	60.1	61.1	65.4	70.4	65.1
20	Gender pay gap in unadjusted form	%	1999	84*	89	86	81	87	86*	88	78	91	82°	79	79	95	81	83	78
21am	Life expectancy at birth - males	Years	2000	75.3	74.6	74.5	74.7	75.5	75.5	75.2	74.2	76.3	74.9	75.5	75.4	72.7	74.2	77.4	75.4
21af	Life expectancy at birth - females	Years	2000	81.4	80.8	79.3	80.7	80.6	82.7	82.7	79.2	82.4	81.3	80.5	81.2	79.7	81.0	82.0	80.2
21bm	Healthy life years - males	Years	1996	63	65	62	63	67	65	60	64	67	61	63	62	59	56	:	61
21bf	Healthy life years - females	Years	1996	66	69	62	69	70	68	63	67	70	64	63	66	61	59	:	62
22at	Serious accidents at work - total	Index points (1998 = 100)	2000	99*	82~b	89	96	88	108	102	72	99	104	105	92	94*	89	111	111
22am	Serious accidents at work - males	Index points (1998 = 100)	2000	98*	80~b	88	96	92	109	101	69	98	105	:	92	96*	89	113	109
22af	Serious accidents at work - females	Index points (1998 = 100)	2000	104*	101	99	99	76	113	111	88	104	100	:	93	93*	88	106	118
22b	Fatal accidents at work	Index points (1998 = 100)	2000	79*	100	61	70	73	85	85	39	66	149*	115	100	79*	88	85	88
Nr.	**Key indicator**	**Unit**	**Year**	**EU-15**	**B**	**DK**	**D**	**EL**	**E**	**F**	**IRL**	**I**	**L**	**NL**	**A**	**P**	**FIN**	**S**	**UK**

° = See comment in the corresponding portrait. The figure may be from another year (latest available) or may have some other limitation.

Reading note for each key indicator see page 36

Key social indicators per acceding State and candidate country

Nr.	Key indicator	Unit	Year	EU-15	BG	CY	CZ	EE	HU	LV	LT	MT	PL	RO	SK	SI	TR
3	Old age dependency ratio	%	2001	24.3°	24.0	17.3	19.8	22.7	21.4°	22.6	20.2	18.1	17.8	19.6	16.5	20.2	:
4	Net migration rate per 1000 inhab.		2000	3.1°	0.0	1.5	0.6	0.2	0.0	-0.8	0.0	3.5	-0.5	-0.2	0.3	1.4	:
5t	Early school-leavers not in further education or training - total	%	2001	19.4	20.3	14.8	:	14.5	13.2	:	14.2	:	7.3	21.3	:	8.3	:
5m	Early school-leavers not in further education or training - males	%	2001	21.9	21.1	18.2	:	17.5	13.4	:	18.6	:	9.1	21.4	:	10.3	:
5f	Early school-leavers not in further education or training - females	%	2001	16.8	19.5	12.0	:	11.4	12.9	:	10.0	:	5.6	21.3	:	6.3	:
6t	Lifelong learning - total	%	2001	8.4	:	3.4	:	5.3	3.0	:	3.7	:	5.2	1.1	:	3.7	:
6m	Lifelong learning - males	%	2001	7.9	:	3.4	:	4.0	2.5	:	2.4	:	4.6	1.1	:	3.4	:
6f	Lifelong learning - females	%	2001	8.9	:	3.4	:	6.3	3.5	:	4.9	:	5.9	1.0	:	4.0	:
7	Employment rate (cf. nrs 19m & 19f)	%	2001	64.0	49.6	65.9°	65.1	61.3	56.5	58.7	60.1°	54.2	55.0°	62.4	56.8	63.8	50.6
8at	Employment rate of older workers - total	%	2001	38.6	23.9	49.2°	37.1	48.4	24.1	36.9	41.6°	31.0	28.4°	48.2	22.4	25.5	34.1
8am	Employment rate of older workers - males	%	2001	48.7	34.2	67.3°	52.6	56.6	34.9	46.2	51.8°	52.5	36.7°	54.3	37.7	35.9	50.8
8af	Employment rate of older workers - females	%	2001	28.9	14.7	32.0°	23.2	42.1	15.3	30.0	33.9°	11.3	21.4°	42.9	9.8	15.8	18.4
8t	Effective average exit age - total	years	2001	59.9	:	:	:	:	:	:	:	:	:	:	:	:	:
8m	Effective average exit age - males	years	2001	60.5	:	:	:	:	:	:	:	:	:	:	:	:	:
8f	Effective average exit age - females	years	2001	59.1	:	:	:	:	:	:	:	:	:	:	:	:	:
9t	Unemployment rate - total	%	2001	7.4	19.6	4.5	8.0	12.3	5.7	12.8	16.1	6.8	18.6	6.8	19.7	6.0	8.5
9m	Unemployment rate - males	%	2001	6.4	20.5	3.0	6.8	12.0	6.4	14.1	18.4	6.2	17.2	7.3	20.5	5.7	8.8
9f	Unemployment rate - females	%	2001	8.5	18.6	6.5	9.9	12.5	5.0	11.6	13.8	8.2	20.3	6.3	18.8	6.3	7.9
10	Youth unemployment/population ratio	%	2001Q2	6.6	13.6	3.4	6.7	8.7	3.7	8.6	10.2	:	15.6	7.0	17.6	5.7	:
11t	Long-term unemployment rate - total	%	2001	3.2	12.6	1.2°	4.3	6.2	2.6	7.4	8.1°	2.9	7.4°	3.3	11.3	3.7	2.4
11m	Long-term unemployment rate - males	%	2001	2.8	13.2	0.5°	3.5	6.8	3,0	8.3	9.9°	3.3	6.0°	3.5	11.3	3.5	:
11f	Long-term unemployment rate -females	%	2001	3.9	11.9	2.1°	5.2	5.4	2.1	6.4	6.2°	1.7	9.1°	3,0	11.3	4,0	:
12	Social protection expenditure as a percentage of GDP	%	2000	27.3	:	:	:	:	:	:	:	:	:	:	20,0	26.6	:
13	Old age and survivors benefits as a percentage of total social benefits	%	2000	46.4	:	:	:	:	:	:	:	:	:	:	38.4	45.2	:
14	Public expenditure in active LMP as a percentage of GDP	%	2000	0.681	:	:	:	:	:	:	:	:	:	:	:	:	:
15	Inequality of income distribution	Ratio	1999	4.6*	3.6	4.4°	:	6.3°	:	5.1	5,0	4.5°	4.2	4.4	:	3.2	10.9°
16a	At-risk-of-poverty rate before social transfers	%	1999	24*	17	18°	:	26°	:	22	22	21°	28	22	:	18	26°
16b	At-risk-of-poverty rate after social transfers	%	1999	15*	14	16°	:	18°	:	16	17	15°	15	16	:	11	23°
17a	Population in jobless households. persons aged 0-65	%	2002	12.1	18.3	6,0	9.9	11.3	15.6*	11.8	11.2*	:	11.3°	11.1	12.9	8.1*	:
17b	Population in jobless households. persons aged 0-60	%	2002	8.9	15.1	4.4	6.9	9.0	12.4*	9.0	8.1*	:	8.5°	9.0	10.6	5.4*	:
18	Female share in national Parliaments	%	1998	23°	:	:	15	18	8	:	:	9	13	:	:	12	:
19m	Employment rate - males (cf. nr. 7)	%	2001	73.0	52.6	79.1°	73.3	65.5	63.4	61.9	61.9°	76.4	61.2°	67.8	62.0	68.6	74.3
19f	Employment rate - females (cf. nr. 7)	%	2001	54.9	46.8	53.2°	57.0	57.3	49.8	55.7	58.5°	31.6	48.9°	57.1	51.8	58.8	26.7
20	Gender pay gap in unadjusted form	%	1999	84	:	:	:	:	:	:	:	:	:	:	:	:	:
21am	Life expectancy at birth - males	Years	2000	75.3	68.5	75.3°	71.7	65.6	67.2	65.0	67.5	75.1	69.7	67.7	69.2	72.3	66.5°
21af	Life expectancy at birth - females	Years	2000	81.4	75.1	80.4°	78.4	76.4	75.7	76.1	77.7	79.3	77.9	74.6	77.4	79.7	71.2°
21bm	Healthy life years - males	Years	1996	63	:	:	:	:	:	:	:	:	:	:	:	:	:
21bf	Healthy life years - females	Years	1996	66	:	:	:	:	:	:	:	:	:	:	:	:	:
22at	Serious accidents at work - total Index points (1998 = 100)		2000	99*	100~b	112	91	105	94	66	94	94	79	106	88	98	85
22am	Serious accidents at work - males Index points (1998 = 100)		2000	98*	:	:	:	:	:	:	:	:	:	:	:	:	:
22af	Serious accidents at work - females Index points (1998 = 100)		2000	104*	:	:	:	:	:	:	:	:	:	:	:	:	:
22b	Fatal accidents at work Index points (1998 = 100)		2000	79*	100~b	46*	96	56	95	90	78	41*	97	103	71	83	68~b
Nr.	**Key indicator**	**Unit**	**Year**	**EU-15**	**BG**	**CY**	**CZ**	**EE**	**HU**	**LV**	**LT**	**MT**	**PL**	**RO**	**SK**	**SI**	**TR**

° = See comment in the corresponding portrait. The figure may be from another year (latest available) or may have some other limitation.

Reading note for each key indicator see page 36

Reading note for each key indicators

3	EU-wide, the number of persons aged 65 and over corresponded to 24.3% of what is considered to be the working age population (15-64 years) in 2001.
4	The net migration rate for the EU in 2001 was 3.1 per 1000 inhabitants.
5t	In 2001, 19.4% of 18-24 year-olds in the EU had left the education system without completing a qualification beyond lower secondary schooling.
6t	EU-wide, 8.4% of the population aged 25-64 had participated in education/training in the 4 weeks prior to the survey in 2001.
7	64.0% of the EU population aged 15-64 were in employment in 2001.
8at	38.6% of the EU population aged 55-64 were in employment in 2001.
8bt	In 2001, the effective average exit age from the labour market was 59,9 years.
9t	7.4% of the EU labour force (those at work and those seeking work) were unemployed in 2001.
10	7.3% of the EU population aged 15-24 were unemployed in 2001.
11t	3.2% of the EU labour force (those at work and those seeking work) had been unemployed for at least one year in 2001.
12	In 2000, EU social protection expenditure represented 27.3% of Gross Domestic Product (GDP).
13	EU-wide, old-age and survivors benefits make up the largest item of social protection expenditure (46.4% of total benefits in 2000).
14	In 2000, EU public expenditure on active Labour Market Policy measures represented 0.681% of Gross Domestic Product (GDP).
15	As an average in EU Member States in 1999, the top (highest income) 20% of a Member State's population received 4.6 times as much of the Member State's total income as the bottom (poorest) 20% of the Member State's population.
16a	EU-wide before social transfers, 24% of the population would have been living below the poverty line in 1999.
16b	EU-wide after social transfers, 15% of the population were actually living below the poverty line in 1999.
17a	EU-wide in 2002, 12.1% of population aged 0-65 years were living in households with no member in employment (excluding persons in households where all members are aged less than 18 years, or 18-24 years and in education, or 65 years and more and not working).
18	EU-wide, 23% of the seats in the national Parliaments (or Lower House) were occupied by women in 2001.
19	73.0% / 54.9 % of the EU male / female population aged 15-64 were in employment in 2001.
20	EU-wide, the average gross hourly earnings of women were 84% of the average gross hourly earnings of men in 1999. The population consists of all paid employees aged 16-64 that are 'at work 15+ hours per week'.
21a	The average life expectancy at birth of a male / female citizen in the EU was 75.3 / 81.4 years in 2000.
21b	On average, a male / female citizen in the EU should live to 63 / 66 without disability (1996 data).
22at	EU-wide there occurred 1 % less serious working accidents (resulting in more than three days' absence) per 100 000 persons in employment in 2000 than in 1998.
22b	EU-wide there occurred 21 % less fatal working accidents per 100 000 persons in employment in 2000 than in 1998.

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