ANNEXES

Annex to Chapter I

General Introduction

(1.1. Social situation)

Annex 1. Description and assessment of the social situation

Conditions for good social protection and good social integration include a sufficiently high income, a quantitatively valid job, adequate training, good health and good housing. A system of effective, lasting social protection is needed to ensure these conditions for everyone.

In the first part, we will consider to what extent these conditions are achieved today. The second part will focus on the performance and sustainability of the social protection system, referring to the regulations and instruments that must be implemented to achieve this social protection and social integration.

The analysis is done based on general, common indicators, agreed on European scale as concerns the open coordination method for social protection and social integration (see the list in annex), plus national indicators where necessary.

Annex 1.1. Analysis of the social situation

1. A sufficiently high income [1]

Everyone should have a sufficiently high income to be able to fully participate in life in society. The policy's objective is to ensure that people confronted with a social risk can nevertheless maintain their former standard of living sufficiently, thus avoiding poverty.

General inequality of income

The proportion of income **S80/S20** gives a rough indication of the general inequality of income. In 2004 (income for 2003) total income of the richest 20% of the population was four times higher than that of the poorest 20%. This proportion is below the average for EU-25 which is 4.8. Measured by means of this indicator, inequality of income in the EU is the lowest in Slovenia (3.1) and highest in Portugal: 7.2.

Risk of poverty

With a **percentage of the risk of poverty** at 15%, Belgium was about average for the EU-25 (16%)[2]. For the population 16 and over, this percentage is 14% (women 15%, men 13%). The lowest percentage mentioned in the EU is in the Czech Republic (8 %). Slovakia, Ireland and Portugal have the highest percentage (21%). The threshold for the risk of poverty in Belgium, for an isolated person is at € 9,325 per year or € 777 per month (year/12). In terms of an international comparison (expressed in equivalent purchasing power) this threshold is relatively high (seventh among the 25 EU Member States).

An analysis of figures concerning the risk of poverty shows that certain subgroups in society are very exposed to the risk of winding up in the condition of poverty.

[1] Unless specified otherwise, the Belgian figures on the risk of poverty used here are based on the EU-SILC 2004 (reference income: 2003).

[2] Measurements based on the European methodology agreed in common. The threshold for the risk of poverty is equal to 60% of the equivalent median income.

The position on the labour market, both at individual level and at household level, is an important explanatory factor for this. In Belgium, and in comparison with other EU countries, there is also a very large difference in the risk of poverty of those who work (4%), and the unemployed (28%) and other inactive members of the population (27%). The very high risk of poverty for jobless households (households without children: 30%, with children: 70%) gives particular cause for concern.

The importance of a good education to reach a good standard of living is underlined by the fact that people who have at most a lower secondary school degree run a risk of poverty three times higher than those who have a higher education degree (23% versus 7%).

The percentages of the risk of poverty of children (0 to 15) and young adults (16 to 24), respectively 17% and 16%, are very close to those of the population on the whole; however, a certain number of subgroups including single-parent households (36%) and jobless households with children (70%) have a significantly higher risk of poverty.

The elderly (65+) also show a significantly higher risk of poverty (21%). There are no significant differences between women (21%) and men (20%)[3].

Another group at high risk of poverty consists of people of non-European nationality (percentage of risk of poverty about 50%). This is a major challenge from the standpoint of training and integration in the labour market.

The situation of tenants is very precarious. The percentage of risk of poverty is more than twice that of homeowners (27% versus 11%). The considerable rise in rents and the cost of housing in general give particular cause for concern (see below).

There are important differences between the percentages of risk of poverty in the various regions. The figure for the Flemish region (11%) is considerably lower than in the Walloon Region (18%). Despite a lack of accuracy in the assessment done for Brussels, it can be affirmed that the Brussels-Capital Region is where the percentage of the risk of poverty is the highest (27%). The differences between the Flemish and Walloon Regions are found among young people: children, adolescents, young adults and people of working age under 55.

For the intensity of the risk of poverty, as measured by the **mean gap of the risk of poverty**, at 23%, Belgium is close to the average for the EU (22%). The mean gap for the risk of poverty is the gap between the mean income of people at risk of poverty and the poverty threshold, expressed as a percentage of that threshold. Mean intensity of the risk of poverty is higher during working life (16-64): 24% and the lowest for the elderly: 65+: 18% and 75+: 15%.
For children (0-15), the gap is 23%. For the population 16 and older, the mean gap for the risk of poverty is slightly higher for men than for women: 24 versus 21. The gap is comparable in all three regions.

It should be noted that the income situation in certain groups is hard to assess using quantitative indicators. Often, these are people in situations of extreme poverty, such as the homeless and illegal immigrants. At this time, no sets of indicators are available for them. For that matter, by and large these indicators only concern the population in private households.

The standard of living of the elderly

[3] When this text refers to statistical elements, the degree of reliability is 95%.

In the context of the pension policy, it is helpful to have a closer look at the income of retired persons. Pensions must not just prevent poverty among elderly pensioners, they must also allow these people to maintain the standard of living they had during their professional career.

As mentioned above, the **risk of poverty for the elderly** (65 and over) was above the average for the entire population in 2004 (income of 2003). Compared to the younger age group (0-64), the elderly have a risk of poverty 1.5 times higher (21% versus 14%). The risk of poverty of the elderly in Belgium is higher than the European average (18%); Belgium is one of the 15 Member States where senior citizens face a relatively higher risk of poverty than young people. The risk of poverty people over 75 is the same in Belgium for the broader age group 65 and older.

Even if this percentage of persons at poverty risk in the older age group (65+) is higher than for the younger age groups, the intensity of the risk of poverty in this group is the lowest, as, for that matter, in all EU Member States (see above).

The elderly run a risk of poverty, both when they live alone (23% and as a couple (20%). Although significant differences between men and women as concerns the total population cannot be expected, it is clear that isolated elderly women are more affected by the risk of poverty than isolated elderly men (24% versus 19%). In a population of 75 and over, the difference between isolated elderly women and isolated elderly men is still greater (25% versus 16%).

Differences between men and women are confirmed in analyzing administrative data pertaining to persons who are entitled to a guaranteed income for the elderly. The number of women receiving this social allowance, based on a survey on the means of subsistence, is considerably higher than the number of men. In January 2006 there were 48,195 women beneficiaries as compared to 21,894 – more than two thirds of beneficiaries are women.

The differences between men and women in the field of pensions originate in the differences in behaviour on the labour market. Women are often absent from the labour market for long periods of time; they are more likely to work part time and often receive lower salaries.

Significant differences in the level of pensions cannot immediately be detected in the general figures on the risk of poverty of the elderly are due to the fact that the risk of poverty is assessed on the basis of the total income of the household[4]. Combined with other types of income, the low income of a member of a household can contribute to a higher standard of living. It must also be recalled that figures on the risk of poverty only concern the population of private households. The elderly population living in institutions, where women are overrepresented, is not taken into consideration. In 2001, about 6% of the population 65 and over was domiciled in a collective household (8% of women and 3% of men). For the subgroup of 75 and over, the percentage corresponded to 12% (15% women and 6% of men).

Inequality of income in the population of 65 and over, measured by means of a proportional indicator (S80/S20) is lower in Belgium than for the population of younger complementary age groups. On the whole, the richest 20% of elderly persons have an income 3.4 times higher than the poorest 20%. In the population from 0 to 64, this ratio is 4.1. In the European context, Belgium, with its 3.4%, is in an average position. Inequality of income for the elderly is the highest in Portugal: 6.5, and the lowest in Hungary: 2.5.

[4] On measuring poverty, all incomes are added together and then divided in equal parts corresponding to the number of members of the household.

The **mean income ratio,** referring to the ratio between the relevant mean income at 65 and over, to the relevant mean income of younger age groups (0 to 64) is 76 % in Belgium. This is a fairly low figure from the European standpoint. The average for EU-25 is 87%. The lowest ratio was observed in Ireland at 62%, and the highest in Poland at 113%. There is no significant difference between men and women in Belgium.

2. A good job

A good job is a source of income leading to better living conditions, but it can also promote social participation and enable people to fully achieve their potential. Although work significantly reduces the risk of poverty, income from a remunerated job is not always sufficient to keep people out of poverty. A sufficient degree of activity is needed to guarantee viability of the social protection system. To ensure job openings, a strong economic surface is required. The Belgian strategy with regard to economic development and employment is described in the Belgian National Reform Programme.

Rates of activity, employment and redundancy

In the context of an aging society (see below), increasing the rate of activity is important. This indicator, which gives the share of workers and jobless in the population for 15 to 64 years old, measures general participation on the labour market[5]. The Belgian **rate of activity** can be considered low from the European comparative standpoint: 66.7% in 2005 (women: 59.5%, men 73.9%), as compared to European average (EU-25) of 70.2% (women: 62.5%, men 77.8%). For the group at working age (25-54 years old), the rate of activity is comparable to the EU-25 average; for younger and older groups, it is significantly lower. There seems to be a trend to increase the rate of activity from 60.6% in 1992 to 66.7% in 2005.

Raising the rate of activity depends mainly on economic growth. After stable, substantial **real growth of GDP** at the end of the 90s, Belgium experienced a significant slowdown in growth at the beginning of the years 2000. Only in 2004 was a relatively high growth rate recorded (2.6%). After a new period of low growth in the second half of 2004 and the first half of 2005, economic activity should pick up, as in most European countries, to reach growth figures higher than 2% in 2006. The European Commission is expecting a rate of real growth 2.3% for 2006 and 2.1% 2007.

Alongside a slowdown in economic activity, the total volume of the active population has dropped slightly in 2002 (- 0.2%) and in 2003 (- 0.1%), but it rose again in 2004 (+ 0.6%) and in 2005 (+ 0.9%). The **rate of employment** in Belgium was 61.1% in 2005 (women: 53.8%, men's 68.3%) and therefore it is lower than the average for EU-25 which is 63.8% (women: 56.3%, men 71.3%). Like for the rate of activity, differences as compared to the European average are not found in the population from 25 to 54 – with a rate of activity at 78.3%, this is even higher than the European average (77.2%) – but for young people (15 - 24) and the older age groups (55 - 64). With a rate of 27.5%, the rate of activity of young people is sharply lower than the European average of 36.8%. Activity of elder workers (55 - 64) is comparatively lower at 31.8% (EU-25 average: 42.5%). Over a longer period, nevertheless there is a clear trend upwards. In 1992, the rate of activity was still 56.3%. Consequently there has been a rise of five percentage points (ppt). Increase in the rate of activity is mainly for women between 25 and 54 (plus 12 percentage points from 58.1% in 1992 to

[5] Ideally, to see activation in a broader light, an indicators should be developed to take account of socially useful, but unpaid, activities such as volunteer health-care …

70.4% in 2005), and for both sexes in the age group from 55 to 65: from 22.2% in 1992 to 31.8% in 2005 (a women: plus 11 ppt and men plus 8 ppt).

Great efforts will still be needed to reach the European objectives proposed for the rate of activity (70% for the rate of activity for both sexes, 60% for women and 50% for elderly workers). The strategy on this issue is described in the Belgian National Reform Programme[6].

The fact that growing participation of women in the labour market has consequences for informal care in households should be taken into account. There is demand for child care, care for disabled persons or persons suffering from long-term health problems, as well as for elderly persons who need considerable care.

The results of the Survey on the labour force show that **part-time work** is increasing in Belgium. In 1995, 15.4% of employees were working part-time. In 2005, they were 24.1%. Part-time work is also unequally shared by men and women. In 2005, 43.5% of women worked part time, as compared to 8.1% of men.

The **rate of unemployment** in Belgium reached a temporary minimum in 2001 at 6.6%, and then grew to 8.4% in 2005 (women 9.5%, men: 7.6%). The figure for EU-25 is 8.7% (women: 9.8%, men: 7.9%). The European Commission is expecting a drop to about 8% in 2006 and 7.6% in 2007. The significant growth in **unemployment of young people** between 15 and 24 gives cause for concern: from 16.8% in 2001 to 21.5% in 2005. The rise was the highest for men: from 14.5% in 2001 to 21% in 2005. For women there was an increase from 19.5% to 22.1%. Recent figures on unemployment of young people show stabilization or a slight decrease.

It is important to observe that there are not only large differences as concerns the rates of unemployment and activity depending on age and sex, but also between other subgroups in society. From the standpoint of social protection, the low rates of activity and the high rates of unemployment of non-native workers, people with little education and the disabled, are cause for concern.

The rate of activity of people who do not have EU-15 nationality was 26 ppt higher than citizens of EU-15 in 2004 (20 ppt for men and 30 ppt for women). The difference was hardly smaller than in the period 2001-2003, when it reached about 28 ppt. By considering ethnic origin, rather than nationality, the difference seems higher still[7].

The rate of activity of people who have a lower secondary education degree at most was 20 ppt lower than that of the total population in 2004 (17 ppt for men, 23 ppt for women). This figure was 18 ppt in 2002-2003.

In 2002, the rate of activity for persons suffering the disability was about 17 ppt lower than that of the total population (about equal for men and for women).

Long-term unemployment, jobless families, geographic concentration of reduced activity and high unemployment

[6] Under the Belgian National Reform Programme, recent growth in the total rate of activity and in that of women in Belgium is observed to be a little bit faster than the EU average, and growth in the rate of activity of elderly workers is significantly faster.

[7] The distinction between native and non-native populations can be made in different ways. At European level, criteria of nationality and country of birth are used. The Flemish labour office (VDAB) uses a criterion of nationality combined with that of the name and the declarations of the person in question to reach a classification based on ethnic origin. The percentage of ethnic non-Europeans among unemployed jobseekers has been growing for the 1999-2006 period.

The lack of a remunerated job becomes an increasingly serious problem when it is long-term, when no one in the household has a job or when unemployment rates and inactivity show strong geographic concentration.

Long-term unemployment (one year and more) is highly problematical from the standpoint of social integration. What is at stake is not simply the loss of income during a long period of time, but also the fact that long-term unemployment results in a loss of professional skills and can therefore reduce self-respect, which is crucial for finding a job. In 2005, the degree of long-term unemployment reached 4.4% in Belgium, 5% for women and 3.8% for men. That year, the EU-25 average was 3.9% (4.5% for women and 3.5% for men). In Belgium, there seems to be a rising trend, since 2002 when 3.6% of the active population was long-term unemployed. Isolated persons (8%), people holding a lower secondary school degree at most (8%) and particularly single parents (14%) as well as those who do not have EU-25 nationality (20%) show a much higher risk of long-term unemployment. With 6.2%, long-term unemployment is more common for young people from 15 to 24, than for older age groups from 25 to 49 (4.4%) and from 50 to 64 (6.2%).

The standpoint of income of the population in **jobless households** gives particular cause for concern. Living in a jobless household can also have harmful effects on the future performances of children, both in school and in the labour market. The major objective for employment policy can be found here. In Belgium, in 2005, the share of adults (18 to 59) living in a jobless household had reached the highest level of all EU countries, except for one, (14%, 12% for men and 15% for women). The EU-25 average was 10%. 13% of children (up to 17) live in a jobless household (EU average 9.6%). This percentage has remained almost stable over time, despite the increased rate of employment of women (concentration of remunerated work at household level). 69% of the adult population of working age lived in a household without children (31% isolated people, 24% living as couples and 14% living in another type of household), 31% lived in a household with children (13% in a single-family household, 13% as couples, and 6% is another type of household). 56% of children in a jobless household lived in a single-family household.

Geographic concentration of low rates of activity and high rates of unemployment poses a particular problem. Differences as concerns the rate of activity between provinces (NUTS 2 level) are measured by means of a **regional cohesion indicator**: this is the coefficient of variation of degrees of activity[8]. At 8.7 in 2004, this indicator reached the highest level since 1999 when it was measured for the first time. There are large differences between the rates of activity per province and for women (10.7) than for men (7.2). Similarly, in comparing figures in the Regions, major differences are observed in rates of activity and unemployment.

The risk of poverty, even for people who have a job

Although exercising a remunerated job is the most determinant factor in avoiding poverty, having a job does not preclude any risk of poverty. In Belgium,4% of workers (on salary plus self-employed) were confronted with a risk of poverty. Compared with figures recorded in other European countries, this is a good score. The EU-25 average was 9%. Given the amplitude of the group of workers, this means that 14% of people at risk of poverty already have a job. In this case, the risk of poverty may be associated with the duration of the work (part-time work or irregular work), low wages or heavy family expenses. On this question, single-family households, large families and non-EU-25 nationals are vulnerable groups. People working under a contract for a limited duration and, in particular, people working part time, are exposed to an increased risk of poverty.

[8] Definition: standard deviation of rates of employment at NUTS 2 level (in Belgium-provinces) divided by weighted national average..

3. A good education

Access to work, the income situation, health, opportunities for social integration and participation, are all factors associated with the level of education. In a society in which education is increasingly determinant for position on the social scale, those who benefit from a low level of education only are often excluded. Attention has already been drawn to the fact that a low level of education is synonymous with a low rate of employment and increased risk of poverty. Well-educated labour forces are indispensable for economic growth.

Basic education, in particular, is of crucial importance. In 2005, the number of young **school dropouts** (young people between 18 and 24 not enrolled in any educational course and not having finished their secondary school) was 13% in Belgium (girls: 11% and boys: 15%), the EU-25 average was 15% (girls: 13% and boys: 17%). No systematic decreasing trend – the objectives set is to reduce this percentage to 10% -- can be observed on the horizon of 2010. Major differences can be observed in the regions: 11% in Flemish Region, 16% in the Walloon Region and 19% in the Brussels-Capital Region. The survey of the labour force done in 2000 showed that children of parents who hold a degree that does not exceed lower secondary school are exposed to a risk almost 9 times higher of dropping out of school than children whose parents had a higher education.

The **result concerning training of students aged 15** are measured using a method that allows for international comparisons under the OECD **PISA survey.** One of the indicators shows the percentage of students who obtained the lowest score (level 1 or lower on a scale of five levels) in a **reading test**. This low score does not necessarily indicate illiteracy, but it does mean that the person has serious problems when confronted with written information in any learning process based on writing. The students, in all likelihood, are not able to make optimal use of vocational training opportunities offered to them, which endangers their future training or professional path. With 17.8% in 2003, Belgium has a better score than the European average (19.8%). In 2000, the score was 19.0% (for a weighted European average of 19.4%). The relative figure for Belgium clouds differences between the communities (the Flemish Community: 12.4%, French Community: 25.1% and German-speaking Community: 20.1%) and the general averages of the communities in turn cloud an important gap in results (excellent scores alongside very poor scores. Children whose parents have a high social-professional status (upper quartile) on the whole get much higher scores than children whose parents have a low social-professional status (lower quartile). Disparities in scores vary from one community to another, and are also significant for the communities as a whole. A recent study of the OECD, based on the PISA study, showed important gaps in performances between students in view of their status as migrants, native children got significantly better scores than non-native children (first and second generation).

Given the rapid developments within society and the economy, continuing training, after basic training is increasingly important (**lifelong learning**). Since the beginning of the 90s there has been a sharp increase in participation in training courses in Belgium in the lifelong learning context. With a score of 10%, Belgium in 2005 has a place slightly below the EU-25 average (10.8%). Differences between men and women are negligible. As is also the case in other countries, the rate of participation in the lifelong learning process is higher for people who benefit from a high level of education and for those having only a low level of education. (In 2004: 3% of people who had a degree in lower secondary education at most, 16% of people with a higher education degree). Age also constitutes a major factor. Older workers, and generally those with a lower level of education, seem to participate less in training courses.

4. Good health

The possibility of living for a long time in good health constitutes an essential aspect of welfare. Social protection policy must contribute to giving all groups in society access to good health on as equal a basis as possible.

Life expectancy, referring to the age that, at birth, one can hope to reach is one of the most commonly used indicators to give an idea of the general state of health of the population. It is determined by a large number of factors, including general welfare, hygiene of life and the quality of health care. Like in most countries in the EU, life expectancy in Belgium has grown continually over recent decades. In 2004, it reached 82.4 years for women and 72.7 years for men (showing a difference of 6.7 years in favour women). In comparing the figures for 2003 (women 81.7; men 75.9) with those of other EU Member States, it appears that life expectancy in Belgium is relatively high. The best results were observed in Sweden (women: 82.5, men: 77.9), and the worst in Latvia (women: 75.9, men: 65.7).

It is important to verify what part of **life expectancy** takes place in **good health**, so as not to focus exclusively on length of life, but also on quality of life. Life expectancy in good health is also important in the context of "active aging" strategies targeting a longer active life for older persons. Elderly persons in good health can make an important contribution to their family, community in which they live and the economy, either by continuing a professional activity, or by undertaking informal duties such as minding children, people who are ill, the elderly. It has been shown that there is a relation between health, economic growth and social welfare.

Expectations in the field of health have recently been calculated based on data pertaining to mortality from the National Statistical Institute and questions pertaining to the state of health were included in the social-economic survey in 2001.[9] The state of health was assessed based on a question asked to respondents about their subjective state of general health: what is your state of general health? Chronic diseases were observed in the base of the question: do you suffer from one or several long-term diseases, chronic disorders or disabilities?

For women, life expectancy was 81.7 years at birth, life expectancy in good health was 59.5 years and life expectancy without chronic diseases was 63.4 years. For men, life expectancy was 75.4 years, life expectancy in good health was 58 years and life expectancy without chronic diseases was 59.7 years. Consequently women had life expectancy six years longer than men, but their subjective expectations in terms of health only exceeded amends by 1.5 years and they can expect in a 2.9 years longer than men with a chronic disease.

At 65 for women, life expectancy was 20.2 years, life expectancy in good health was seven years and life expectancy without chronic diseases was 10.1 years. For men, in 2001, life expectancy at 65, was 16.2 years, life expectancy in good health was 6.6 years and life expectancy without chronic diseases was 8.6 years.

One may ask the question as to whether an increase in life expectancy as time goes by does not go hand-in-hand with an increase in the number of years spent in poor health (compression, stability or expansion of poor health). This question is also important in establishing relative projections of the cost of aging.

An assessment at three different times (1997, 2001 and 2004), using the Health Survey each time to measure the (subjective) state of health, confirms the compression theory (an increase in life expectancy goes hand-in-hand with the

[9] Van Oyen, H. Bossuyt, N.Bellamammer, L. Deboosere, P. Demarest, S.Lorant, V. Miermans PJ. Composite Health measures in Belgium based on the 2001 census, 32p (unpublished).

compression of years spent with a chronic disease)[10]. During the period 1997-2004, life expectancy for men increased by 1.82 years, whereas the increase in the number of years spent without a chronic disease increased by 3.35 years. For women, life expectancy grew by 1.29 years, and the increase in the number of years spent without chronic disease rose by 2.47 years.

Alternative figures concerning life expectancy in good health, based on the European structural index 'disability-free life expectancy'

The European structural index 'disability-free life expectancy' is available for the 1995-2003 period. The index is calculated on the basis of a survey (ECHP) on restrictions of daily activities due to a disease or handicap[11]. During the period under review, life expectancy at birth grew by 1.5 years for women and disability free life expectancy by 2.8 years. For men, life expectancy rose during that same period by 2.5 years, and disability free life expectancy by 4.1 years. The growth in both indices is therefore higher for men than for women. In 2003, women could expect to spend 84.7% of their lives without disabilities (as compared to 82.8% in 1995), and men 88.8% (versus 86.2% in 1995). In the European context, Belgium had good marks, confirmed by recent trends.

During that same reference period, disability-free life expectancy at 65 seems to be growing for both men and women, but less than their life expectancy (women: life expectancy +0.8, disability-free life expectancy +0.7; men: life expectancy +1.9, disability-free life expectancy +1.3. Here too, growth is recorded for both groups, but it is higher for men than for women.

There are significant differences per region: life expectancy and life expectancy in good health are lower in the Walloon Region and higher in the Flemish Region.

A few years ago, **life expectancy in good health** was calculated **in comparison with the level of education**. Based on a combination of data from the national mortality data bank, monitoring the 1991 census for five years, and a Health Survey in 1997, the conclusion was drawn that persons with a lower level of instruction (no degree or primary education only) not only live shorter lives in Belgium (women: 2.8 years; men 5.2 years), they also live shorter lives in good health (women: 14.5 years; men: 15.5 years) than those who benefited from more education (higher education degree).

The higher the level of instruction, the better access to information concerning health and the people are prepared to put this knowledge into practice. On the other hand, the level of instruction helps determine the position in the labour market and professional satisfaction and therefore, indirectly, the state of health. There is also a clear link between the social-economic position and lifestyle.

In comparison with 12 other EU Member States for which EU-SILC data were collected in 2004, the percentage of persons in Belgium 16 and older who declare that during the last 12 months they **needed a medical examination or treatment but did not receive it** is limited to 1.8%. This percentage is higher for dental care, for which it is nearly 4%. On this point, Belgium is among the best of the Member States. There is no remarkable difference between men and women. The age group between 45 and 54, isolated persons and single-parent families are the most vulnerable, along with the

[10] Van Oyen, H. Cox, B. Trend in disability free life expectancy in Belgium between 1997 and 2004. Reves 2006. 14 p.

[11] ECHP 1995-2001: Are you hampered in your daily activities by any physical or mental health problem, illness or disability? (2002 and 2003 are extrapolations)

jobless, 10% of whom did without medical care and 23% without dental care. As concerns dental examinations and care, there is a clear difference with the level of education: 30% of those who have no degree or only primary education renounced dental care, as compared to a bit more than 10% of persons with a higher education. Among the reasons for not fulfilling needs for medical treatments and examinations, financial reasons dominate (more than 60%). For dental care, financial reasons are also important (45%), but other reasons play a role as well (fear of the dentist, lack of time...)[12].

5. Quality housing

Not everyone has the same facility of access to quality housing at an affordable price. On this subject, we have already referred to the lower income of tenants as compared to homeowners (percentage of risk of poverty in the population living in rented lodgings: 27 %, as compared to 11% for homeowners). Studies have shown a **major rise in the cost of lodging** during the 90s. This phenomenon particularly affects the weakest social categories who rent lodging on the private market and often have to devote a very large share of the family budget to housing[13]. In 2003, 33 % of tenants whose income was below average devoted more than one third of the household budget to paying the rent. This percentage is similar to that observed in previous surveys (2000 and 2001).

Since 1995, the number of **social housing** units, expressed as a percentage of the total number of households, has remained constant. This observation holds for all three regions. In the Flemish Region, the percentage is slightly lower (5%) than in the Walloon Region and in the Brussels-Capital Region (7%). In all three regions, there are very long waiting lists.

As concerns non-EU-25 nationals, **quality of housing** seems less good in many cases. Similarly, the situation with regard to housing of households with children, without a job or exercising a precarious job, seems problematical. More than the population on the whole, this category seems to occupy lodgings that have one or several structural defects, or that lacked room. Generally speaking, weak categories from the social standpoint (single-parent families, unemployed, ill/incapacitated) seem more likely to live in lodgings that have two or more structural defects. Moreover, they are often tenants.

Households in Brussels, much more than households in other regions, are confronted with the problem of lack of room (17 % as compared to 4 % in the others). More Walloon and Brussels households (23 %) occupy housing with a structural defect than do Flemish households (14 %).

Belgium does not have recent statistics on the number of **homeless persons**.

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[12] In the context of the Belgian Health Survey, the assessment of unsatisfied health-care needs is done differently from the EU-SILC. In the EU-SILC, people are questioned individually, whereas for the Health Survey, the reference person answers for the entire household. In the EU-SILC questions are asked about unsatisfied needs for medical or dental examinations and treatment; in the Health Survey the questions pertain to the following aspects of health care: medical care and operations, dental care, prescribed drugs, glasses, mental care (psychological or psychiatric care, for example)… in this context, a household that had to postpone medical consumption is a household that postpones at least one of these five types of care. In the EU-SILC, the question relates to unsatisfied needs for various reasons. In the Health Survey, the only target is care postponed or dropped for financial reasons.

[13] In the absence of an adequate alternative the NAPincl indicator for the cost of housing is calculated on the basis of the survey concerning the household budget, which, given the limited scope and the significant number of invalid answers for this survey, is not an ideal basis for making reliable observations on the evolution of categories at risk.

Annex 1.2. Analysis of performances and sustainability of the system of social protection

Impact of social allowances on the risk of poverty

The system of social protection plays a major role in fighting the risk of poverty. On calculating the percentage of the risk of poverty **after deducting all social transfers from income (including pensions)**, the result is 42%. On deducting all social transfers excluding pensions, the result is 28%. Social transfers (excluding pensions) reduce the risk of poverty by 46%. This percentage is higher than the EU-25 average (which is 38%), knowing that several other Member States, such as Denmark, Sweden and Finland, have a better score (more than 60%). The worst students in the European class (less than 20%) are Greece, Italy and Spain, where expenditures for pensions dominate social expenditures.

The value of allowances

The award of sufficiently high allowances to persons who do not find a job on the labour market is a continual concern for political officials, given budgetary restrictions.

In Belgium, a series of minimum allowances are below the poverty threshold. In 2003, for an isolated person the integration income was 75% of the poverty threshold, the unemployment allowance was 91%, the minimum compensation in case of 100% percent incapacitation at a minimum pension of a worker from the private sector who had worked for a full career was 107%. For a single-family household with two children, the integration income plus family allowances was 91%, for a couple with two children 69%, for a couple without children 67% of the poverty threshold. The minimum wage of an isolated person was at 130% of that threshold. These figures result from calculations done on a national scale. Using the OECD-EU methodology, gives roughly the same figures for the integration income of the following three types of households: isolated persons, single-parent families with two children and couples with two children. For single-parent families, Belgium is more or less on the average of the EU Member States for which this indicator has been calculated. For the other two types of households (isolated and couples with two children), Belgium has a fairly weak score from the international standpoint.

Another indicator verifies to what extent a retired person can maintain his standard of living exclusively on the basis of his pension[14]. **The theoretical net rate of replacement** expresses the pension income during the first year of acceptance for retirement as compared to the net income on the job for the last year before retirement. Calculated for a (male) worker in the private sector who worked for 40 years, and had had an average salary, and who was accepted for retirement at 65 (typical base case), the rate of replacement in 2004 was 63% (first pillar only). Internationally speaking, this is a fairly low rate of replacement.

Projection of the theoretical net rate of replacement of the pension using the methodology of the Indicators subgroup of the European Committee for Social Protection shows how setting up a second pillar can contribute substantially to maintaining an adequate rate of replacement in the long term, subject to the condition

[14] Indicator calculated using the methodology developed by the Indicators Subgroup of the European Committee for Social Protection (standard simulation on the basis of a typical case), see: Current and Prospective Theoretical Pension Replacement Rates. Report by the Indicators Sub-Group (ISG) of the Social Protection Committee. May 19th 2006.

that a sufficiently high contribution is paid during a sufficiently long period. The contribution of 4.5% of net wages for 40 years can contribute to increasing the gross rate of replacement by 10% in the typical case referred to above.

Financial employment and activity traps

Allowances must be sufficiently high, but initially, it is also appropriate to see that the gap maintained with working income is sufficiently large to provide financial compensation for acceptance of a remunerated job.

A series of indicators show to what extent accepting a remunerated job is financially advantageous as compared to replacement income (identifying **"financial traps**"). At European level, this aspect is analysed in relation to the effective rate of marginal taxation which indicates the proportion of the gross wage that is lost to tax[15] when the beneficiary of a replacement income accepts a remunerated job[16]. We propose to look at to two indicators briefly: employment traps and activity traps[17].

The « **employment trap** » indicated compares the income of a person who has just been made redundant after having worked for a salary corresponding to two thirds of the average salary of a worker in an industry with the income of a person who works at that same wage level. In the case of a household with two children, family allowances are also taken into consideration. Four typical households were analyzed. In all four cases, the effective marginal rate of taxation in Belgian in 2004 was higher than 75%. In other words, in a case of acceptance of a job, less than 25% of the gross wage is kept due to the ceasing of the allowances, taxes and social contributions. With 88%, Belgium has the worst score as concerns isolated persons. This means that 88% of gross income is lost to taxes and other contributions and gross income rises by only 12%. Only Denmark has a higher marginal rate of taxation (89%). These figures should be put in context, however. On considering not the first, but the 13th month of unemployment, at 80%, Belgium is closer to the European average, due to the significant regressive rate in Belgian unemployment allowances over time. The employment trap for single-parent household is 79%, for a household with two children where only one of the partners works is 76% and for a household with two children both partners work (initial situation: one partner works and the other accepts a job when he is drawing unemployment benefits), is 77%. For the other typical households, the marginal rate of effective taxation in Belgium is close to or less than the European average. In most countries, the employment trap decreased in the period 2001-2004. In the case of Belgium, the difference between the result of the indicator at the start and at the end of the period given above is small (isolated persons – 1 ppt); household with two children where both partners work – 2 ppt).

The **activity trap** compares the income of the beneficiary of integration income (minimex) with the income of a person who works for a wage corresponding to two thirds of APW. The effective rate of marginal contributions in this case is lower than in the case of the employment trap, as the integration income is lower than unemployment allowances. In Belgium, there is no real difference for a single-parent family (73% as concerns the activity trap versus 79% for the employment trap), but for the other types of households, the difference is significant: isolated persons: 66% versus 88%; household with two children and one working parent: 67% versus 76%;

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[15] The interruption or decrease in allowances, taxes and social contributions are taken into account.

[16] In Belgium, habitually, the relative increase in net income is used as an indicator. This indicator is easier to interpret.

[17] The higher employment trap for the gross wage, which reflects the financial trap that may face a worker who moves from poorly paid work to better paid work, is another type of indicator.

household with two children where both parents work: 45% versus 77%. An analysis also include unemployment allowances in the calculation indicates a relatively relatively large marginal rate of taxation (between + 6% and + 14% depending on the type of household).

These indicators should be interpreted prudently. In this case good scores indicate that accepting remunerated work entails good financial compensation, but countries with the best scores often get them because the integration income or unemployment allowances are very low. There is no need to belabour the point that the position of beneficiaries of replacement income who are unable to find a job is particularly problematic in those countries. Finally, as a partial solution to the employment and inactivity traps, net income from work could be increased by reducing taxes and/or contributions on low wages or by awarding « in work benefits ».

Investment in the social protection system

Belgium **invests** substantially in the **social protection system.** In 2003, 29.7 % of GDP was devoted to social protection (**Esspros definition**) (**total gross expenditures**)[18], which is more than the European average (28 %). The share of expenditures for various social protection functions as compared to GDP was as follows: retirement and survival pensions: 12.6%; illness and health care: 7.6%; unemployment: 3.5%; children/household: 2.2%; incapacitation at work: 1.9%; social exclusion: 0.5%.

The comparison with the situation in other EU Member States indicates that the social protection in Belgium is only based to a limited extent on an inquiry in the means of subsistence (3% of expenditures) and a relatively small percentage on assistance by means of advantages in kind (about 25%). Like most of the other Member States, expenditures expressed as a percentage of GDP peaked in 1993 (Belgium: 29.3%) and then decreased until 2000 (Belgium: 26.8%) and began to grow again. The increase in the last three years (from 2000 to 2003) is significantly higher in Belgium (plus 2.9% of GDP) than the European average (+ 1.1 % GDP). The strong increase is explained above all by share growth in expenditures for the old age and survival function (+ 1.5% GDP) and the illness/health-care function (+ 1.4% GDP) expenditures for unemployment have increased by 0.5% of GDP. Expenditures for social assistance have increased slightly (+ 0.1%), expenditures for children and families have remained stable in terms of percentage of GDP.

Aging and sustainability of a social protection system

Like for the other EU Member States, aging of the population, resulting from the increase in life expectancy and low birth rates, is a problem and a major challenge in Belgium. This question is monitored closely in the annual reports of the Study Committee on Aging.

This Committee bases its calculations on an increase of life expectancy at birth from 81.6 years to 88.9 years in 2050 for women and from 75.1 years to 83.9 years for men[19]. As concerns birth rates, an increase from 1.61 to 1.75 is expected. The

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[18] Excluding administrative costs and other expenditures, this is equivalent to 28.3% of GDP allocated to allowances and services. Studies indicate that total net expenditures for social protection in Belgium (considering direct taxes in allowances on one hand, and fiscal advantages on the other) are slightly lower than the gross amount. See:: Adema, W. and Ladaique, M. (2005) 'Net social Protection Expenditure'. Social Employment and Migration Working Paper n° 29, OECD.

balance of migration is considered to be relatively stable, oscillating around 17,000 to 18,000 for the same period.

The **degree of dependence of the elderly** (population 65 and over as a percentage of the population from 15 to 64) will increase, according to the Study Commission on Aging, from 26% in 2004 to 46% in 2050 (+ 21 percent points, equivalent to + 80 %). In other words, in 2004, about four people were active for one person over 65; in 2050 there will only be two. The anticipated increase is slightly lower than the European average (+ 27 percentage points). Similarly, the level anticipated in 2050 is also lower than the European average (51 %). The share of the category of the elderly over 85, in the category of persons over 65 will increase from 9% in 2004 to 22% in 2050.

Undoubtedly, the evolution of household structure is another important variable. As concerns the average size of households, with 2.24 persons Belgium is close to the European average of 2.5. In the long run, there is clearly a trend towards smaller households. In 1981, the average size of households was still 2.7. The share of isolated people in Belgium is lower than the European average in 2005 (EU-25): 12.5% as compared to 14.6%. An increase in the number of isolated persons is expected. This share of the population living in Belgium in a single-parent family is relatively high: 6.6%.[20] in EU-25, only Great Britain has a higher percentage (8.4 %).

Shrinking households, also due to the increased instability of households (fewer marriages, more divorces), combined with an increase in the rate of activity and employment, particularly of women can be expected to result in a reduction of informal care within families and therefore, will increase the need for facilities to take care of children, disabled persons and the elderly (in residential care (institutions) and home care).

According to the May 2006 report, the Study Committee on Aging, the budgetary cost of aging, defined as the increases from 2005 to 2050 of all the social expenditures of the authorities, expressed as a percentage of GDP, will be 5.8 percentage points. Expenditures for pensions will increase by 3.9 ppt (from 9.1 %), expenditures for acute health care by 2.4 ppt (from 6.2 %) and expenditures for long-term care by 1.3 ppt (from 0.9 %). A decrease in expenditures for unemployment is expected (-1,1 ppt, from 2.2 %), for family allowances (-0.6 ppt, from 1.6 %), incapacitation for work and early retirement (both –0.1 ppt, respectively from 1.2 % and from 0.4 %). Other social expenditures included in the projections of the Commission on Aging (occupational diseases, accidents at work, integration income) will be relatively stable as a percentage of GDP (1.4%). In all, social expenditures (using the concept of the Committee on Aging which is different from that ESSPROS) will increase from 23.1% of GDP in 2005 to 28.8% of GDP in 2050. The measures taken in the context of the Pact between generations, insofar as the Federal Planning Bureau was able to simulate their effects (it was not possible to put all of the measures in figures) should decrease the budgetary cost of aging slightly (-0.1 % of GDP) by 2050.

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[19] See on this subject: *Conseil Supérieur des Finances*. Commission d'Etude du Vieillissement. Rapport annuel. May 2006. 158 p.

[20] Figures.based on the 2005 Survey on the labour force

Difference between the (Belgian) estimate of the Committee on Aging and the (European) estimate of the Working Group on Aging

For a certain number of points, the projection of the Commission on Aging differs from that used by the Working Group on Aging for economic policy (WGA)[21]. The latter estimate is based on a more restricted concept of social expenditures (family allowances, working accidents, occupational diseases and integration income are not included), nor does it take account of the Pact between Generations, so that a direct comparison is not possible. In the WGA projection, expenditures for pensions and unemployment allowances are higher, expenditures for health care (acute care and long-term care) are lower. These gaps can be explained by differences in the hypotheses and the methodology[22].

According to the WGA study, the total cost of aging will increase significantly faster (by 6.3 ppt) than the EU-25 (+3.4 ppt). Public expenditures in the field of pensions and long-term care will increase more in Belgium: pensions: Belgium: + 5.1 ppt – UE25 : +2.2 ppt; long-term care: Belgium: + 1 – UE25: 0.6. On this question, it should be observed that Belgium devotes a smaller share of GDP to pensions than the average in the euro zone or in the EU-25 in 2004. Conversely, expenditures for acute care increase less than the European average (1.4 ppt versus 1.6), expenditures for education (BE : -0.7 – UE25 : -0.6) and for unemployment (B : -0.5 – UE25 : -0.3) fall somewhat more.

The strategy implemented by Belgium is essentially geared to maintaining the possibility of financing the social protection system by gradually reducing public debt as compared to GDP and constituting a demographic reserve fund (the aging fund) which, in the long run, should contribute to supporting the cost of aging of the population. This fund could be drawn on as from 2010 to contribute to financing the cost of aging of the population, or in any case, once the debt has been reduced to 60% of GDP.

This strategy is described in the Belgian National Reform Programme. In recent years, gross public debt has decreased significantly. While it was still 136% of GDP in 1994, it was reduced to 93% of GDP in 2005) the EU-25 average being 63%). The debt reduction strategy foresees a decrease to 75.3% of GDP in 2010 and to 36.1% by 2030. By 2050, the debt should have risen again to 63.5% (programme scenario)[23].

[21] The impact of the aging on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050). Report prepared by the Economic Policy Committee and the European Commission (DG ECFIN). In : European Economy. Special Report n° 1/2006.

[22] For a description, see the report of the Committee on Aging.

[23] See Public Finances in EMU 2006. Long-term sustainability of public finances based on the 2005/06 updates of the stability and convergence programmes. Table I.19. p. 60.

Annex: List of the commonly agreed overarching indicators[24]

	Commonly agreed EU indicator (EU) Commonly agreed national indicators (NAT)[25]	Definition
1a	**EU: At-risk-of-poverty rate** **+ Illustrative threshold value** ***In future consider the possibility to add At-persistent risk of poverty rate***	Share of persons aged 0+ with an equivalized disposable income below 60% of the national equivalized median income[26]. Value of the at-risk-of-poverty threshold (60% median national equivalized income) in PPS for an illustrative household type (e.g., single person household) Source: SILC
1b	**EU: Relative median poverty risk gap**	Difference between the median equivalized income of persons aged 0+ below the at-risk-of poverty threshold and the threshold itself, expressed as a percentage of the at-risk-of poverty threshold.
2	**EU: S80/S20**	Ratio of total income received by the 20% of the country's population with the highest income (top quintile) to that received by the 20% of the country's population with the lowest income (lowest quintile). Income must be understood as equivalized disposable income. Source: SILC
3	**NAT: Healthy life expectancy**	Number of years that a person at birth, at 45, at 65 is still expected to live in a healthy condition (also called disability- free life expectancy). To be interpreted jointly with life expectancy Source: Eurostat

[24] Portfolio of overarching indicators and for the streamlined social inclusion, pensions, and health portfolios. Version adopted at 22 May SPC. June 2006.

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

[26] **Equivalized median income** is defined as the household's total disposable income divided by its "equivalent size", to take account of the size and composition of the household, and is attributed to each household member (including children). Equivalization is made on the basis of the OECD modified scale.

4	**EU: Early school leavers**	Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training attained is 0, 1 or 2 according to the 1997 International Standard Classification of Education – ISCED 97) and have not received education or training in the four weeks preceding the survey. Source: LFS
5	**EU: People living in jobless households**	Proportion of people living in jobless households, expressed as a share of all people in the same age group[27]. This indicator should be analysed in the light of context indicator N°8: jobless households by main household types Source: LFS
6	**NAT: Projected Total Public Social expenditures**	Age-related projections of total public social expenditures (e.g. pensions, health care, long-term care, education and unemployment transfers), current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-20-30-40-50) Specific assumptions agreed in the AWG/EPC. See "The 2005 EPC projections of age-related expenditures (2004-2050) for EU-25: underlying assumptions and projection methodologies" Source: EPC/AWG
7a	**EU: Median relative income of elderly people**	Median equivalized income of people aged 65+ as a ratio of income of people aged 0-64 Source: EU-SILC
7b	**EU: Aggregate replacement ratio**	Median individual pensions of 65-74 relative to median individual earnings of 50-59, excluding other social benefits Source: EU-SILC
8	***Unmet need for care***	*Use, definition and breakdowns yet to be agreed upon once data is available for all countries.* *Source: EU-SILC*
9	**EU: At-risk-of-poverty rate anchored at a fixed moment in time (2005)** ***Possibly replaced or supplemented in future by material deprivation or***	Share of persons aged 0+ with an equivalent disposable income below the at-risk-of-poverty threshold calculated in year 2005 (1st EU-SILC income reference year for all 25 EU countries), up-rated by inflation over the years. Source: SILC

[27] Students aged 18-24 years who live in households composed solely of students are not counted in neither numerator nor denominator

	consistent poverty indicators	
10	**<u>EU</u>: Employment rate of older workers** ***Possibly replaced or supplemented by "average exit age from the labour market" when quality issues are resolved***	Persons in employment in age groups 55 - 59 and 60 – 64 as a proportion of total population in the same age group Source: LFS
11	**<u>EU</u>: In-work poverty risk**	Individuals who are classified as employed[28] (distinguishing between "wage and salary employment plus self-employment" and "wage and salary employment" only) and who are at risk of poverty. This indicator needs to be analysed according to personal, job and household characteristics. It should also be analysed in comparison with the poverty risk faced by the unemployed and the inactive. Source: SILC
12	**<u>EU</u>: Activity rate** ***Possibly replaced or supplemented in future by MWP indicators***	Share of employed and unemployed people in total population of working age 15-64 Source: LFS
13	**<u>NAT:</u> Regional disparities – coefficient of variation of employment rates**	Standard deviation[29] of regional employment rates divided by the weighted national average (age group 15-64 years). (NUTS II) Source: LFS
14	***To be decided following ISG work on health indicators***	

[28] Individuals classified as employed according to the definition of most frequent activity status. The most frequent activity status is defined as the status that individuals declare to have occupied for more than half the number of months in the calendar year.

[29] Standard deviation measures how, on average, the situation in regions differs from the national average. As a complement to the indicator a graph showing max/min/average per country is presented.

<u>Possible alternative measures:</u>

Regional disparities – underperforming regions. *Source LFS*

1. Share of underperforming regions in terms of employment and unemployment (in relation to all regions and to the working age population/labour force) (NUTS II).

2. Differential between average employment/unemployment of the underperforming regions and the national average in relation to the national average of employment/unemployment (NUTS II) Thresholds to be applied: 90% and 150% of the national average rate for employment and unemployment, respectively. (An extra column with the national employment and unemployment rates would be included)

Context information	
	GDP growth
	Employment rate, by sex
	Unemployment rate, by sex, and key age groups
	Long term unemployment rate, by sex and key age groups
	Life expectancy at birth and at 65
	Old age dependency ratio, current and projected
	Distribution of population by household types, including collective households
	Public debt, current and projected, % of GDP
	Social protection expenditure, current, by function, gross and net (ESPROSS)
	Jobless households by main household types (see breakdown of Social Inclusion indicator 1a)
	Making work pay indicators (unemployment trap, inactivity trap (esp. second earner case), low-wage trap.
	Net income of social assistance recipients as a % of the at-risk of poverty threshold for 3 jobless household types .
	At-risk of poverty rate before social transfers (other than pensions), 0-17, 18-64, 65+
	NAT: Change in projected theoretical replacement ratio for base case 2004-2050 accompanied with information on type of pension scheme (DB, DC or NDC), and change in projected public pension expenditure 2004-2050. (These results should systematically be presented collectively in one table).

Annexes to Chapter II

The Social Inclusion Action Plan

1. **Good practices**
2. **Report on the implemention of NAP Inclusion 2003-2005 and its updates for 2005-2006**
3. **All the actions in detail**
4. **List of abbreviations used**

PS: Readers will find an annex on NAP Social Inclusion indicators in a separate document.

Annex Inclusion 1. Good practices

A.2.1. Ensuring affordable, quality housing for everyone: a cross sector experiment for integration of the homeless in the Brussels-Capital region: *Direct access from the street to housing for homeless*

Name of Policy/Project	**Member State**
Direct access from the street to housing for homeless	Belgium - Brussels-Capital Region

End Purpose of the Initiative

The purpose is to promote access to housing for the homeless and to stabilize them there.
Housing is not considered as an end in itself, but as a starting point, a driver for a certain fulfilment, social ties and social integration.

Main Results

For the homeless, this experiment gives access to housing, stability in decent housing, experiments in daily social relations, the use of one's own space and more responsible recourse to social services.

Targeted Beneficiaries		**Policy Focus**	
General Population	☐	Social Exclusion	☒
Children	☐	Healthcare	☐
Single-parent families	☐	Long-term Care	☐
Unemployed	☐	Governance	☐
Older people	☐		
Young People	☒	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☐
Ethnic Minorities	☐	Regional	☒
Homeless	☒		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]	☐		

Context/Background to the Initiative

Living in the street is the culmination of extreme social exclusion and the visible manifestation of serious social problems (not limited to housing problems).
Housing in an institution is only a partial, temporary solution for the homeless. Saturation of shelters, ranging from emergency to medium and long-term, and the lack of decent housing, accessible and financially affordable in the Brussels Region, create a context where every organization focuses increasingly on emergencies. The type of life in an institution is organized by the institution, and leaves little room for the choices and involvement of each person in the organization of his own life. Regular attendance at institutions can in certain cases result in a loss of the landmarks of an independent life, dependence and even chronic need. Relations of force between the institution and users cause breaches in certain situations, which reinforces exclusion and goes counter to the objectives sought.
People who do not or no longer want to live in an institution often have no choice but to live alone in lodgings. This raises the problem of isolation and financial resources needed to cope with the very high rents in Brussels.

Details of the Initiative

1.	**Specific Objectives**
	This type of community housing is - a response to the difficulties of gaining access to housing for financial reasons. - a response to social isolation, which is why individual lodgings often lead to failure of social integration of people coming from the street. This reality encourages these people to make social ties, to find grounds of understanding, to relearn about negotiation, to express their limits, their needs, their agreements and disagreements, to jointly determine the rules of living together - a place for learning and experimenting social ties between generations (adult homeless people and young people receiving aid to youth). - a way of developing living rules between housemates, entailing personal responsibility in community life, an obligation to use a clean space, to deal with different ways of occupying limited space, to envisage a pace of life … - a way of recovering control of their own lives and using social services more responsibly and less dependently.
2.	**How did the initiative address these objectives?**
	This project is the result of a job done by a network active in the homeless sector (shelters and accompanied housing) and the housing sector (Social Real Estate Agency - AIS), who shared their observations of the failure of integration. This is a joint effort between social workers in different sectors. Workers in the homeless sector and accompanied housing take charge of accompanying the potential tenants, while AIS rents the housing units. The social services negotiate with landlords to find a house suitable for the project. In a first stage, the social workers organize and attend meetings between potential residents. 3 to 6 persons live in a housing unit, with a private area and common facilities. They define the rules for cohabitation themselves, with the help of the social workers. They learn to manage the consequences of cohabitation. The only rule is nonviolence and the obligation to take part in meetings requested by one of the tenants. They meet the social workers on their own initiative, and in view of their needs, either individually, or collectively. Collective accompaniment is considered to be the basis of support for cohabitation. The social workers help these people find a solution themselves to the problems they encounter, by teaching them to better use their own resources.
3.	**What is/was the timescale for implementing the initiative?**
	There is no timetable for implementing this project. Its duration depends exclusively on the desires of the tenants and the financial and human resources available to social services.
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	Partners in the project are: - a social real estate agency - an association for accompanied living - a night shelter - an association working in the street - a residential shelter - an association assisting youth Partners meet once a month to assess and do a progress report on the

Outcomes	
1.	**To what extent have the objectives been met?**
	All the objectives have been reached. However, the project of cohabitation with young people from the youth aid service had to be a readjusted in view of the problems encountered.
2.	**What obstacles/risks were faced in implementing the initiative?**
	- legislative norms (the amount of the social integration income associated with the category of co-resident, norms pertaining to living area) - housing shortage for temporary housing - facilities in the housing unit - financial balance and organizational constraints of the partner services - representations of social workers on the capacity of people to live together - defining the procedures for entering and leaving the collective housing - the limits of collective accompaniment - the lack of financial support from the authorities
3.	**How were these obstacles and risks addressed?**
	- special negotiation with the CPAS that award social integration income to persons living in community housing - seeking housing outside the AIS quota and temporary housing - contact to sensitize and negotiate with the authorities (resulting in 2006 in a flat-rate subsidy) - awareness work by social workers via networks, but the difficulty persists)
4.	**Were there any unexpected benefits or weaknesses?**
	- Contrary to the opinion of certain social workers, the potential residents showed a capacity to gain access to housing without going through a straight-line institutional scheme (night shelter, residential shelter, accompanied housing, private housing) - great tolerance and great understanding of comportment or excessive behaviour of housemates - relations between social workers - users lead to a more balanced relational scheme where professional distance serves as a motivation-boosting catalyst and for organizing personal resources. - the rent is divided between several persons, which means that access to housing is possible for low incomes, and avoids discrimination. - the social workers' assessments are confronted and discussed. Professional practices are no longer fragmented; complementarity increases their effectiveness.

A.2.1.2. Developing activation and diversity of employment: managing diversity in the Walloon Region

Name of Policy/Project	**Member State**
Management of diversity	Belgium - Walloon Region
End Purpose of the Initiative	
The objective is to support hiring of persons suffering from discrimination on the labour market due to their origin, gender, disability or age. The "management of diversity" measure also targets stimulating continued growth of corporate social responsibility by increasing visibility and increasing awareness of the social partners.	
Main Results	
The anticipated results are an increase in the number of persons getting a job for those who are the farthest from the labour market résultats.	

Targeted Beneficiaries		Policy Focus	
General Population	☐	Social Exclusion	☒
Children	☐	Healthcare	☐
Single-parent families	☒	Long-term Care	☐
Unemployed	☒	Governance	☐
Older people	☒		
Young People	☐	**Geographical Scope**	
People with disabilities	☒		
Immigrants / Refugees	☒	National	☐
Ethnic Minorities	☒	Regional	☒
Homeless	☐		
Specific Illness/disease	☒	**Implementing Body**	
Other [Please specify:]	☒	WR, FOREM, social partners, Regional employment missions, CPAS	

Context/Background to the Initiative

The cross-sector strategic plan called "creation of activities and jobs" implemented by the Walloon Region integrates a "diversity management" strand. This reinforces other schemes already in place for these groups such as the Professional Transition Programme (Transition professionnelle - PTP), the integrated social-professional scheme (Dispositif intégré d'insertion socioprofessionnelle - DIISP), agreements concluded with various commercial and non-commercial sectors for the integration of foreigners or people of foreign origin, hiring of integration agents by the CPAS to promote the integration of beneficiaries of the social integration income (RIS) and reinforcement of Regional Employment Missions (Missions régionales pour l'emploi) by "job coaching" to promote persons of non-native origin, RIS beneficiaries and single parents.
The BIT study done in 1998 shows, for example, that for equivalent skills, a Belgian of Moroccan origin does not have the same chance to find a job as the "native" Belgian. The idea is to reinforce operational schemes across sectors and to encourage potential employers to use positive discrimination on hiring, by awarding concrete recognition in the form of a label.

Details of the Initiative

1.	**Specific Objectives**
	Developing a set of incentives to benefit the public and private partners involved (company, non-commercial employers, Economic and Social Council, FOREM, CPAS, Missions régionales pour l'emploi, etc) to stimulate hiring of vulnerable groups. Defining a new human resource label for companies when they undertake to hire workers to favour access to employment of vulnerable groups. This label includes 4 criteria: cultural origin, gender (men/women), disability and age. An annual prize will be awarded to an outstanding company in this field.
2.	**How did the initiative address these objectives?**
	Implementing incentives for public and private partners to stimulate hiring of vulnerable groups. Improving awareness of companies about the label by means of a promotional campaign, plus the Walloon "diversity management" award; 4 Walloon companies are being accompanied to the label.
3.	**What is/was the timescale for implementing the initiative?**
	Label 2006: Label created;

	2007: Walloon award and accompanitment of 4 companies to acquire the label; 2008: Extension of the scheme. DIISP, CPAS, reinforcement of the MIRE: implementation in 2006
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	Now being developed.
Outcomes	
1.	**To what extent have the objectives been met?**
	The evaluation will be done subsequently.
2.	**What obstacles/risks were faced in implementing the initiative?**
	The evaluation will be done subsequently.
3.	**How were these obstacles and risks addressed?**
	The evaluation will be done subsequently.
4.	**Were there any unexpected benefits or weaknesses?**
	The evaluation will be done subsequently.

A.2.1.3. Fighting poverty affecting children: example in the French Community

Name of Policy/Project	Member State
Strategic plan on integration of information and communication technologies in schools for mandatory education and social promotion education	French Community of Belgium

End Purpose of the Initiative

The integration of ITC at school in the French Community was initiated to supply educational teams with a teaching aid and to promote equal opportunities by allowing all students to have access.
To correctly fulfil its teaching mission, the educational sector benefits from appropriate, high quality instruments. Traditional tools are essential and should be developed, while modern technologies offer new, complementary perspectives. The idea is to provide educational infrastructures with up-to-date computer adapted to the educational level, to train people to use new technologies and to put quality software at their disposal.

Main Results

Among these objectives, examples of good practices are:
- the ITC passport
- equipping schools with educational computers
- developing an inter-network educational server
- constituting an on-line educational data bank

Targeted Beneficiaries		Policy Focus	
General Population	☐	Social Exclusion	☒
Children	☒	Healthcare	☐
Single-parent families	☐	Long-term Care	☐
Unemployed	☐	Governance	☐
Older people	☐		
Young People	☒	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☐
Ethnic Minorities	☐	Regional	☒
Homeless	☐		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]	☐		
enseignants, directeurs d'école		French Community Walloon Region Brussels-Capital Region	

Context/Background to the Initiative

In July 2002, the Government of the French Community adopted a Strategic Plan for integrating information and communication technologies in schools for mandatory education and social promotion education.
By means of this plan, the Government defines a coherent strategic vision and provides a coordinated approach for future developments in the field of integrating ITC into schools, in both the Walloon and the Brussels Regions.

Details of the Initiative

1.	**Specific Objectives**
	This Plan consists of 48 measures along four guidelines: Facilitating management of schools by the introduction of ITC; Providing equipment to schools and insuring maintenance, Integrating ITC in educational practice,

2.	**How did the initiative address these objectives?**
	On the basis of this plan, 4 good practices have been developed: 1. The ITC passport: The objective of this project is to enable students to acquire computer skills. The ITC passport officializes the skills acquired by students in the computer field, independently of success or failure in school. It is addressed to students in the first half of secondary education and specialized education in the forms 2 and 3. All educational documents for the ITC passport can be downloaded from the site www.enseignement.be/pass. 2. Equipping schools with educational computers: Cyber school and Cyber class plans For the Walloon Region: As part of this cyber schools project, about 18,940 multimedia computers connected to Internet were installed in primary, secondary and social promotion schools in Wallonia in 1998-2000. This equipment plan was the result of a cooperation agreement proposal approved in 1998 by the Governments of the French Community, the German-speaking Community and the Walloon Region. The Region was in charge of making the equipment available and its maintenance for a period of three years, the Communities were in charge of organizing the integration of this equipment in the educational contexts by providing training for teachers, the presence of a resource person in each school and developing an educational server. The equipment could not be used for administrative purposes. In August 2005, a cooperation agreement was signed between the French Community, the German-speaking community and the Walloon Region. This project (2006-2009) targeted replacing and increasing the quantity of computers in schools in the Walloon Region. This was the initiation of the "cyber class" project. The objective of this cooperation agreement is to have the three authorities provide more efficient synergies to improve training in new technologies in schools. The mission of the Walloon Region mainly consists of ensuring the continuity of the previous project, with the objective of gradually renewing the old equipment and increasing the number of computers made available to schools, in order to approach a standard of one computer for 15 students. The project also provided for the installation of a network in the school by making a server available for each school campus and wiring a number of rooms in the school as the size of the school warrants. The Walloon Region is also in charge of maintenance, insurance and assistance in the use of the equipment provided. For their part, the Communities undertake to provide training to staff members in the educational use of ITC, to appoint a resource person in each school, to update and develop educational servers and take charge of costs for the Internet connection. All schools should be equipped by the end of 2009. For the Brussels Region: A first plan for equipment was made in the protocol of agreement concluded between the Minister-President of the Brussels-Capital Region and the Minister-President of the French Community in September 1998, was made for primary and secondary schools in the Brussels Region. The deployment in secondary schools began in 1998 and was completed in 1999. 8 personal computers equip the computer room in schools with a central server, a hub and three printers. A second phase from 1999 to 2001 was used to deploy equipment in primary schools. This consists of four PCs to be put in a computer room with a central server, a hub and a printer. Each school appointed a resource person in charge of first-line maintenance in the school. Each resource person was given the possibility to take a half-day or day course

3.	**What is/was the timescale for implementing the initiative?**
	The strategic plan for the integration of information and communication technologies in schools for mandatory education and social promotion education decided in 2002 has just been assessed. On the basis of this assessment, the plan will be updated and new deadlines will be set.
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	The 48 measures in the strategic plan are given in the form of individualized data sheets. The presentation of each data sheet generally mentions the operational objective that it helps to reach, the administrative and political authority responsible for piloting the operation, the deadlines, and inventory giving the context of the measure; the operational description describes the stages needed to implement the measure concretely and the timetable for implementation plus the budget. An evaluation of this plan has just been done. In order to guarantee objectivity of the evaluation, the General Audit Service of the Ministry of the French Community was asked to do the audit in collaboration with a private company.
Outcomes	
1.	**To what extent have the objectives been met?**
	For the four measures described above: 1. The ITC passport: a pilot project has been set up for the school year 2003-2004. The assessment of this pilot project was very positive, so it will be continued in subsequent years. The ITC passport is evolving continually. More

2.	**What obstacles/risks were faced in implementing the initiative?**
	The risks were relatively low. The problem with ITC lies in a broader social question related to changes in attitudes required by the "Information Society". Schools are the right place for this movement, but the teachers need to be made aware of and to perceive its advantages and implications. At this point, not all teachers are sensitive to ITC and their integration in class practice.
3.	**How were these obstacles and risks addressed?**
	By intensifying awareness work, information and training of target audiences. Several projects contribute to awareness and informing teachers: teacher training, the site enseignement.be that offers a host of information, organization of a conference in ITC, the publication of a decree for approval and financial aid to schools for the acquisition of approved software...
4.	**Were there any unexpected benefits or weaknesses?**
	Not enough time has gone by since the achievement of these measures, so it is hard to answer this question objectively.

A.2.1.4. Measures taken for better governance:

A.2.1.4. a) The integration of field mediators for the poverty and social exclusion issue

Name of Policy/Project	Member State
The integration of field mediators for the poverty and social exclusion issue	Belgium

End Purpose of the Initiative

Three central objectives were defined for this project:
- bringing the viewpoint of people living in poverty within federal public services
- contributing to achieving greater accessibility and services for all, and to the fulfilment of fundamental social rights
- creating a new kind of function within the federal administration

Main Results

In 2004, the Council of Ministers decided to hire field mediators for poverty and social exclusion within the federal administration. The Federal Public Service for social integration was appointed to implement this project for which cofinancing had been awarded by the European social fund.
-initially, two field mediators were hired by the Federal Public Service for social inclusion
-two coordinators were appointed to set up a framework for the project, and to hire, follow, and accompany the field mediators, in collaboration with the field mediators for the federal public service for social integration.
- 16 field mediators (3 with a degree and 15 in training), of whom 8 were Dutch speaking and 8 French-speaking, were hired in September 2005 and seconded to 10 federal public services, including the five Social Security institutions.
- from the French-speaking side, training for field mediators in poverty and social exclusion was set up on the impetus of the European Social Fund in collaboration with the Institut Roger Guilbert. This training course began in October 2005. The first two field mediators were effectively seconded at the end of December 2005 to CAAMI; they began in August 2006 for the Finance federal public service.

Today, the following results have been recorded:
- Under the impetus of the project, more explicit attention can be seen in the services involved for situations experienced and the viewpoint of people living in poverty
- more explicit attention in the services concerned for possibilities of contributing to achieving fundamental social rights
- more explicit attention to recognition of "living expertise" within the federal administration.
The involvement of field mediators in the project is far from easy for them, but it contributes to helping them in their personal and professional development process.

Targeted Beneficiaries		Policy Focus	
General Population	☒	Social Exclusion	☐

Children	☒	Healthcare	☐
Single-parent families	☒	Long-term Care	☐
Unemployed	☒	Governance	☒
Older people	☒		
Young People	☒	**Geographical Scope**	
People with disabilities	☒		
Immigrants / Refugees	☒	National	☒
Ethnic Minorities	☒	Regional	☐
Homeless	☒		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:] People living in poverty and social exclusion	☐		

Context/Background to the Initiative

The main idea underlying the project is the way the various public services can reach "participation" (in the meaning of the General Report on Poverty of 1994) of the people living in poverty in the context of specific missions. The most important context here is the achievement of fundamental social rights.
The project is meant particularly to reflect a certain vision of poverty and the fight against poverty:
- the approach to poverty as a structural problem (meaning a societal approach which is not necessarily geared to support and accompaniment of individuals)
- a participatory approach to the fight against poverty
- correspond to initiatives in active and passive accessibility to administrations
- correspond to the concept of diversity in the federal administration

Details of the Initiative

1.	**Specific Objectives**
	- defining, and then refining the function and assignments of field mediators in each department - developing a financial and legal context for beginning work, and evolving as field mediators within the departments - developing an appropriate context to support the services (coaches and mentors for field mediators, for example) - developing a common context for training and recruiting field mediators - developing and adapting a vision and a reference framework for the project - developing a political and institutional base to continue the project -identifying the added value of the project, in collaboration with the services concerned and the field mediators themselves; as added value must be for the target group of people living in a poverty situation, rather than for the departments involved, or the field mediators themselves, or for the outside world (other administrations, social sector, citizens in general).
2.	**How did the initiative address these objectives?**
	The following stages were decided to reach the objectives described above: - setting up training on the French-speaking side - setting up a specific procedure for recruitment to hire field mediators (call

3.	**What is/was the timescale for implementing the initiative?**
	First phase: preparation (October 2004-August 2005) - hiring in October 2004 of two field mediators in the Federal Public Service for social inclusion - hiring a French-speaking coordinator in April 2005 - applying for and obtaining support from the ESF - agreement with the Regions concerned and training institutes for setting up French language training - hiring a Dutch-speaking coordinator in August 2005. Second phase: recruitment, hiring and seconding field mediators - recruitment and hiring 8 French-speaking field mediators in training - starting French-language training in November 2005 - recruiting and hiring 5 Dutch-speaking mediators in training and 3 graduates - publishing objectives and the framework of the pilot project - introduction of the pilot project in the federal public services involved - starting up and then continuing negotiations with the services involved - setting up a system of community work and individual support with the field mediators - drafting cooperation agreements and actual start-up of seconded positions - agreement with a recognized research institute for evaluation of the project pilot Third phase: monitoring and assessment - intermediary assessment with the help of the auditors (HIVA research institute and ULB), plus the organization of a conference in November 2006

	- follow up per department by means of monthly monitoring interviews (for the first 6 months) then every other month; these interviews are held with the coordinator, the field mediators, the Federal Public Service for social inclusion, the coach and/or mentor for the service in question, and the field mediators themselves. - by means of regular team meetings with all field mediators (French-speaking or Dutch-speaking and occasionally, also exchanges between the two teams). - regular mutual consultation with the training institutes concerned and an assessment of the field mediators as concerns the general follow up + concertation of the two training institutes - a limited accompaniement committee, an ESF steering group and a enlarged accompaniment committee - external audit by HIVA and ULB (intermediate assessment November 2006 and final audit end 2007) - final audit scheduled per service with the field mediators, representatives of the personnel service and with the presidents or general administrators of the services concerned and the Federal Public Service for social inclusion. - regular contacts with external partners involved in the fight against poverty and social exclusion
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	- the project does not include quantifiable objectives. The negotiation process, the hiring of services and the fact that 16 field mediators began effectively is already a first crucial stage. - the process and discussion on the function and content of the field mediators' assignments are intensive and are still central priority for the upcoming period; here we can talk about a qualitative results, which is the fact that more explicit attention is given to the experience and the point of view of people living in poverty and this has resulted from the negotiations and the integration of the field mediators (the difficulties of this stage described below) - in each department, field mediators carry out different assignments; generally they pertain to taking part in individual support and accompaniment (within the social service, a call center, a reception service, a front-line answering service, …) an intervention as concerns the effectiveness of information and communication (folders and brochures, sites web, correspondence, …), taking part in research (for example electing and transposing documents from associations where poor people speak out, taking part in research to reflect the client's point of view -- for example satisfaction surveys, collection of testimony and proposals from users and nonusers, … - collaboration in concrete projects, in training and awareness work of the staff as concerns the problem of poverty and social exclusion …). The assignments vary from one department to another and depend both on the expectations and possibilities of the department, and on the evolution of field mediators and what they propose. As already

Outcomes	
1.	**To what extent have the objectives been met?**
	The project faces resistance on several levels: resistance in departments, in training institutes, from the field mediators themselves, and in view of the context. 1. In the departments, we note the following challenges: - recognition and appreciation of another type of skill and expertise, which is living experience - the difficulty of defining an adequate function description outside the existing frameworks - the difficulties associated with integrating the mediators in the department - expectations set too low or too high (for example the risk of asking too much of a mediator and overestimating his/her capacity for resistance) 2. In the training institutes, making the concept of a field mediator, as developed in Flanders, applicable to the context of the federal administration, where emphasis is determined by the political authorities, is a real challenge; for the training course itself, process-oriented accompaniment and monitoring based on experience is indispensable, this also necessitates planning the resources and supervision. 3. As concerns field mediators, integration in the departments is not easy, particularly since they generally are the first and the only field mediators. In addition, their commitment to the fight against poverty and social exclusion does not stop after working hours. Contributing to support the emancipation process of field mediators also means taking account of the various levels of their living experience of poverty. 4. Resistance from the outside is particularly related to the discussion of methodology concerning the way the viewpoint of the persons living in poverty can be taken on board in these departments, and questions on the legitimacy of the "enlarged personal experience".

2.	**What obstacles/risks were faced in implementing the initiative?**
	- Dialogue is essential, both with field mediators and with the departments, the training institutes, and external experts. - support of the authorities, both at political level and of the management of the departments involved, is a sine qua non condition for setting up, developing and continuing the project. A great deal has been invested in a clear description of the value added of collaborating with field mediators. - a great deal has also been invested in accompaniment of field mediators and the departments. - flexibility, as well as continual reflection among all parties involved given the objectives and the reference framework of the project, and given the function, assignments and support of field mediators, is indispensable.
3.	**How were these obstacles and risks addressed?**
	The intermediate assessment entrusted to the HIVA research Institute and to ULB is expected in the near future.
4.	**Were there any unexpected benefits or weaknesses?**

A.2.1.4. b) <u>The Flemish Action Plan for fighting poverty</u>

Name of Policy/Project	**Member State**
The Flemish Action Plan for fighting poverty	Belgium - Flanders

End Purpose of the Initiative

The Flemish Action Plan for fighting poverty and its updates are implemented thanks to collaboration between the various fields involved in the policy and the participation of people living in poverty and their organizations. The Action Plan pools all efforts made by the various Flemish ministries to fight poverty. Alongside short-term and longer-term measures, the Plan also includes assessment procedures for the policies enacted.

Main Results

The Flemish Action Plan for fighting poverty 2005-2009 is a policy instrument for a coordinated antipoverty policy, that includes:
- participation of the target group, in which associations where poor people can speak out and the Flemish network are involved
- a description of the overall vision of policy on poverty
- the Flemish policy situation with regard to poverty within the federal and European policies
- long-term and short-term objectives defined for each field of action
- concrete activities
- a timetable for implementation
- indicators to measure progress

Targeted Beneficiaries		**Policy Focus**	
General Population	☒	Social Exclusion	☒
Children	☐	Healthcare	☐
Single-parent families	☐	Long-term Care	☐
Unemployed	☐	Governance	☐
Older people	☐		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☐
Ethnic Minorities	☐	Regional	☒
Homeless	☐		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:] People living in poverty	☒		

Context/Background to the Initiative

Since 2001, the Flemish government has established an Action Plan for fighting poverty every year. With the decree of 21 March 2003 on the fight against poverty, the Action Plan now has a structural framework, built around 10 fundamental rights as set down in the General Report on Poverty.
The political vision on which the decree is based begins with the idea that policy on poverty is an inclusive policy. Targeted actions must be undertaken in the various fields and at all levels, based on a partnership between all players concerned. The partnership with people living in poverty is a necessity.
To ensure coordination between the various fields of action, an instrument has been developed in the form of continual horizontal concertation on poverty, organized in a systematic, structural way.

Details of the Initiative

1.	**Specific Objectives**
	A multifaceted action plan, constructed on the basis of 10 fundamental rights:: - the right to participation - the right to social assistance - family rights - right to justice - right to culture - right to income - right to education - right to employment - right to housing - right to health An action plan with a foundation and a stance. This includes at least: - a description of the overall vision of the Flemish policy on poverty - the situation of the Flemish policy on poverty as compared to federal policies and European policies in the field - long-term and short-term objectives for each field of action An action plan that is concrete, that can be monitored and evaluated, and that has the instruments needed, at least including: - concrete activities - the timetable established for implementation - measurement of indicators in progress made - the instruments used The Action Plan is carried out with a Flemish network of associations where people living in poverty can speak out. This is the target group.
2.	**How did the initiative address these objectives?**
	1) Continual horizontal concertation on poverty is concertation between various fields of action. Representatives of different administrations of the Flemish Community take part (officials in charge of poverty policy) The missions for horizontal concertation include: preparing actions in various fields under the Action Plan analyzing the impact and effects of these actions coordinating the actions at various levels to make them correspond determining the operating and concertation conditions hearing proposals for vertical concertation in each field of action assessing the Action Plan 2) The Flemish Network is part of the continual horizontal concertation. This shapes the participation of people living in poverty. 3) The Action Plan project is presented to people living in poverty by means of provincial consultation sessions. Their thoughts and comments are included in the final action plan. 4) Vertical concertation is organized within each field of action. Vertical concertation is intended to confront the specific political initiatives with the vision and experience of the target group and to propose recommendations. 5) A minister coordinating the fight against poverty 6) A poverty team that coordinates everything within the administration
3.	**What is/was the timescale for implementing the initiative?**
	Nine months after its constitution, the Flemish government must establish an

Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	Evaluation of the content: - by annual updating - by continual vertical and horizontal concertation - via consultations per province Evaluation of the process: - by means of the annual report of the continual concertation
Outcomes	
1.	**To what extent have the objectives been met?**
	The implementation of the Flemish plan to fight poverty ascertains that the policy on poverty is inclusive of all fields and levels of action. This requires a change in attitudes. The fight against poverty goes further than simply a question of welfare. It includes all aspects. The Flemish action plan to fight poverty emphasizes this multi-faceted aspect of poverty and tries to respond to it.
2.	**What obstacles/risks were faced in implementing the initiative?**
	1) Before the decree, there was no legal basis for the action plan. 2) To follow up the action plan, a continual evaluation and recommendations can be made at any time. The contribution of people living in poverty and the way to treat it is still a difficult exercise. It is a good thing that the people living in poverty have an opportunity to give their comments on what is included in the action plan. However, one must be attentive that things don't stop there. Something must be done with these observations. If not, their participation makes little sense. 3) Cooperation between officials as members of the continual concertation on one hand, and the fact that the political authorities are leading this process means that constant attention is needed.
3.	**How were these obstacles and risks addressed?**
	- by holding provincial consultations for each update. People are entitled to know what has been done with their contribution. Real participation must go in both directions -- it's a dialogue. - by a broad diffusion of the action plan - by public moments devoted to the poverty policy
4.	**Were there any unexpected benefits or weaknesses?**
	Danger of participation ad hoc, which does not fundamentally contribute much. Participation of people in a situation of poverty is still a difficult exercise.

Annex Inclusion 2. Report on the implementation of the NAP Inclusion 2003-2005 and the update for 2005-2006

To give the various administrations concerned the time to compile the elements needed for the evaluation, it was decided to draft this report subsequently, at the latest by the end of 2006. An evaluation conference based on this report should be organized early 2007.

Annex Inclusion 3. All the actions in detail

The electronic version of this Action Plan gives direct access to a detailed presentation of each measure (description, timing, budget, responsible persons, anticipated impact, schemes for assessment, directly from the text in sections 2.2.1., 2.3.1. and 2.4.1. (policy measures). The data sheets are not included in the paper version, but they can be consulted on site of the federal administration for social integration (http://www.mi-is.be/Diensten-Services/NAP/HTML/FR/NAP2006-2008.asp).

Annex Inclusion 4. List of abbreviations used

AATL	Administration de l'Aménagement du Territoire et du Logement (Région bruxelloise) (Land-use and urban planning administration for the Brussels region)
AIS	Agence Immobilière Sociale (Social Real Estate Agency)
APL	Association de promotion du logement (Association for the promotion of housing)
AWIPH	Agence wallonne pour l'Intégration des personnes handicapées (Walloon Agency for the Integration of the disabled)
AWT	Agence wallonne des Télécommunications (Walloon Telecommunications Agency)
CCC	Commission Communautaire Commune (Bruxelles) (Joint Community Committee – Brussels)
CEC	Centre pour l'Egalité des Chances et la Lutte contre le Racisme (Centre for Equal Opportunity and the Fight against Racism)
CESRW	Conseil Economique et Social de la Région Wallonne (Economic and Social Council for the Walloon Region)
CFWB	Communauté Française Wallonie Bruxelles (French Community Wallonia Brussels)
CG	Communauté Germanophone (German-speaking Community)
CPAS	Centre Public d'Action Sociale (Public Social Action Centre)
CTPTE	Cellule Transversale du Pacte Territorial pour l'Emploi (Bruxelles)(Cross-sector Cell of the Territorial Employment Pact) (Brussels)
DIIS	Direction interdépartementale de l'Intégration sociale (Région wallonne) (Interdepartmental Social Integration Department) (Walloon Region)
DIS	Droit à l'Intégration Sociale (Right to Social Integration)
EFT	Entreprise de Formation par le Travail (On-the-job Training enterprise)
FLW	Fonds du Logement wallon (Walloon Housing Fund)
FOREM	Office wallon de la Formation professionnelle et de l'Emploi (Walloon Office for Vocational Training and Employments
FSE (ESF)	Fonds Social Européen (European Social Fund)
IFAPME	Institut wallon de formation en alternance et des indépendants et des petites et moyennes entreprises (Walloon Institute for alternating vocational training, self-employed persons and small-business)
KDW	Kenniscentrum voor een Duurzame Woonbeleid (Centre de connaissance pour une Politique durable de l'Habitat) (Centre of expertise for a sustainable housing policy
MET	Ministère wallon de l'équipement et des transports (Walloon Ministry for Public Facilities and Transport
MRW	Ministère de la Région wallonne (Ministry of the Walloon Region)
NARA	Netwerk van Administraties / Réseau des Administrations (Administration network)
OISP	Organisme d'Insertion Socio-Professionnelle (Région wallonne) (Social-Professional Insertion Organization)
OMT	Observatoire du Marché du Travail (Bruxelles) (Labour market Observatory) (Brussels)
ORBEM	Office Régional Bruxellois pour l'Emploi (Brussels Regional Employment Office)
PGV	Service Politique des Grandes Villes du SPP IS (Large Town Policy Department of the Federal Public Service for Social Inclusion)
Plan HP	Plan Habitat Permanent (dans les zones de loisirs) (Région wallonne) (Permanent Habitat Plan - for leisure areas) (Walloon Region)
RBC	Région de Bruxelles-Capitale (Brussels-Capital Region)
RGP	Rapport Général sur la Pauvreté (General Report on Poverty)

SLRB	Société du Logement de la Région Bruxelloise (Brussels Region) Housing Society
SPP IS	Service Public de Programmation Intégration Sociale (Public Service for Programming Social Integration)
SWL	Société wallonne du logement (Walloon Housing Society)
VGC	Commission communautaire flamande (Bruxelles) (Flemish Community Committee) (Brussels)

Annex to Chapter III

National Strategic Report on pensions

A few common indicators and data in the context of the three common objectives in the Pension strategy field

3.1.1. Strategic objective g)

- **The standard of living at retirement. Theoretical rate of replacement**

It is possible to establish the extent to which pension benefits are financially sufficient, at the time of the passage from economic activity to the first year of retirement, by calculating the **theoretical net rate of replacement** for a set of typical cases defined by the Indicators subgroup of the EU Social Protection Committee. These typical cases refer exclusively to an isolated man who constituted his pension in the scheme for workers on salary exclusively, completed by a second pillar pension. An exhaustive description of the working hypotheses and explanation of the results of these calculations is given in the Belgian National Report on Pensions 2005.

The main results of these calculations are given in the table below. For the typical base case, in which an employee in the private sector with a 40-year career and an annual average salary retires at 65, the net rate of replacement for the first pension pillar only is 63%. In comparison with the values obtained for other Member States of the EU, this rate is relatively low for the basic typical case. For retired persons whose career is characterized by lower income rates (two thirds of the average remuneration), the net rate of replacement for the first pillar in 2004 is just a little bit higher at 64%.

For retired persons whose wage profile rises over 40 years of career, the theoretical net rate of replacement for the first pillar in 2004 is less high: respectively 55% (income evolving from 80% to 120% of average wages during the 40 years of career) and 44% (income evolving from 100% to 200% of average wage during 40 years of career). These lower rates are mainly due to a mechanism of wage ceilings, which mean that any remuneration exceeding the ceiling does not generate additional pension rights.

The table below shows that, for the period 2004-2050, the theoretical net rate of replacement for the typical basic case increases by about 6 percentage points. The second pillar pension with a premium of 4.45% of income for the entire 40 years of career contributes substantially to maintaining a satisfactory rate of replacement in the long run. For the typical basic case, the total gross rate of replacement for the period 2004-2050 increases by about four percentage points. This evolution is the result of a decrease of the gross rate by about two percentage points for the first pillar, largely compensated by an increase of six percentage points of the gross rate for the second pillar.

The net total rate of replacement increases by about six percentage points for the period 2004-2050.

Theoretical rate of replacement for an isolated person on salary with a 40 year career.

	Basic type: 100% of average wage:				2/3 of average wage		Increase from 80% to 120% of average wage		Increase from 100 to 200% of average wage	
	2004	2010	2030	2050	2004	2050	2004	2050	2004	2050
Gross rate of replacement first pillar	39.23	40.6	38.16	36.99	43.24	42.24	33.46	31.49	26.96	22.49
Gross rate of replacement second pillar	3.64	5.4	10.19	9.59	0.86	2.26	3.46	7.97	3.37	7.15
Gross rate of replacement total first and second pillar	42.87	46	48.35	46.58	44.09	44.5	36.92	39.45	30.33	29.65
Net total rate of replacement	67.29	71.92	76.41	73.75	65.28	65.57	59.86	65.14	49.88	51.97
Net rate of replacement if first pillar of only	62.81	64.86	63.54	61.47	64.09	62.44	55.31	54.26	43.86	39.63

Source**: Federal Public Service Social Security.**

3.1.2. Strategic objective h)

- **Financial sustainability of pensions**

The Study Committee on Aging evaluates an update of the budgetary costs of aging in the annual report for 2006. However, all of the measures of the Solidarity Pact between Generations have not been taken into account in the most recent estimates.

The table shows below the budgetary cost of aging for the period 2005-2050 estimated at 5.8% of GDP. The cost of pensions for this period is estimated at 3.9% of GDP. For the period 2005-2011 the budgetary cost of aging is assessed at a relatively small amount: 0.4% of GDP.

Budgetary cost of aging 2005-2050 (*)

Components	Budgetary cost as a % of GDP				Relative modifications in %		
	2005	2011	2030	2050	2005 - 2011	2005 - 2030	2005 - 2050
Pensions	9.1	9.0	12.0	13.0	-0.0	2.9	3.9
- salary scheme	*(5.1)*	*(5.1)*	*(7.3)*	*(7.9)*	*(0.0)*	*(2.2)*	*(2.8)*
- self-employed scheme	*(0.7)*	*(0.7)*	*(0.7)*	*(0.7)*	*(-0.0)*	*(-0.0)*	*(-0.0)*
- public sector	*(3.3)*	*(3.1)*	*(4.1)*	*(4.5)*	*(-0.1)*	*(0.8)*	*(1.2)*
Health care and long-term care	7.1	7.9	9.5	10.8	0.9	2.4	3.7
- "acute" care	(6.2)	*(6.8)*	(8.0)	*(8.6)*	-	*(1.8)*	(*2.4*)
- "long term" care	(0.9)	*(1.1)*	(1.5)	*(2.2*)	-	*(0.6)*	*(1.3)*
Incapacitation for work	1.2	1.2	1.2	1.1	0.0	-0.0	-0.1
Unemployment benefits	2.2	2.1	1.3	1.2	-0.2	-1.0	-1.1
Early retirement pensions	0.4	0.4	0.3	0.3	-0.0	-0.1	-0.1
Family allowances	1.6	1.5	1.2	1.1	-0.2	-0.4	-0.6
Other social expenditures	1.4	1.4	1.4	1.4	-0.0	-0.0	-0.0
Total	**23.1**	**23.4**	**26.8**	**28.8**	**0.4**	**3.8**	**5.8**

(*) Study Committee on Aging
Rapport 2006.

In the medium term, 2005-2011, the budgetary cost of aging, as compared to the estimation published in the Committee's annual report for 2005 is about 0.2 percentage points higher on taking account of the measures of the Solitary Pact between generations, about half of which is in the "pensions" branch. In the following period (2011-2030), the measures of the Solidarity pact between generations taken into consideration have a positive effect on expenditures: the budgetary cost of aging is lower this time.

The projections of the Aging Working Group (AWG) in the spring of 2006 differ substantially for Belgium from the estimates of the Study Committee on Aging presented above. The AWG projections show a sharper rise in expenditures for pensions as a percentage of GDP. This must be attributed to the greater rise in the rate of dependency. The additional expenditures for pensions in the AWG projections are due to the fact that the older population is significantly larger than in the Study Committee projections. This difference is not really the consequence of other hypotheses, such as the difference in life expectancy – it is explained above all by a higher balance of migration at the beginning of the period characterized by a much older age structure.

3.1.3 Strategic objective i)

Modern society needs adapted pension systems

In recent years, women have entered the labour market in very large numbers. However, significant differences between men and women as concerns the career can be observed: women work part time more often and take more career breaks. Consequently, men more often have a longer career with fewer assimilated periods. Men working for a salary who are now retiring (between 60 and 65 years old) on the average can show a career of 37 years at age 58 (35 years of employment and two years of assimilation), whereas women on the average show 34 years of career (26 years of employment and eight years of assimilation). The consequence of both of these is that women are taken into consideration must each less often in pension systems that are strongly based on the conditions of the career.

A survey on the labour force done by the Federal Public Service Economy - Statistics Department, the results of which are given in the table below for the period 1995-2005, shows that about 42.6% are women worked part time as compared to 7.8% of men.

Evolution in time of part-time workers (1995-2005)

	Rate of part-time employment (in %)		
Year	**Men**	**Women**	**Total**
1995	3.1	33.4	15.4
2000	5.4	39.3	20.0
2002	5.6	39.5	20.3
2005	7.8	42.6	23.4

Source: Federal public service Economy –Statistics Department; Eurostat, Survey on the labour force.

Annexes to Chapter IV

Health care and long-term care

Annexes 4.1. Descriptive details

Annex 4.1.1 Breakdown of competence in the field of health

Belgium is a Federal State where three types of authorities coexist, each with its own fields of competence: the federal government and the local authorities (the Communities and Regions). In the field of health, the authorities share competence as follows:

A) The competence of the federal government

In the field of health, the Federal Government is competent for the policy for dispensing health-care in health institutions, and outside of them in the following fields:

a) legislation organizing the field (example: the law on hospitals, ...) ;
b) financing their operation, when they are organized by framework legislation (***budgets for the financial resources of hospitals***)[30];
c) ***mandatory health insurance*** (a branch of Social Security) ;
d) setting the basic rules concerning planning;
e) setting the basic rules in financing the infrastructure, including expensive medical equipment;
f) setting national standards of approval, exclusively insofar as they can have an effect on the competence referred to under b), c), d) and e) hereabove;
g) determining the conditions and the appointments of university hospitals in compliance with the legislation on hospitals.

The Belgian Federal State is also competent for fields pertaining to medicinal drugs, medical devices and the trade in certain substances (narcotics, tissues, hormones). Similarly, exercise of healing arts, in the broad sense of the word, and urgent medical aid also fall under the competence of the Federal Government.

Note that the competence of the Federal Government in the field of health is exercised via the Ministry of Public Health and the Ministry of Social Affairs, and by administrative bodies which include the Federal Public Service (FPS) for Social Security, Safety of the Food Chain and the Environment.

B) Competence of the Communities and Regions

The French, Flemish and German-speaking Communities (and the Joint Community Committee for the bilingual institutions located in the territory of the Brussels-Capital Region) are competent for « individualizable matters », both in the field of health policy and that of aid to persons. As concerns health policy, they are competent:

- for the policy for dispensing health-care in and outside of health care institutions, except for that which falls under federal authority as listed above;
- for promotion of health, preventive medical activities and services, except for national prophylactic measures.

[30] Programmed, recognized hospitals are awarded a budget of financial resources. This budget is set annually by the federal authority and constitutes a contribution to the costs associated with residential patients and patient care. In substance, the budget covers part of the investment costs, the cost of room and board in hospital and medical costs. Finally, an important point is that financing has also evolved from structural financing to financing by activity.

Since 1 January 1994, the Walloon region and the French Community Committee, the former in the French-speaking Region and the latter on the bilingual territory of Brussels-Capital, exercise the competence of the French Community in health policy with the exception notably of:

- university hospitals;
- assignments entrusted to the *Office de la naissance et de l'enfance* (ONE - Office of childbirth and childhood) ;
- promotion of health;
- the preventive activities and services;
- medical inspection in schools.

The competence of the local authorities enable them to define and carry out a « policy for dispensing health-care ». It also enables them to:

- set the conditions for approving nursing homes for the elderly, health-care coordination centres and home care, « *maisons médicales* » (integrated health associations), mental health services;
- support, encourage and subsidize those institutions;
- approve general and psychiatric hospitals in compliance with federal standards of approval;
- approve convalescent and nursing homes (MRS), institutions for psychiatric care (MSP), and protected housing for psychiatric patients (HP) in compliance with federal standards of approval;
- apply the basic rules on planning of hospitals, MRS, MSP and HP.

C) Collaboration between the federal government and the local authorities

As a consequence of the federalization of the country, responsibilities in the field of health were broken down among the various levels of authority. To ensure better coordination, particularly between preventive and curative policy, while maintaining the responsibility of each authority for its fields of competence, ***« collaboration agreements »*** have been concluded in many fields, such as policy on drugs, vaccination, and early detection of breast cancer. For example, as concerns vaccination policy, responsibilities are broken down as follows:

- the scientific aspects are discussed in the Higher Council for Hygiene, created at federal level;
- the federal authority manages legally mandatory vaccination, limited to vaccination for poliomyelitis;
- the Communities manage the so-called "non-mandatory" but recommended vaccinations, the organizations for prevention and the circuits for ordering and distributing vaccines to all vaccinating bodies.

Annex 4.1.2. The mandatory health insurance scheme

This annex gives a presentation that summarizes the major components of the **"mandatory health insurance scheme"** in slightly greater detail. This is an integral part of the Belgian Social Security system for which the Federal Government is competent, as mentioned above.

Mandatory health care is based on the principle of ***« social concertation »***. The health-care providers, financiers and mutual societies handling the insurance are present in the various bodies involved in the management and execution of the insurance scheme.

A) Organization, financing and budget of the mandatory health insurance scheme

As a branch of Social Security, the mandatory health insurance scheme is included in the mechanism of global management of Social Security.

In this system of global financing, the *Office National de Sécurité Sociale* (***ONSS - National Social Security Office***) for the employees' scheme and the *Institut National d'Assurances Sociales pour Travailleurs Indépendants* ***(INASTI-***National Social Institute for Self-Employed Workers***)*** for the self-employed play a central role: they pool Social Security resources[31] and then split them up among the various management bodies of the different branches of Social Security in terms of their needs. As concerns health care, this is the Institut national d'assurance maladie-invalidité (***INAMI -*** National Institute for health-incapacitation insurance).

In addition to the financial resources that are allocated in the context of global management of Social Security, health insurance also benefits from other resources (about 19%), consisting on one hand of its own alternative financing (VAT and excise receipts), intended mainly to finance maintenance in hospitals, and specific receipts such as personal contributions due by certain categories of insured parties, an amount of 3.55% withheld on pensions, income from certain insurance contracts (motor vehicle, hospitalization,…), income allocated to the social reintegration of disabled persons, income from a contribution based on sales of reimbursable medicines sold on the Belgian market,...

The health insurance budget is developed within INAMI, a public establishment with legal personality in charge of executing and controlling the mandatory health insurance scheme. To cope with the growing expenditures in health care, a standard has been developed for the budget allocated to health care: it is currently 4.5% per year in real terms.

The budget procedure can be summarized as follows:

- The Conventions and Agreements Committees, consisting of representatives of health-care providers and insurance organizations, determine the needs for their sector (biology, radiology, pharmacy, surgery, ...). They consult the corresponding technical advisory boards that suggest changes in the nomenclature in their field (introduction or elimination of reimbursed services). They establish a projection of the amount of expenditures based on extrapolations of average consumption over the last 4 or 5 years, taking account of the evolution of the price index, changes in nomenclature, evolution of the structure of the population.

[31] These resources come mainly from social contribution on wages paid by employers and workers, for the employee scheme, and for the self-employed workers scheme, from social contributions based on their income. Other budget resources for Social Security consist of State subsidies and receipts from alternative financing (consisting of a percentage of VAT receipts, a portion of receipts from excise taxes on tobacco and property tax, the income from taxation advantages associated with granting share options …)

- The Insurance Committee – consisting of an equal number of representatives of insurance organizations and health-care providers, plus representatives of employers and workers with advisory status – makes an explicit assessment of all needs expressed and clearly defines the criteria on the basis of which priorities are determined. It examines all of the proposals and makes a global proposal for a budget and an equitable breakdown of expenses among the various sectors of health-care insurance. This proposal is transmitted to the General Council and to the Budget Control Committee.
- The General Council, which includes the various financiers for the system (supervisory authorities, workers and employers) and insurance organizations, sets the global budget, with the help of the proposal from the Insurance Committee and the opinion of the Budget Control Committee. If the General Council does not improve the proposals made by the Insurance Committee, it so informs the Minister. The Council of Ministers can then set the amount of the overall annual objective and the global budgets, on a proposal of the Minister of Social Affairs.

B) Who is covered?

Health insurance covers workers on salary, the self-employed, workers in the public sector, unemployed persons, pensioners, welfare recipients, disabled persons, students, residents, etc., as well as their dependents who meet the conditions for cover (mainly concerning income): spouses, live-in partners, children, ...

Under these circumstances, it can be affirmed that essentially the entire population residing in Belgium has access to health care under the mandatory insurance scheme.

A person who enrols with an insurance organization in one of the capacities stipulated in legislation on mandatory health insurance is immediately entitled to an intervention in the cost of healthcare, as from the time that enrolment takes effect. If the enrolment is considered as a re-enrolment, a six-month waiting period is imposed where applicable before the right to an intervention is opened for this new enrolment.

Every beneficiary must meet certain conditions, however, to open the (annual) right to insurance benefits:

- enrolling with an insurance organization: the choice of the insurance organization is unrestricted except for the statutory personnel of the Belgian railways;
- having paid minimum contributions when they are required (for certain categories of the population such as welfare recipients, this contribution is nil), or being entitled in another capacity (example: dependent person);

C) What is the extent of the cover?

At this time, cover of employees (and assimilated) is different from that of self-employed workers. Employees are covered[32] both for "minor risks" for health (consulting general practitioners and specialists, physical therapy, supply of medicinal drugs, dental care, minor surgery, protheses, orthopedics, ambulatory physical therapy and ambulatory nursing care, etc.) and for ***« major risks »*** (mainly hospitalization, as well as major surgery, specific technical services and specific treatments of certain diseases such as cancer, tuberculosis, mental illness, congenital diseases and malformation, etc.), self-employed workers in principle are covered only for the latter. If they want cover for minor risks, they can subscribe to a complimentary insurance policy with a mutual society on paying specific contributions.

[32] In all, the scheme for workers on salary includes 26 categories of reimbursable health services.

However, the government has decided to extend cover of the minor risks to self-employed workers, partially as from 1 July 2006, and completely as from 1 July 2008[33] .

D) How are reimbursable services determined?

Reimbursable health services are determined and their price is set by INAMI, in a concerted way with the various stakeholders (insurance organizations, representatives of health-care professionals, etc.). The medical and paramedical services carried out in a hospital or ambulatory practice and medical drugs which benefit from reimbursement by the health insurance are determined by a royal or ministerial decree after consulting the Insurance Committee and certain other bodies in INAMI including the health-care providers in question and the insurance organizations. Similarly, a whole series of convention or agreement committees including insurance organizations and representatives of the service providers concerned (example: national medical-mutual society committee, including doctors, a committee for medical suppliers-insurance organizations,...) negotiate the price of services in the framework of the budget.

E) What is the intervention of the insurance in the cost of health services?

The health-care insurance does not supply health services, it simply grants a financial intervention in the cost of care. All (totally or partially) reimbursable health-care services are listed in a ***« nomenclature »*** of health-care services. This list contains the relative value of the care as well as any specific rules of application, criteria of competence of the care providers, etc. A similar list also exists for pharmaceutical specialties for which a reimbursement is granted.

The value of the intervention of the insurance in the cost of health services varies in principle with the type of service and the status of the beneficiary. In principle, the share borne by the beneficiary personally, referred to as ***« ticket modérateur »*** is 25%, but, depending on the type of services, it can be higher or lower.

Pharmaceutical specialties are broken down into five reimbursement categories in terms of their social and therapeutic utility. For each category, the portion borne personally by the beneficiary is set, and it varies between 0% and 80%. In case of hospitalization, a hospitalized patient only pays a daily flat rate of 0.62 EUR for his medicines[34].

In addition, to improve accessibility of healthcare, various mechanisms exist to "lighten" the personal contribution of certain patients:

- ***« Bénéfice de l'Intervention Majorée »*** (BIM - Increased Intervention Benefit): this is a preferential scheme that grants higher reimbursements of health-care services for certain categories of persons listed exhaustively by law and to persons in a specific social situation (examples: incapacitated, pensioner, disabled, …) whose income does not exceed a certain amount (€ 13,246.34 per year) plus € 2,452.25 per dependent, amounts on 01/08/2005) or who, because of their social situation, are considered as meeting the income conditions. This increased intervention is valid both for medical and paramedical health services and for medicinal drugs.

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[33] In fact, as of 1 July 2006, this will be the case for needy pensioners (beneficiaries of GRAPA) and for persons beginning a self-employed activity for the first time as their main professional activity as from 30 June 2006. Beginning 1 January 2008, this will be the case for all self-employed persons.

[34] Note that this amount covers only reimbursable specialties. The cost of non-reimbursable medicines is borne by the patient.

- The « ***Maximum charge »*** (MAF)**:** This is a mechanism whose objective is to give each family the certainty that it will not have to spend more than a given amount for reimbursable, and necessary health care[35]. This maximum amount varies with the family income. There are two types of maximum charges:
  - The *« maximum social charge»* is granted to families who have actually paid € 450 in personal contributions and have a member who benefits from increased insurance or who is entitled to an allowance for disabled persons. Once the ceiling of € 450 has been reached, the personal contribution (ticket modérateur) for the rest of the year will be equal to zero. The insurance organizations are responsible for implementing the maximum social charge.
  - The *« maximum income charge »* is valid for all families[36] and also provides for reimbursement when the family has paid personal contributions higher than a reference amount applicable in view of their annual net income[37].

  Note the special situation of a child under 19. A child who is under 19 on 1 January of the year for which the MAF is granted and who has borne the cost of « tickets modérateurs » for an amount of € 650 can benefit personally from the MAF.
- Creation of a ***« global medical file »*** (GMF) The global medical file is a functional, selective set of pertinent medical, social and administrative data concerning a patient, that are processed manually or by computer. The purpose is to optimize the quality of care given and to avoid overlapping of medical acts and contradictory prescriptions. The family doctor - who manages the GMF – transmits, with the consent of the patient, all necessary and helpful data to colleagues, general practitioners and specialists, who are treating the patient in question; this improves communication with other health service providers. Since 1 May 2002, any person who wishes to establish a global medical file can benefit from a reduction of 30% of the amount of his personal contribution to health care costs (ticket modérateur) if he consults his family doctor.

F) How do insured parties obtain reimbursement of care?

There are two simultaneous means of intervention of the insurance scheme:

- The rule is ***« reimbursement a posteriori »*** : The patient pays the health service provider of his choice, who gives the patient a certificate mentioning the type of service. The patient then submits the certificate to his insurance organization to get a reimbursement.
- The derogation to the rule is the ***« third-party payer »***: the third-party payer system is mandatory for hospitalized patients and clinical biology. The hospital sends the patient an invoice showing the total cost of care received, but the patient does not pay this entire cost: the patient only pays the amount corresponding to his personal contribution, (ticket modérateur) plus any supplements. The hospital

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[35] The costs targeted for setting the maximum to be invoiced are personal contributions (tickets modérateurs) for doctors' fees, nursing care, fees of paramedics and for the costs of technical services (medical imagery, surgical operations, laboratory examinations, …), indispensable medicines (specialties in categories A, B and C) and hospital expenses (personal contribution in the cost of a day's room and board).

[36] The family taken into consideration for the calculation of income for the "maximum charge" consists of the members of the family as registered in the national registry.

[37] http://www.riziv.fgov.be/secure/fr/maf/

also sends an invoice to the patient's insurance organization -- that organization will pay the hospital directly for the amount corresponding to the intervention of the insurance. A similar system is applicable for medicines: the patient goes to a pharmacy to purchase reimbursable medicines prescribed by his doctor and pays only a part of the total price of the medicine (which corresponds to his personal contribution)[38]. The application of the third-party payer scheme in the ambulatory sector is also possible but under certain conditions and to the benefit of certain categories of the population.

[38] Insofar as the patient presents his SIS card or the pharmacist has his « mutual society data ». Note that the third party payer system is difficult or even impossible for a foreign injured person presenting a CEAM, because the pharmacist does not have the data needed to apply the scheme.

Annex 4.2. Examples of « Good Practice »

4.2.1. The « Maximum charge » as an instrument in showing better financial accessibility of health care

Name of Policy/Project	Member State
Maximum à facturer (Maximum charge)	Belgium

End Purpose of the Initiative

Ensuring better financial accessibility of health-care

Main Results

Annex bis 4.2.1. for 2002 - 2005 gives an idea of the number of families and persons who obtain reimbursement in application of the maximum charge.

The data are broken down by field of application of the maximum charge.

The data for 2005 are still incomplete.

Targeted Beneficiaries		Policy Focus	
General Population	☒	Social Exclusion	☐
Children	☐	Healthcare	☒
Single-parent families	☐	Long-term Care	☐
Unemployed	☐	Governance	☐
Older people	☐		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☒
Ethnic Minorities	☐	Regional	☐
Homeless	☐		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]	☐	Institut national d'assurance maladie-invalidité (National Institute for illness-incapacitation insurance	

Context/Background to the Initiative

The maximum charge was introduced further to the observation that despite existing measures to ensure easier financial access to health care, protection was still insufficient for families confronted repeatedly or continuously with health-care costs.

Details of the Initiative

1.	**Specific Objectives**
	Setting a ceiling on personal contributions to the cost of health care of households, in view of their income.
2.	**How did the initiative address these objectives?**
	Mandatory health care insurance intervenes in health-care expenditures up to a certain percentage of the official price. The mechanism of the maximum charge ensures that, per calendar year, the total amount of the part at the

3.	**What is/was the timescale for implementing the initiative?**
	The measure was introduced in July 2002.
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	1) A special cell was created within the Administrative Control Service in charge of monitoring the full process of the application of the maximum charge by the insurance organizations. For example, this cell serves as a relay for all necessary information that the insurance organizations must have as concerns income. These questions are transmitted by insurance organizations to the Administrative Control Service which communicates them in turn to the tax administration for processing. The response of the tax administration to the insurance organizations goes through the Administrative Control Service. 2) An in-depth study of the maximum charge is now going forward at the Federal Centre for knowledge of health-care.
Outcomes	
1.	**To what extent have the objectives been met?**
	The annexes ter and quater in the following pages show the data for the 2005 financial year (expenditures entered in account by the insurance organizations): * annex ter 4.2.1 Annex ter 4.2.1. shows the expenditures recorded in account per age group and the expenses borne by the patients ("tickets modérateurs") actually paid. These data do NOT take into account the application of the maximum charge. The annex also shows the average cost per insured person. The "ticket modérateur %" gives the relation between the expenses borne by the patients (ticket modérateur) that were actually paid and the sum of reimbursements (expenditures) and the tickets modérateurs. The average "charge" of the ticket modérateur = 8.32% * annex quater 4.2.1 The annex quater 4.2.1 contains analagous data AFTER applying the maximum charge. The totals show that an amount of about 200 million EUR is "transferred" from the column "tickets modérateurs" to the column "expenditures" because this amount has been reimbursed to insured parties under the maximum charge provision. The result is a reduction of the average charge of the ticket modérateur to 7.23%.
2.	**What obstacles/risks were faced in implementing the initiative?**
	1. Implementing the maximum charge requires exchanging data between different Administrations. Some of these data are "sensitive" (data pertaining to income) and require particular care in respecting privacy.

	2. The maximum charge can result in a double reimbursement of personal contributions of insured parties when other systems bear these costs (particularly in the context of complementary insurance policies).
3.	**How were these obstacles and risks addressed?**
	1. Information flows were created via the Social Security Registry (Banque Carrefour de la Sécurité sociale) and between INAMI and the tax administration, using principles that maintain privacy to the utmost. 2. A project targets the creation of information flows to enable persons paying personal contributions to know when a given insured person is entitled to a maximum charge, so that they can take this into account in their own reimbursements.
4.	**Were there any unexpected benefits or weaknesses?**
	The weak point in the system is the amount of time that goes by between the moment when the persons have contributed the costs and the moment when they are reimbursed. A recent reform has contributed to reducing this, in certain cases, but there is still a gap corresponding to the need to verify a series of data and if applicable to consult the insured person himself.

ANNEX bis 4.2.1

MAF (maximum charge) 2002

	Number of families	Number of persons	Reimbursements made €
MAF income	163,294	295,217	68,162,136.00
MAF social	165,249	397,625	50,599,410.34
Social franchise	-	-	1,607,782.15
Child under 16	-	2,890	708,291.78
Increased family allowances	-	1,036	350,689.62
TOTAL	**328,543**	**696,768**	**121,428,309.89**

MAF (maximum charge) 2003

	Number of families	Number of persons	Reimbursements made €
MAF social	194,667	418,458	62,870,444 .62
MAF low income	94,737	154,626	36,180,585 .01
MAF modest income	119,202	219,849	53,925,348 .85
Increased family allowances	-	1,609	276,840 .59
Child under 16	-	4,001	983,734 .29
TOTAL	**408,606**	**798,543**	**154,236,95 3.36**

MAF (maximum charge) 2004

	Number of families	Number of persons	Reimbursements made €
MAF social	204,456	425,967	75,641,719.63
MAF low income	91,398	150,139	40,851,030.35
MAF modest income	123,577	233,353	62,480,644.49
Increased family allowances		774	284,734.29
Child under 19		5,432	1,567,315.58
TOTAL	**419,431**	**815,665**	**180,825,444.34**

MAF (maximum charge) 2005 – situation on 10-07-2006

	Number of families	Number of persons	Reimbursements made €
MAF social	211,796	442,819	70,778,547.26
MAF income (€ 450)	100,051	167,316	39,650,429.84
MAF income (€ 650)	131,014	248,278	63,427,699.09
MAF income (€ 1.000)	37,203	76,506	19,220,665.10
MAF income (€ 1.400)	9,862	21,070	6,189,131.31
MAF income (€ 1.800)	12,914	31,804	7,679,437.16
Increased family allowances		648	247,337.34
Child under 19		5,521	1,573,861.73
TOTAL	**502,840**	**993,962**	**208,767,108.83**

ANNEX ter 4.2.1

Total without MAF financial year 2005		Expenditures WITHOUT maximum charge					Age groups	
				Costs	Costs	ticket modérateur%		
Age group	Expenditures	Personal contributions (tickets modérateurs) (*)	Insured parties	Expenditures	tickets modérateurs	(*)		
1	449,572,142.12	45,396,197.93	510,288	881.02	88.96	9.17	< =	4
2	340,609,534.77	34,087,825.82	583,909	583.33	58.38	9.10	5	9
3	313,131,331.82	35,747,872.72	615,799	508.50	58.05	10.25	10	14
4	381,794,366.40	37,833,122.80	623,296	612.54	60.70	9.02	15	19
5	424,819,820.48	44,735,062.94	621,926	683.07	71.93	9.53	20	24
6	549,318,212.84	62,237,072.06	656,083	837.27	94.86	10.18	25	29
7	626,918,174.42	71,167,976.15	695,620	901.24	102.31	10.19	30	34
8	678,279,903.42	76,048,903.19	753,583	900.07	100.92	10.08	35	39
9	793,897,778.11	87,353,102.77	802,956	988.72	108.79	9.91	40	44
10	905,538,625.98	98,007,577.25	768,233	1,178.73	127.58	9.77	45	49
11	1,028,526,271.74	109,711,459.64	701,297	1,466.61	156.44	9.64	50	54
12	1,161,152,268.94	119,727,920.17	664,063	1,748.56	180.30	9.35	55	59
13	1,081,593,351.21	105,943,490.31	503,984	2,146.09	210.21	8.92	60	64
14	1,312,292,536.01	123,007,798.57	490,523	2,675.29	250.77	8.57	65	69
15	1,566,451,218.96	137,906,895.02	469,038	3,339.71	294.02	8.09	70	74
16	1,743,255,540.57	137,066,770.33	401,569	4,341.11	341.33	7.29	75	79
17	1,681,492,407.72	113,873,501.84	296,617	5,668.90	383.91	6.34	80	84
18	927,182,009.53	49,723,184.35	122,594	7,563.03	405.59	5.09	85	89
19	573,360,256.79	22,688,990.66	56,979	10,062.66	398.20	3.81	90	94
20	185,046,293.10	5,595,283.47	15,133	12,228.00	369.74	2.93	>=	95
	16,724,232,044.93	1,517,860,007.99	10,353,490	1,615.32	146.60	8.32		

(*) WITHOUT application of the maximum charge

ANNEX quater 4.2.1

Total MAF (max. charge) expenditures 2005				Expenditures WITH maximum charge			Age groups	
				Costs	Costs	ticket modérateur %		
Age groups	Expenditures	tickets modérateurs (*)	Insured persons	Expenditures	tickets modérateurs	(*)		
1	452,013,810.32	42,954,529.73	510,288	885.80	84.18	8.68	< =	4
2	342,260,437.62	32,436,922.97	583,909	586.15	55.55	8.66	5	9
3	314,780,547.60	34,098,656.94	615,799	511.17	55.37	9.77	10	14
4	384,080,586.33	35,546,902.87	623,296	616.21	57.03	8.47	15	19
5	427,593,257.27	41,961,626.15	621,926	687.53	67.47	8.94	20	24
6	552,997,704.41	58,557,580.49	656,083	842.88	89.25	9.58	25	29
7	630,784,555.24	67,301,595.33	695,620	906.79	96.75	9.64	30	34
8	682,936,890.21	71,391,916.40	753,583	906.25	94.74	9.46	35	39
9	799,844,939.19	81,405,941.69	802,956	996.13	101.38	9.24	40	44
10	912,386,416.69	91,159,786.54	768,233	1,187.64	118.66	9.08	45	49
11	1,036,623,124.42	101,614,606.96	701,297	1,478.15	144.90	8.93	50	54
12	1,171,199,954.15	109,680,234.96	664,063	1,763.69	165.17	8.56	55	59
13	1,093,491,855.74	94,044,985.78	503,984	2,169.70	186.60	7.92	60	64
14	1,331,626,392.83	103,673,941.75	490,523	2,714.71	211.35	7.22	65	69
15	1,594,725,744.51	109,632,369.47	469,038	3,399.99	233.74	6.43	70	74
16	1,776,124,840.33	104,197,470.57	401,569	4,422.96	259.48	5.54	75	79
17	1,711,839,994.60	83,525,914.96	296,617	5,771.21	281.60	4.65	80	84
18	941,123,362.21	35,781,831.67	122,594	7,676.75	291.87	3.66	85	89
19	579,648,691.18	16,400,556.27	56,979	10,173.02	287.84	2.75	90	94
20	186,440,124.44	4,201,452.13	15,133	12,320.10	277.64	2.20	>=	95
	16,922,523,229.29	1,319,568,823.63	10,353,490	1,634.48	127.45	7.23		

(*) WITH application of maximum charge

4.2.2. Policies for early detection of breast cancer to identify tumours as rapidly as possible in order to increase the effectiveness of treatments

Name of Policy/Project	Member State
Programme for early detection by mammogram for wormen between 50 and 69	Belgium – French and Dutch —speaking Communities

End Purpose of the Initiative

Detecting a tumour as quickly as possible to facilitate effective treatment and reduce mortality due to the disease

Main Results

Early indicators of the impact of the programme on mortality due to breast cancer correspond to European indicators

Participation is quite low (Flanders: 35%)

Targeted Beneficiaries		Policy Focus	
General Population	☐	Social Exclusion	☐
Children	☐	Health care	☒
Single-parent families	☐	Long-term Care	☐
Unemployed	☐	Governance	☐
Older people	☐		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☒
Ethnic Minorities	☐	Regional	☐
Homeless	☐		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:] Women 50-69	☒	Federal State and Communities	

Context/Background to the Initiative

Recommendations of experts as concerns early detection of breast cancer, based on the results of studies, have shown that detection by mammogram can reduce mortality due to breast cancer.

Details of the Initiative

1.	Specific Objectives
	- increasing the number of women affected by benign tumours without nodules (Flemish Community; invasive tumours discovered cannot exceed 1 cm) - increasing participation of women in the target population

	- reducing the number of unnecessary examinations
2.	**How did the initiative address these objectives?**
	- Flemish and French Community: programme with guaranteed quality including control of quality of the early detection procedures and processes plus assessment at all levels - French Community: personal invitation for mammogram Flemish Community participates in the early detection programme in two ways - adhesion of family doctors - personal invitation
3.	**What is/was the timescale for implementing the initiative?**
	French Community: the programme is currently planned until December 2009 Flemish Community has not planned a date to end the application of the programme
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	- Continual quality control of early detection procedures and processes, radiographic and radiological performances and equipment - Evaluation in keeping with European recommendations
Outcomes	
1.	**To what extent have the objectives been met?**
	The quality of early detection by mammogram has improved significantly Early substitution indicators of the impact of the programme on mortality due to breast cancer correspond to European recommendations Participation is rising but is not yet high enough A trend is becoming visible of a shift from an opportunistic diagnosis by mammogram (without presumption of cancer, and therefore in fact as a preventive measure) to preventive detection by mammogram (under the framework of the programme)

2.	**What obstacles/risks were faced in implementing the initiative?**
	High percentage of opportunistic detection
3.	**How were these obstacles and risks addressed?**
	Communication in the programme and its results to the public and particularly to women in the target population Improving awareness of women in the target population Collaboration and mutual consultation between partners concerned (radiologists, family doctors, various governments, local and regional networks, physicists, mutual societies, …)
4.	**Were there any unexpected benefits or weaknesses?**
	The network of family doctors, specialists and health-care workers has improved. Breast cancer is becoming less and less a taboo subject The quality of early detection by mammogram for diagnostic purposes has improved. Collaboration between the various governments in Belgium has improved and given rise to the positive results described above.

4.2.3. The « Coma » project as a line of health care adapted to patients in a persistent neuro-vegetative condition (PNVC) or a pauci-relational condition (PRC)

Name of Policy/Project	Member State
Line of health care adapted to patients in a persistent neuro-vegetative condition (PNVC) or a pauci-relational condition (PRC)	BELGIUM

End Purpose of the Initiative

General objective

Offering adequate care to the right patient, at the right time and the right place, using the right resources, while insuring continuity within the same health-care circuit. The idea is thus to obtain optimal adequacy between the supply of consistent care and the need for revalidation and chronic care.

Main Results

Operationalization of the health-care circuit.

1. The external liaison function must not be ignored. Thanks to this function, the team in the hospital expertise centre is familiar with the nursing homes where it sends patients. As a result, mutual understanding is improved and the families of patients in CNVC or PRC are also better informed. These two elements contribute to promoting the quality of care and services provided. Quality is also promoted by the fact that the nursing home team can acquire additional skills through training programmes offered in the external liaison context.

2. The pilot project promotes multidisciplinary collaboration.

3. For the first time, cooperation across sectors organized in an official framework.

4. The referring hospital for continuity of care plays a central role in the health-care network.

5. The geographic location of hospital expertise centres and chosen nursing homes is such that patients can get care near their homes.

6. Since the federal platform of experts consists of a representative of each expert hospital centre and the same number of representatives of long-term care, the field is in direct contact with the authorities, which means that solutions for problems that arise can be sought together.

Targeted Beneficiaries		Policy Focus	
General Population	☐	Social Exclusion	☐

Children	☐	Healthcare	☒
Single-parent families	☐	Long-term Care	☒
Unemployed	☐	Governance	☐
Older people	☐		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☒
Ethnic Minorities	☐	Regional	☐
Homeless	☐		
Specific Illness/disease	☒	**Implementing Body**	
Other [Please specify:]	☐		

Context/Background to the Initiative

Every day, there are victims of traffic accidents, accidents in the home, heart attacks with cerebral anoxia, infarctus, or cerebral haemorrhaging (non-congenital disease of the nervous system) resulting in acute brain damage. This can cause coma, and if the patient does not completely recover from that coma, he/she may evolve towards a persistent neurovegetative condition (PNVC) or a pauci-relational condition (PRC). This type of patient represents a significant share of the problematic group of patients suffering from non-congenital chronic disorders of the nervous system. For all of these patients, the real problem lies in the lack of suitable residential care facilities. In fact, in the chronic phase of the condition, these patients are treated in various structures that are not initially intended to meet their major needs for continual global and specific care. This causes problems both as concerns the quality of care (inadequacy of human and material resources), and accessibility of care.

Details of the Initiative

1.	**Specific Objectives**
	Specific objective Creating a network of care adapted to patients in a persistent neuro-vegetative condition (PNVC) or in a pauci-relational condition (PRC). Supplying quality care adapted to the specific needs of these patients
2.	**How did the initiative address these objectives?**
	To try to solve the problem mentioned above, the federal authorities, the Communities and Regions have concluded a protocol on « Health policy to be implemented with regard to patients in a persistent neurovegetative condition » (24/05/2004, BOJ 27/09/2004). Thanks to this protocol, hospital expertise centres and a network of adapted care have been created for patients in PNVC or in PRC. This health-care network can be represented briefly as follows: Hospital expertise centres Once the patient's vital functions have been stabilized in a general hospital, the health-care scheme provides: Hospitalization for transition in a hospital expertise centre which, during the recovery (six months on the average),

The quality and continuity of long-term care is guaranteed by close, durable collaboration between the expertise centres (external liaison). Consequently, training courses will regularly be sent out and good continuity will be insured. With this in mind, the expertise centre will provide specialized opinions whenever necessary to the team of healthcare providers treating the transferred patient.

1) Hospital expertise centres (14 centres: 80 beds)

As soon as the patient's condition is stabilized, the patient leaves the general hospital and is transferred to one of the Hospital expertise centres, specialized in treating and recovery of PNVC or PRC patients. After an overall assessment, a specific, intensive recovery programme for six months on the average will give the patient a maximum chance of recovery. The care and treatment provided will offer optimal conditions for recovery and prevention of complications. When intensive recovery care is no longer appropriate, a solution for long-term accompaniment is sought in consultation with the family. In this context, the hospital expertise centres have a collaboration (external liaison) agreement with specialized nursing homes, the institutions of AWIPH, and the VFSIPH nursing homes and SISD, to ensure continuity of optimal care.

Via the external liaison, the missions of the hospital expertise centres are: Developing and disseminating criteria for good professional practice; - continuity of care for patients under optimal conditions; - providing continuing training courses for health care teams in the long-term structures; - preparing the transfer of the patient in collaboration with the other health-care providers

2) long-term care: specialized nursing homes (30 nursing homes - 165 beds)

When the patient leaves the hospital expertise centre, a nursing home that is a member of the health-care scheme takes charge. The specialized nursing homes have the staff and infrastructure adapted to the target group. They guarantee quality care and accompaniment in the family environment, emphasizing comfort and care to the patient. Continuity of care is insured by long-term collaboration with the hospital expertise centre that provides continuing training courses and expert opinions.

Long-term care at home * in an institution of the AWIPH, SBFPH or VFSIPH

3.	**What is/was the timescale for implementing the initiative?**
	This project was implemented first as a pilot project for two years. The assessment of the pilot period has just ended and in view of the results, the Minister of Public Health has decided to give a structural organization to this health-care scheme. Standards of approval and financing are being made to take account of the recommendations of the federal platform of experts set up for this project. It recommends increasing the number of beds in expert hospitals by 21% and increasing financing of the external liaison, which is crucial to success and smooth operation of this circuit! This project is an excellent model of totally integrated care and will certainly be used as a basis for thinking about reforming the recovery sector after seeking a solution for care of other non-congenital diseases of the nervous system.
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	Under the protocol, a federal platform of experts was created to assess this project; it consists of a representative of each hospital expertise centre and the same number of representatives of long-term care. Each Community and Region also has a representative on the platform. The chairmanship and secretariat are provided by the Federal Public Service for Public Health. This platform has drafted a standard activity report for expertise centres in which quantitative and qualitative data are presented. In order to assess this project as completely as possible, after two years of operation, a semi-open questionnaire was sent to nursing homes participating in the project and to the Integrated Home care Services (SISD). Over a period of two years, epidemiological, medical and clinical data were collected for 392 patients who benefited from this new line of healthcare.

	In order to study certain particular aspects of this new model of healthcare in depth, the platform of experts has decided to create various working groups: - visibility of the project - medical report - report of activities for expertise centres - needs for specific medical material in nursing homes - ethics - guideline
Outcomes	
1.	**To what extent have the objectives been met?**
	The initial objectives have been entirely fulfilled. 1. The external liaison function has not been neglected. Thanks to this function, the team in the hospital expertise centre has got to know the nursing homes to which it refers patients. Consequently, mutual understanding has improved and the families of patients in PNVC or PRC are also better informed. These two aspects contribute to promoting the quality of care and services provided. Quality is also favored by the fact that the team in the nursing home can acquire additional skills by means of training courses given in the external liaison context. 2. The pilot project favours multidisciplinary collaboration. 3. For the first time, cross-sector cooperation is organized in an official framework. 4. The hospital referring for continuity of care plays a central role in the health-care network. 5. The geographic location of hospital expertise centres and selected nursing homes means that patients can be treated near their homes. 6. Since the federal platform of experts consists of a representative of each of the hospitals expertise centres and an equal number of representatives of long-term care, the field has a chance to be in direct contact with the authorities, which means that solutions to the problems that arise can be sought together.
2.	**What obstacles/risks were faced in implementing the initiative?**
	The project is not yet sufficiently well-known by the sector. The problem of affordability of long-term care in nursing homes, since the cost for the patient remains very high and is decidedly higher than the cost of care at home and in retirement homes.

3.	**How were these obstacles and risks addressed?**
	Publicity of the project by means of an informational brochure or a symposium, among others, is essential to give this innovating cross-sector project a place in the health-care landscape. A 21% increase in the number of beds and expertise centres will probably be achieved in 2007. A discussion is scheduled with the Communities and Regions to review the distribution of nursing homes if necessary and the role of AWIPH and VFSIPH in the treatment circuit.
4.	**Were there any unexpected benefits or weaknesses?**

4.2.4. The interministerial protocol « elderly persons » n° 3 allocating the budgetary and organizational framework of investments in health care for the elderly in the various Communities and Regions over a six-year period.

Name of Policy/Project	Member State
Protocol 3 CONCLUDED BETWEEN THE FEDERAL GOVERNMENT AND THE AUTORITIES TARGETED BY ARTICLES 128, 130, 135 AND 138 OF THE CONSTITUTION, CONCERNING HEALTH CARE POLICY FOR THE ELDERLY	BELGIUM

End Purpose of the Initiative

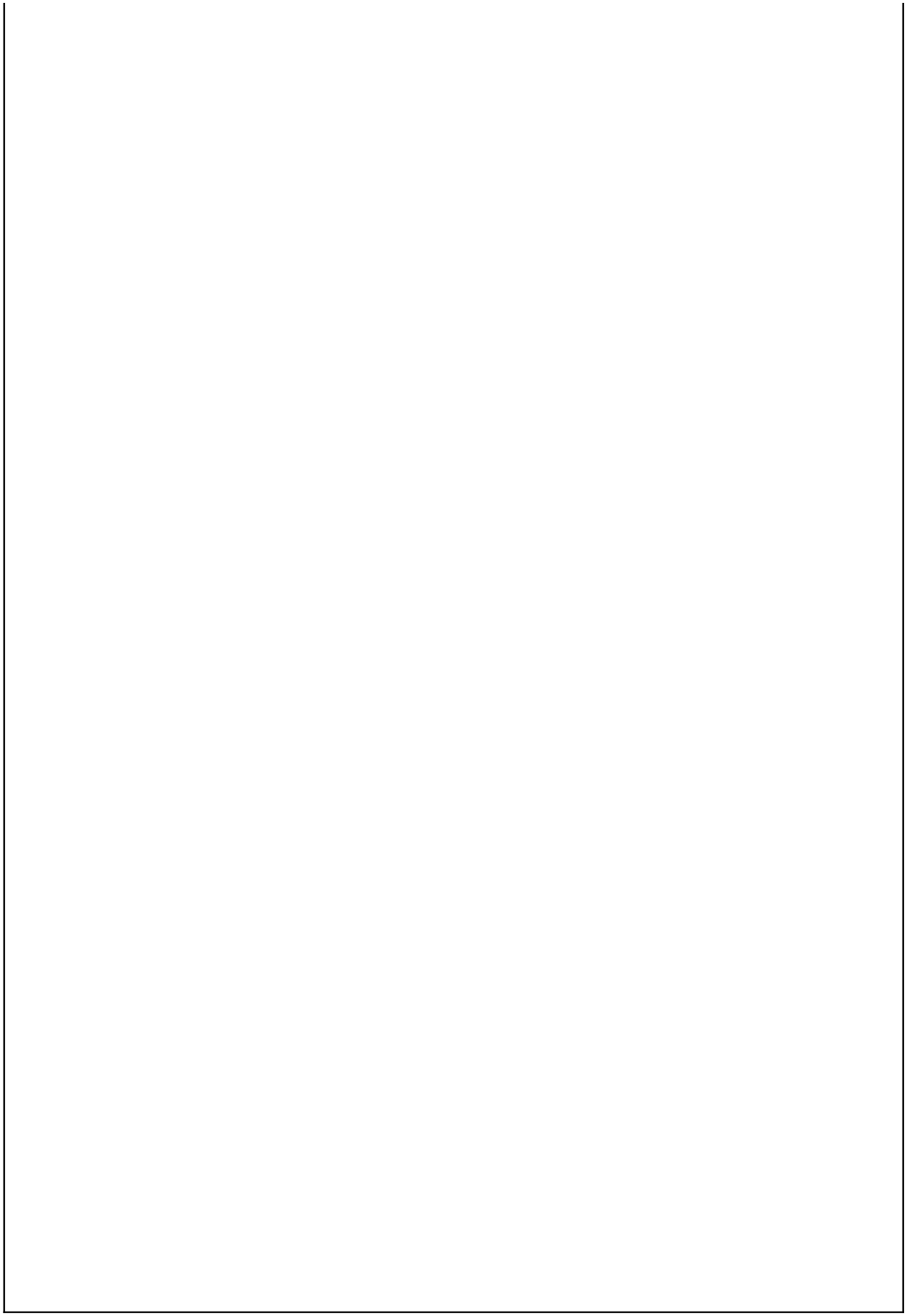
The objective of the social agreements that were concluded in 2005 in the non-commercial sector is to achieve a better framework and to decrease on-the-job pressure. In this context, the following text was included in the agreements: under the programme for reconverting 28,000 beds in homes for the elderly into nursing homes, according to the principle of "nursing home equivalents": the creation of 2,613 full-time equivalent positions of which 70 are intended for nursing care at home in order to develop the supply of health care for seriously dependent persons living at home, in collaboration with an innovating organization of basic health care and institutions to prevent or postpone institutionalization. The sectors of homes for the elderly and home nursing services will be involved in the inter-ministerial consultation that will culminate in a new collaboration protocol in the health-care policy to be implemented with regard to the elderly.

The third protocol of agreement sets the budgetary framework for health-care investments in the various Communities and Regions, over a period of six years. Since emphasis is put in creating additional jobs in the health-care sector, it is important to be attentive to maintaining a sufficient number of healthcare workers, financed adequately. Policy on employment and education will play a major role here.

The creation of 2,613 full-time equivalent positions, resulting from the conversion of 28,000 beds in retirement homes into beds in nursing homes is related to the signature of collective labour agreements by the social partners.

The collective agreements or royal decrees that are needed pertain to:

- reducing the point at which trade union representation becomes mandatory;
- immediate replacement in the event of absence;
- communicating working hours to workers sufficiently in advance and a sanction to be applied for modifying working timetables;
- implementing the "employment contract" measure;
- granting additional days off for certain categories of members of the personnel;
- adapting the provisions concerning measures at the end of the career, concluded in execution of the multiannual plan for the federal health sectors concluded on 1 March 2000.



Main Results

Targeted Beneficiaries		**Policy Focus**	
General Population	☐	Social Exclusion	☒
Children	☐	Healthcare	☒
Single-parent families	☐	Long-term Care	☒
Unemployed	☒	Governance	☐
Older people	☒		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☒
Ethnic Minorities	☐	Regional	☐
Homeless	☐		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]	☐		

Context/Background to the Initiative

Details of the Initiative

1.	**Specific Objectives**
2.	**How did the initiative address these objectives?**
3.	**What is/was the timescale for implementing the initiative?**

Monitoring and Evaluation

	How is/was the project monitored/evaluated?
	An inter-cabinet working group composed of representatives of the various ministries signing the Protocol that meets at least once a month is monitoring the achievement of objectives.
Outcomes	
1.	**To what extent have the objectives been met?**
	No objective has been reached (see below)
2.	**What obstacles/risks were faced in implementing the initiative?**
	Collective labour agreements have not all been signed, and all homes for the elderly have not yet been converted into nursing homes, nor have the creation or reinforcement of alternatives to institutionalization been initiated. Consequently no jobs have been created to date.
3.	**How were these obstacles and risks addressed?**
	Meetings in a joint management/labour commission have still been scheduled to reach an agreement. However, some sectors have signed all the collective labour agreements, so we have not reached a deadlock, and in these sectors job creation will begin soon.
4.	**Were there any unexpected benefits or weaknesses?**

4.2.5. Vaccination policies targeting a reduction in morbidity and mortality of avoidable infectious diseases by immunizing target groups

Name of Policy/Project	Member State
Vaccination programme.	Belgium (French Community)

End Purpose of the Initiative

Reduction in morbidity and mortality of avoidable infectious diseases by immunizing target groups.

Main Results

In young children (up to age 11-12), the rates of mortality and morbidity are satisfactory as compared to international standards except as concerns hepatitis B and measles.

For adolescents and the elderly, results are still insufficient.

Targeted Beneficiaries		Policy Focus	
General Population	☐	Social Exclusion	☐
Children	☒	Healthcare	☒
Single-parent families	☐	Long-term Care	☐
Unemployed	☐	Governance	☐
Older people	☒		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	☒
Ethnic Minorities	☐	Regional	☐
Homeless	☐		
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]	☐		

Context/Background to the Initiative

Recommendations of the World Health Organization

General prophylactic policy on transmissible diseases

Recommendations of the Higher Counsel for Hygiene.

Details of the Initiative

1.	Specific Objectives
	For children and young people from zero to 18 years old, role in maintaining or increasing the rate of vaccination cover for the following diseases: poliomyelitis, diphtheria, whooping cough, tetanus, hepatitis B, measles, German measles, mumps, meningococcus C invasive diseases, Haemophilus influenzae type b and pneumococcus (as from January

	For adults: giving information on the periodicity of vaccination recalls for everyone (diphtheria and tetanus) and specific vaccinations for the most vulnerable (flu and pneumococcus).
2.	**How did the initiative address these objectives?**
	By the developing the knowledge and motivation of the population concerning vaccination (information of target audiences on what is at stake, improvement of the understanding of officials and those involved in representing vaccination to the public). By ensuring maximum access to vaccinations to targeted children and adolescents (costs-free and availability of doses of vaccines, free choice of the vaccinator, facilitating formalities for beneficiaries). By the coherence and pertinence of the programme (consultation and coordination of partners, data transmission between child care services, and those in charge of promoting health at school, scientific rigour and assessments of the programme by means of epidemiological supervision and measurement of vaccination cover). For this purpose, in French Community, collaboration has been organized between DG Health and the inter-university Association Provac, in charge of implementation of the programme. By ensuring the implementation and continuity of the programme at regulation, administrative and political levels.
3.	**What is/was the timescale for implementing the initiative?**
	This is a continual process.
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	Epidemiological monitoring Regular measurement of vaccination cover
Outcomes	
1.	**To what extent have the objectives been met?**
	Satisfactorily except as concerns the rates of cover -of children for measles; -of adolescents for hepatitis B; -of healthcare professionals and persons at risk for flu
2.	**What obstacles/risks were faced in implementing the initiative?**
	• difficulty in maintaining sufficient compliance of children beyond primary school; difficult detection of cases of diseases that have become rare;

3.	**How were these obstacles and risks addressed?**
	fighting the impression that certain diseases are benign by improving awareness of the public and professionals (specific letters, seminars, TV spots); setting up a system for declaring rare diseases by the Scientific Institute for Public Health; in the French Community, a selective system of access to vaccines available in the supply and delivery circuit has been organized.
4.	**Were there any unexpected benefits or weaknesses?**

Annex 4.3. Statistical analysis of Health (using indicators)

Brief discussion of results of health indicators

Health indicators supply information on the state of health of the population, its lifestyle and the existence of risk factor, the field covered by preventive policy, accessibility, costs and use made of healthcare, long-term feasibility of healthcare expenditures. The analysis was done on the basis of common European indicators, completed by national indicators[39].

1. State of health

Life expectancy – and life expectancy in good health

Life expectancy, meaning the age that, at birth, one can hope to reach, is one of the indicators used most often to get an idea of the general state of health for population. It is determined by a large number of factors, including welfare in general, hygiene of living and the quality of healthcare. In 2004, it was 82.4 years for women and 75.7 for men, (representing a difference of 6.7 years in favour of women).*in comparing the figures 2003 (women 81.7 and men 75.9) with those of other Member States of the EU, it seems that life expectancy in Belgium is relatively high. The best results were observed in Sweden (women: 82.5; men: 77.9), and the worst in Latvia (women: 75.9; men: 65.7).

It is important to see how much of **life expectancy** takes place in **good health**, so as not to focus exclusively on length of life, but also on the quality of life. Life expectancy in good health is also important in the context of « active ageing » strategies targeting a longer active life for the elderly. Elderly persons in good health can make a major contribution to their families, the community in which they live and the economy, either by continuing a professional activity, or by engaging in informal activities such as minding children, the sick, and the elderly. It has been shown that there is a relation between health, economic growth and social welfare.

Recently, expectations in terms of health were calculated based on data on mortality from the national statistical institute, and questions concerning the state of health were included in the social-economic survey in 2001[40]. The state of health was assessed based on the question asked about the subjective general state of health: what is your general state of health? Chronic illnesses were identified based on the question: do you suffer from one or several long-term illnesses, chronic disorders or handicaps?

For women, life expectancy was 81.7 years at birth, life expectancy in good health was 59.5 years and life expectancy without chronic illnesses was 63.4 years. For a man, life expectancy was 75.4 years, life expectancy in good health was 58 years and life expectancy without chronic illnesses with 59.7 years. Women therefore have a life expectancy of six years more than men, but their subjective expectations in terms of health exceed those of men by only 1.5 years, and they can expect to live 2.5 years longer than men with a chronic disease.

In 2001, for women, life expectancy at 65 was 20.2 years, life expectancy in good health was 7 years and life expectancy without chronic diseases 10.1 years. For men,

[39] The indicators in the National Action Planned for Social Integration concerning the health dimension have been included in the analysis.

[40] Van Oyen, H. Bossuyt, N. Bellamammer, L. Deboosere, P. Demarest, S. Lorant, V. Miermans P-J. Composite health measures in Belgium based on the 2001 census, 32 p. (Not published).

life expectancy at 65 was 16.2 years in 2001, life expectancy in good health 6.6 years and life expectancy without chronic diseases was 8.6 years.

One may ask the question as to whether an increase in life expectancy as time goes by does not go hand-in-hand with an increase in the number of years spent in poor health (compression, stability or expansion of poor health). This question is also important in establishing relative projections of the cost of aging.

An assessment at three different times (1997, 2001 and 2004), using the Health Survey each time to measure the (subjective) state of health, confirms the compression theory (an increase in life expectancy goes hand-in-hand with the compression of years spent with a chronic disease)[41]. During the period 1997-2004, life expectancy for men increased by 1.82 years, whereas the increase in the number of years spent without a chronic disease increased by 3.35 years. For women, life expectancy grew by 1.29 years, and the increase in the number of years spent without chronic disease rose by 2.47 years.

Alternative figures concerning life expectancy in good health, based on the European structural index 'disability-free life expectancy'

The European structural index 'disability-free life expectancy' is available for the 1995-2003 period. The index is calculated on the basis of a survey (ECHP) on restrictions of daily activities due to a disease or handicap[42]. During the period under review, life expectancy at birth grew by 1.5 years for women and disability free life expectancy by 2.8 years. For men, life expectancy rose during that same period by 2.5 years, and disability free life expectancy by 4.1 years. The growth in both indices is therefore higher for men than for women. In 2003, women could expect to spend 84.7% of their lives without disabilities (as compared to 82.8% in 1995), and men 88.8% (versus 86.2% in 1995). In the European context, Belgium had good marks, confirmed by recent trends.

During that same reference period, disability-free life expectancy at 65 seems to be growing for both men and women, but less than their life expectancy (women: life expectancy +0.8, disability-free life expectancy +0.7; men: life expectancy +1.9, disability-free life expectancy +1.3. Here too, growth is recorded for both groups, but it is higher for men than for women.

There are significant differences per region: life expectancy and life expectancy in good health are lower in the Walloon Region and higher in the Flemish Region.

A few years ago, life expectancy in good health was calculated in comparison with the level of education. Based on a combination of data from the national mortality data bank, monitoring the 1991 census for five years, and a Health Survey in 1997, the conclusion was drawn that persons with a lower level of instruction (no degree or primary education only) not only lives shorter lives in Belgium (women: 2.8 years; men 5.2 years), they also live shorter lives in good health (women: 14.5 years; men: 15.5 years) than those who benefited from more education (higher education degree).

The higher the level of instruction, the better access to information concerning health and the better one is prepared to put this knowledge into practice. On the other hand, the level of instruction helps determine the position in the labour market and

[41] Van Oyen, H. Cox, B. Trend in disability free life expectancy in Belgium between 1997 and 2004. Reves 2006. 14 p.

[42] ECHP 1995-2001: Are you hampered in your daily activities by any physical or mental health problem, illness or disability? (2002 and 2003 are extrapolations)

professional satisfaction and therefore, indirectly, the state of health. There is also a clear link between the social-economic position and lifestyle (see below).

Foetal-infant mortality

The rate of infant mortality (mortality of children in the first year of their lives as compared to the total number of live births) and of perinatal mortality (death in the first week after birth, including stillborn children) have increased in Belgium in recent decades. The degree of infant mortality (expressed per thousand births) was still 12.1 in Belgium in 1980. In 1990, it had dropped to 6.5 and in 2000 to 4.8. In 2004, the rate was 4.3, which is a bit lower than the average in EU-25, which is 4.5. Within the EU, infant mortality is the highest in Latvia (9.4) and the lowest in Sweden (3.1).

An analysis of the number of stillborn children, death during the first week after birth, and deaths after the age of one week but before one year old was done for the period of 1980 to 1994 in terms of the social-professional category of the father. It showed that there is a clear social-economic progression. Child mortality in professional categories is always significantly higher in categories with lower status, although these gaps are decreasing over time. Recent analyses in the Flemish Region and the Brussels-Capital Region based on more recent data confirm that the importance of the social-economic status of the parents is unchanged as concerns infant mortality [43].

Subjective state of health[44]

Based on the results of the Health Survey, one can get an idea of the subjective state of health (as described by persons themselves) of the population.

In Belgium, 23% of the population declares that they are in a mediocre or a very poor state of health (percentage more or less stable for the period 1997-2004). **A poor state of subjective health,** defined in this way, increases with age, as one might expect. The percentage of persons who declare that they are in a mediocre to very poor state of health varies between 8% in the age category from 15 to 24, to 53% for persons 75 and older. As of the age of 45 years old, women declare they are in poorer state of health than men (for all ages: 25% as compared 21%). Persons with a lower level of instruction clearly are dissatisfied with the state of health more often (45%) versus those who benefited from more education (13.6%).

Nearly a quarter of the population (24%) declares that they suffer from **a long-term illness or handicap.** This percentage is fairly stable for 1997-2004. The probability of contracting a long-term disease increases significantly with age (75+ : 53%). Long-term disorders are declared more frequently by persons whose level of education is lower (37%) than by persons having benefited from more education (19 %). Persons with a lower level of instruction more frequently referred to bronchitis, heart disease, high blood pressure, diabetes, depression, vertigo causing falls, headaches, persistent back aches, worn joints, infected joints, other forms of chronic rheumatism, stomach ulcers and ulcers of the small intestine. Persons with higher instruction mention allergies more often. Persons with less instruction are more subject to co-morbidity, the simultaneous appearance of several disorders (primary education or no degree: 21%; higher education degree: 3%).

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[43] See : Administratie Gezondheidszorg – Team Beleidsevaluatie. Foeto-infantiele sterfte. In: Ministerie van de Vlaamse Gemeenschap. Gezondheidsindicatoren 2001-2002. Page 33-48. Analyse voor de Vlaamse Gemeenschap 2001-2002. Observatorium voor Gezondheid en Welzijn van Brussel Hoofdstad. Welzijnsbarometer. Edition 2005/1 P.26 (figures for 1998 – 2003).

[44] Analysis based primarily on ISSP Enquête Santé Belgique 2004 IPH/EPI Reports n°. 2006 - 035.

10% of the population declare that they suffer from **a chronic disorder hindering them in their daily activities** (stable percentage for 1997-2004). Here too, a stronger prevalence of women, the elderly, people with a low level of instruction and people with low income can be observed (16% in the first income bracket, 5% in the highest income bracket).

Alternative figures on the subjective state of health, based on the EU-SILC 2004

State of health observed subjectively

About 8% of the population 16 and over declare that they are in a poor to very poor state of health (women: 8.6%; men: 7.3%). For young people (16 to 24) this percentage is 2%, for people 85 and over in this 26.1%. In the lowest income bracket, 41% declare they are in a poor state of health. In the higher income brackets that percentage is 11%.

Restrictions of daily activities.

Nearly 27% of the population over 16 declare that they are limited in their daily activities (28% of women and 26% of men). 11,5% are seriously restricted (13% of women and 10% of men). This percentage increases sharply with age: 5% of persons between 16 and 24 are confronted with serious restrictions, as are 45% of persons of 85 and over. In the lowest income bracket, this percentage is 33%, which is significantly higher than for the highest income bracket (17%).

Prevalence of depression can be analyzed based on the answers given in the Health Survey on a scale of 13 points[45]. Measured in this way, depression is present for 8% of the population (unchanged since 2001), more for women (10%) than for men (6%) and it increases with age (13% in the population over 75). People in the lowest income bracket (18%) are often more depressed than in the higher income bracket (5%), persons who hold a lower secondary school degree (12%) are more often depressive than graduates of higher education (4%). Groups particularly at risk are: single parent families (17%) and isolated persons (12%), and above all people who are ill /incapacitated (38%) and jobless (12%).

The Health Survey therefore gives indications on social-economic differences with regard to the subjective state of health. Those whose social-economic status is the lowest generally show worse health. The causal relationship goes two ways: they have a low social-economic status because their health is poor, or they are in poor health because of their low social-economic status[46]. For most of these indicators, the Flemish Region shows better results than the Brussels-Capital Region and the Walloon Region.

2. Lifestyle – risk factors

Research has shown that lifestyle, such as physical exercise, diet, consumption of alcohol and tobacco, have a major influence on health. The Health Survey for 2004 gives an idea of the prevalence of different lifestyles.

[45] These are the 13 points of what is called the sub-scale SCL-90-R on depression. The questions asked constituted a survey on various symptoms of depression (lack of energy, crying often, feeling hopeless about the future, etc…).

[46] According to the Scientific Institute for Public Health, a consensus has been reached concerning the first causal relationship: a low social-economic status because one is in poor health, only explains a very limited stand of the link between a low social-economic status and the condition of health.

25% of the population run a health risk because they have no physical exercise during their leisure time. 22% have irregular eating habits. 15% eat vegetables less than once a day. About 40% eat too little fish, fruit and whole grain bread. 44% are confronted with excess weight (BMI > 25), 13% are really obese (BMI > 30). 7% of the population are heavy drinkers (on the average 22 glasses of alcoholic beverages per week). 10% are heavy smokers (20 or more cigarettes a day)[47].

It seems that once again, those who have a lower social-economic position are often characterized by a lifestyle enhancing risks for health. For example, we can mention the prevalence of obesity and excess tobacco use. In 2004, as already mentioned, 13% of the Belgian population 18 and over were obese (BMI > 30). For persons with the lowest level of instruction, this figure reaches 20%, and for those with higher education, 6%. The percentage of heavy smokers (20 or more cigarettes a day) in the same category reached 10%, as indicated above. Here too, the percentages are higher for people with a lower level of instruction than for those with higher education (13% versus 6%).

3. Objectives of the preventive policy

Preventive policy aims at preventing new cases of disease or detecting disease more rapidly (screening). The Health Survey raises the question of the degree of participation of the adult population in prevention and screening activities. These include vaccination and screening of cardiovascular disorders, breast cancer and cervical cancer. These figures are based on the declarations of the respondents. Objective data on reimbursements from insurance companies are often significantly lower.

Vaccination

49% of the population has a vaccination card. In the last 10 years, 60% of the population of 15 years old and more were vaccinated for tetanus, 29% for hepatitis B. Vaccination cover for tetanus is decreasing, whereas cover for hepatitis B is rising. Over the last five years, 12% of the population at risk (45+) was vaccinated against pneumococcus. In the last three years, 14% of the population was vaccinated against type C meningococcus (cervical inflammation). 30% of the population 15 and over declared that they had been vaccinated against the flu at least once in the last vaccination season (September to December). For persons 65 and over, this figure rises to 47%. Vaccination cover for flu tends to be increasing.

For a number of vaccinations (flu, pneumococcus) differences corresponding to the degree of education cannot be detected. However, a positive influence of the social-economic position is observed in the case of vaccination for tetanus, hepatitis B and type C meningococcus. The higher the level of education, the higher the degree of vaccination.

With regard to **vaccination of young children**, recent figures are available for Flanders. The survey on vaccination 2005 shows that in Flanders, vaccination of infants is excellent, with the rate of vaccination as high as 90% for all vaccines offered free of charge. In comparison with a similar survey done in 1999 with 1000 young children, the degree of vaccination for all vaccines has significantly improved. According to this study, 97% of infants are fully vaccinated for polio, tetanus, croup, whooping cough and influenza H type b in the first six months and 92% have received

[47] According to comparison on an international scale, Belgian marks a relatively good mark as concerns smokers, and average for consumption of alcohol and obesity.

their fourth dose by the time they are two. More than 92% of the children are fully vaccinated against hepatitis, and 94% against measles, mumps and German measles and meningococcus C. It was possible to achieve these results thanks to the concerted, systematic efforts of doctors and vaccinating authorities as well as a high-level vaccination policy, backed by scientific corroboration. The data for the last survey in the French Community date from 2003. The percentage of cover for infants (18-24 months) varies from one vaccine to another from 85 to 90%. Among other European countries with a similar vaccination policy, only Finland and the Netherlands have reached as high a rate of vaccination.

Screening for cardio-vascular disorders and diabetes

90% of the population 15 years old and more declares that their **blood pressure** has been controlled over the last five years, 62% say that their **rate of cholesterol** in the blood has been controlled. 50% of the population 15 and over affirms that their **level of blood sugar** has been controlled over the last three years.

With regards to blood pressure, cholesterol and blood sugar, differences were not detected in view of social-economic status.

Screening for cancer

In 2004, 72% of women from 25 to 64 declare that they had had a **Pap smear** done in the last three years (the administrative data on reimbursements give a lower figure: 59%). Only 50% of persons with no degree or only a primary education declare that they had had this examination, as compared to 80% of women with a higher education degree. 36% of women 15 and over declared that they had had a **mammogram** in the last two years. In a specific target group for early detection of breast cancer (50 to 69 years old), this percentage was 71%. Here too, differences were observed with respect to the level of instruction.

4. Affordability, utilization, cost of healthcare

In comparison with 12 other EU Member States for which EU-SILC data were collected in 2004, the percentage of persons in Belgium of 16 and older who declare that during the last 12 months they **needed a medical examination or treatment but did not receive it** is limited to 1.8% this percentage is higher for dental care, or it is nearly 4%. On this point, Belgium is among the best of the Member States. There is no remarkable difference between men and women. The age group between 45 and 54, isolated persons and single-parent families are the most vulnerable, along with the jobless, 10% of whom did without medical care and 23% without dental care. As concerns dental examinations and care, there is a clear difference in view of the level of education: 30% of those who have no degree or only primary education renounced dental care, as compared to a bit more than 10% of persons with a higher education. Among the reasons for not fulfilling needs for medical treatments and examinations, financial reasons dominate (more than 60%). For dental care, financial reasons are also important (45%), but other reasons play a role as well (fear of the dentist, a lack of time...)[48].

[48] In the context of the Belgian Health Survey, the assessment of unsatisfied health-care needs is done differently from the EU-SILC. In the EU-SILC, people are questioned individually, whereas for the Health Survey, the reference person answers for the entire household. In the EU-SILC questions are asked about unsatisfied needs for medical or dental examinations and treatment; in the Health Survey the questions pertain to the following aspects of health care: medical care and operations, dental care, prescribed drugs, glasses, mental care (psychological or psychiatric care, for example)… in this context, a household that had to postpone medical consumption is a household that postpones at least one of these five types of care. In the EU-SILC, the question relates to unsatisfied needs for various reasons. In the Health Survey, the only target is care postponed or dropped for financial reasons.

Concerning affordability of medical care, it is important to verify to what extent the population is covered by health insurance, and what is the weight of expenditures for medical care in the household budget.

According to administrative statistics, **mandatory public health care insurance cover** is essentially total for Belgium: 99% for 'major therapies'. For 'minor risks', the percentage of cover is lower: 94%. This is due to the fact that for the self-employed, insurance for minor risks was not mandatory as part of the Social Security scheme. As from 1/7/2006, this insurance will gradually become mandatory for them too. There are still some problems for those who do not meet the administrative requirements in the 'non-insured persons' scheme. Persons residing in Belgium without a valid residence permit are entitled to urgent medical assistance. It seems that the administrative procedure to be complied with to benefit from this right in fact constitutes an obstacle. For people whose incomes are too low, the fact that they must pay medical care upfront poses a problem, even if they are reimbursed later.

Not all health-care expenses are reimbursed. It is hard to assess the **health care expenditures** in comparison to the income of households by means of a survey. Particular care must be given to the specific definition of the concept of health-care expenses. Ideally, one should have an idea of expenses over longer periods and take account of reimbursements. In the recent Health Survey, questions were asked about medical expenses for the past month, but reimbursements were not taken into account. The average health-care expenses measured in the context of the Health Survey are constant for the three reference years (1997, 2001 and 2004): about 6 % of the household budget. The share of health-care expenses increases sharply with the age of the reference person in the household[49] (2% of the household budget where the reference person is very young, up 13% for reference person of 75 and over) as might be expected, the share of the household budget for the highest income bracket is considerably smaller (3%) than for the lowest bracket (14%).

In verifying how the **burden of the cost of health-care in household expenses is considered subjectively,** it is observed that 29% of all households consider that their own health-care costs are (very) hard to bear. This percentage is decreasing with the various Health Surveys (33% in 1997 and 30% in 2001). Households for which the reference person is a woman (40%) consider their own health care expenses as a greater burden than households for which the reference person (25%) is a man. Major differences are observed in view of the level of instruction (higher level of instruction in the household) and with household income. More than half (51%) of households with little education considered that the burden is (very) heavy, as compared to 14% of households with a high level of education. As concerns the level of income, the corresponding percentages are 56% for the lowest level of income and 9% for the highest. In this context, single-parent households are particularly vulnerable (47%).

The lack of **supply of health care** is hardly mentioned in the SILC survey as a cause for not satisfying a need for a medical examination or treatment. Almost no one mentions waiting lists. A few common European indicators show that by international comparison, Belgium is characterized by a relatively high supply of doctors and midwives, well over the average, and an average number of beds for emergency care.

The number of active doctors for 100,000 inhabitants was 394 in 2003. This is a relatively high number. In the EU, the lowest figure (216) was recorded for the United

[49] The person in the household who provides the information requested for the entire household. In principle, this is the person who is best able to provide the information.

Kingdom, and the highest (454) in Greece (figures for 2001). In addition, in Belgium in 2003 there were 563 **nurses and midwives for 100,000 inhabitants.** As an international comparison, this figure is lower than the average. The lowest number found in 2002 was in Slovenia (166), and the highest in Ireland (1488). In 2001, in Belgium there were 499 **beds available for emergency medical care for 100,000 habitants.** Belgium was thus in the average within Europe (Finland and Sweden 235, Germany and Slovakia more than 670). Particularly due to the small size of the Belgian territory, there is no problem as concerns the geographic location of the supply.

Medical consumption does not seem or hardly seems to show major differences for the levels of education. The significant differences appear only for a certain number of specific indicators. People with little education (no degree or primary education only) have more contacts on the average with the family doctor and these are more often visits to the home, rather than consultations at the doctor's office. People with a low level of education also go less often to a specialist. People with higher level of education go more often to see a specialist. Dental care shows the influence of the social-economic level. The number of people who had contact with the dentist during the last year regularly increases with the level of education: 34% for people with a low level of education (no degree or primary education only; 56% for the better educated.

As concerns the use of prescribed drugs, controls by age and by sex did not show significant difference with the level of education. It is true, however, that people with a higher level of education use over-the-counter drugs more often.

The use of **long-term care** has evolved considerably in recent years, both as concerns admissions in institutions and home care.

For **residential care**, the difference can be observed between 1995 and 2005 -- there has been an increase of about 20% of the number of people admitted into nursing homes and retirement homes for the elderly: about 91,000 on 1/1/1995 about 118,000 on 31/3/2005[50]. Of these 118,000 persons for the elderly, about 70% are over 80. In 1995, this percentage was about 60%. 39% of persons admitted resided in nursing homes, which means that they are quite dependent. In 1995 this was the case for about 20%. In 1995, 90% of residents in nursing homes were over 80; in 2005, this figure was 75%, which may mean that the oldest groups in the population are actually aging in better health so to speak.

In Flanders, **home care** has grown remarkably. Since 1990, the number of users of home care has increased from fewer than 45,100 to more than 70,000, representing an increase of more than 55% in 15 years. It is difficult to assess to what extent this evolution is the consequence of a policy that tries to encourage people to get care at home insofar as possible, before transferring them to (expensive) institutions, or whether this is the result of changing needs, that goes hand-in-hand with an extension in the supply of care.
Existing waiting lists for admission into a nursing home show, however, that there is a real need for these services, that the current supply is not in a position to fully satisfy.

5. Quality of healthcare

A simple way to judge the quality consists of using the evaluation of the health-care system by the population. A recent Eurobarometer shows that the population is satisfied with the Belgian health-care system. In 2005, 92% of persons questioned declared they were very satisfied or rather satisfied with this system. This is the

[50] Figures provided by the *Institut National d'Assurance Maladie-invalidité* (National Institute for Illness/Incapacitation Insurance - INAMI).

highest percentage among EU Member States. The average for EU-25 countries is 61% and for EU-15 64%.

The way quality is promoted in hospitals in Belgium consists of making comparative data available, intended to enable various hospitals to compare their own performances with those of others. Various aspects can be considered: clinical performances, financial performances, capacity, intervention and attention given to patients. A multidimensional « feedback » system integrated into administrative hospital data is currently in an exploratory stage.

The first analyses of administrative hospital data concerning the number of cesareans done on low-risk mothers, and the ablation of the gallbladder by laparoscopy (laparoscopic cholecystectomy) give the impression that there are major differences in practices in hospitals[51]. Frequent use of cesareans for low-risk mothers may indicate excessive use of this kind of intervention. A laparoscopic cholecystectomy may have been considered a qualitatively better technique than an open cholecystectomy (a traditional operation) due to the lower degree of mortality, the shorter time required for the operation, faster recovery, less post-operative pain and a shorter stay in hospital. Regular reports should enable hospitals to take the position themselves and to draw their own conclusions with regard to their practices. Another field currently under review is behaviour in prescribing antibiotics.

6. Long-term financial viability of healthcare expenditures and long-term care

In comparison with other EU Member States, investments in health care are relatively high in Belgium. In 2002, the most recent year for which the data is available for all member countries of the EU, for equivalent purchasing power, US $ 2,607 **per person were spent on health care** (SEC95 methodology). This is significantly more than the EU average which is US $ 2,198. Thus Belgium is in sixth place after Luxembourg, Germany, Netherlands, France and Denmark. The Baltic countries spend the least, between US $ 625 and 450).

Expressed in percentages of **gross domestic product (GDP)**, expenditures in Belgium are relatively high. With 9.1%, Belgium was in seventh place in 2002 among the EU Member States. The EU average was 8.7%. Over the years, one can observe a clearly rising tendency for the share of national wealth devoted to health. In 1970, only 4%, in 1980 6.4% and in 1990 7.4% was spent for health care. Since 1996, about 70% of these expenditures are borne by the public sector (Social Security and various authorities). The share of purely "out-of-pocket" expenses (expenses financed directly by the households themselves) in total expenditures has dropped significantly in recent years according to certain indices (from more than 24% in the years 1998-2000 to less than 22% in the years 2003 in 2004). This decrease is probably due to the introduction of the maximum to be charged (MAF - maximum à facturer).

Since at the same time the share of private financing of health care (including complimentary private insurance) is relatively stable (about 30% of total health expenditures), it can be stated that private health insurance continues to spread.

Total expenditures taken into consideration in this context diverge slightly from the results of the « Health accounts » for Belgium, which at this time are available for 2003 only. Using this methodology (called SHA, developed by OECD in 2000), healthcare expenditures were about 9.9% of GDP in Belgium in 2003.

[51] See: *DG Organisation des provisions en matière de soins de santé – Feedback multidimensionnel et intégré des données administratives hospitalières. Phase exploratoire*. April 2006, 74 p. Other operations were also reviewed (myocardial infarctus, hip fractures, pneumonia).

In its latest report (May 2006), the study committee on aging considered that, in the period 2005 to 2050, **the budgetary cost of healthcare will increase from 7.1% to 10.8% of GDP** (+ 3.7 ppt)[52]. This projection takes account of both demographic factors (volume effect and aging effect) and non-demographic factors (in view of income per capita). A separate projection has been made per type of care: ad hoc care and long-term care. For ad hoc care, the Study Committee anticipates growth from 6.2% to 8.6% of GDP (+ 2.4 ppt.). Expenditures for long-term care are expected to increase from 0.9% to 2.2% of GDP (+1.3 ppt.).

The working group on aging of the European Committee for Economic Policy, which had already done a similar comparative study in European scale, expects a smaller increase in expenditures[53]. For the period from 2004 at 2050, public expenditures for health care are expected to increase from 7.1% to 9.5% of GDP (+2.4 ppt.). For ad hoc care the estimated increase is from 6.2% to 7.6% of GDP (+ 1.4 ppt.). Long-term health expenditures will allegedly increase from 0.9% to 1.9% of GDP. (+1 ppt.). In the context of the European comparison, the expected increase of expenditures for ad hoc care will be less than the average (EU-25 = +1.6 ppt.), whereas the expected increase in expenditures for long-term care will be higher than the average (EU-25 = +0.36 ppt.).

The differences between these two projections can be explained partially by the more pessimistic starting point of the Study Committee with regard to future state of health of the population[54]. The study committee considered that the profile of expenditures per capita was stable over time and equivalent to that of the base year. Given the lengthening of life expectancy, this point of view indicates that the initial hypothesis is for a larger number of years in poor health. WHO takes a more optimistic hypothesis as a starting point, according to which there's a certain improvement in the health of the elderly at a given age. The demographic impact of aging is therefore less important for the case envisaged by the WHO. As concerns non-demographic factors too, the Study Committee began with more pessimistic hypotheses that the WHO. In fact, it hypothesized greater elasticity of income and supposed a larger influence of the growth of income per capita on public health expenditures.

[52] See Higher Financial Council, *Comité d'étude sur le vieillissement, Annual report* , May 2006. This percentage differs to a certain extent from the one given above, because different concepts were used as concerns health care expenditures..

[53] The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050). Report prepared by the Economic policy Committee and the European Commission (DG ECFIN). In: European Economy. Special Report n° 1/2006.

[54] For a detailed comparison between the two projections, see the Higher Council of Finance, Study Committee on aging, Annual Report, May 2006, . p. 91-111.