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Tackling poverty and exclusion from day one

Combating child poverty and disadvantage is the major theme for the European Commission's social inclusion activities in 2007. EU Member States have already responded to the 2006 spring European Council's challenge to prioritise cutting child poverty, so as to break the cycle of deprivation that can be passed on from one generation to the next and ensure that all youngsters start life with the best opportunities available.

The network of independent experts set up to contribute to the Peer Review and Assessment in Social Inclusion programme is compiling a report assessing efforts in the EU Member States, to be published later this year. The document will examine policy measures for the inclusion of children and young people, and access to services such as childcare, schools and decent housing.

At the same time, a questionnaire is going out to national governments on child poverty and social exclusion, and the results will feed into the 2008 Joint Commission/Council Report on Social Protection and Social Inclusion.

The Social Protection Committee has also set up a task force on child poverty and child well-being in its Indicators Sub-Group. On the basis of its report and the other information that will have been gathered by then, the committee will organise a peer review on the topic in early October.

Good quality pre-school facilities and measures to discourage early school leaving are regarded as key elements of successful policy, and conditions for migrants and ethnic minorities also deserve special scrutiny. In the Commission's view, there is plenty of scope here for Member States to benefit from mutual learning and exchange of good practice, to reach a deeper understanding of the best way to tackle cycles of deprivation.

¹ COM (2007) 13 final

Key messages for future action

In its January Communication¹, the Commission finds that the Open Method of Coordination (OMC) has already proved its worth in supporting Member States in their drive for greater social cohesion, and in promoting the wider involvement of stakeholders at both European and national levels. For example, many governments are moving to active inclusion measures with support tailored to individual needs as the best way to get vulnerable people into the labour market while ensuring adequate minimum resources for all. At the same time, encouraging different services to work together (see Swedish Peer Review in this newsletter) and adopting a bottom-up approach involving local users are also emerging as important strategies, while evaluation and monitoring are recognised as crucial. There is, however, scope to further improve this, and some questions, such as the gender dimension, need higher priority.

Member States also recognise more clearly that economic and labour market reforms in the context of the relaunched Lisbon Strategy must help strengthen social cohesion, while social

Tackling poverty and exclusion from day one	1
Key messages for future action	1
Delta: a one-stop shop for rehabilitation services	2
New ways of working	2
Healthcare access - plugging the gaps	3





policies should at the same time support economic growth. "Social objectives have been taken into account more this past year in broader strategies," confirms Adam Tyson, head of the unit responsible for streamlining social policies in the Commission's Employment and Social Affairs Directorate-General. He adds that "there is still quite some

way to go before social inclusion is fully integrated into Member States National Reform Programmes". The so-called 'feeding in and feeding out' process will be taken up in the expert network's second report towards the end of 2007.

Delta: a one-stop shop for rehabilitation services

"We wanted to avoid people being passed from one service to another without finding the help they needed. It's important that we are located in the same building because people come with lots of different problems, so we need different professionals to see them and decide how best to support them."

Annika Lundin is manager of the primary healthcare unit in Hisingen in Göteborg, Sweden, that makes up part of the Delta project, a multidisciplinary centre offering integrated rehabilitation services for people most in need, and she is enthusiastic about its groundbreaking approach.

"We save money, because the sick rate goes down. Patients get better treatment, and there is a better climate in the workplace. Our assessment shows that clients are satisfied

and they feel safe," says Ms Lundin. "Having social insurance in the same building is very important because the reaction is quicker if you can talk to someone rather than sending letters to and fro."

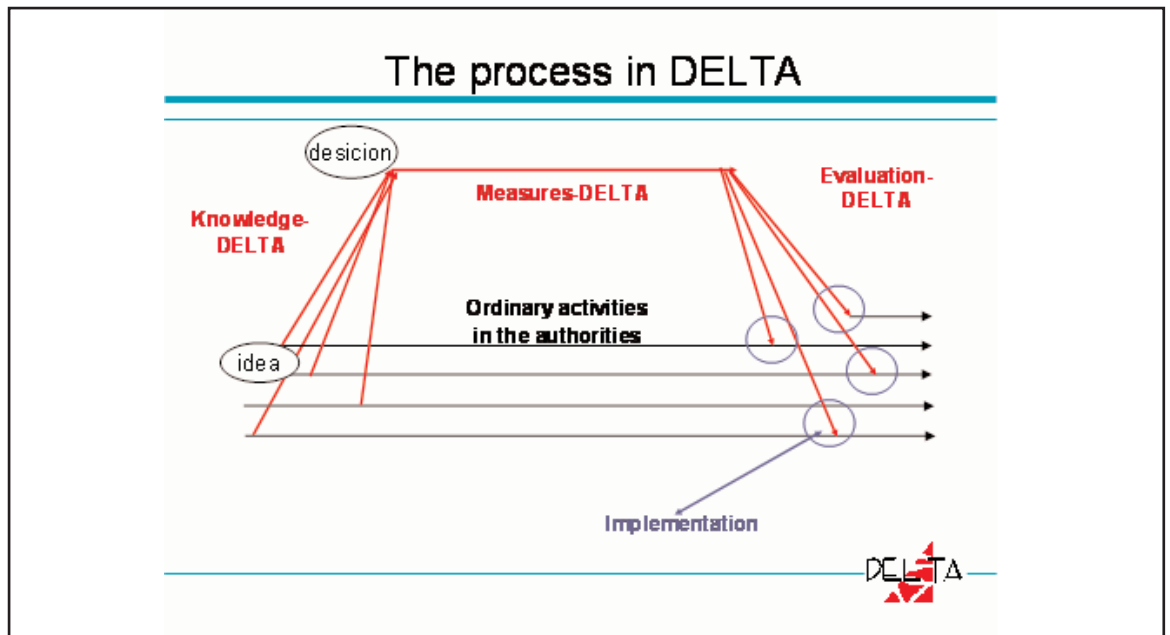
The Peer Review meeting in December 2006 looked at Sweden's framework for financial coordination, extended across the country by legislation in 2004. It enables social insurance, primary healthcare, employment and municipal social services to pool part of their budgets in order to offer integrated support to the 5% of the population judged to have multiple problems. In many EU countries, finding a holistic approach for dealing with the most socially excluded individuals, furthest from the labour market, is a pressing issue, so there was a lot of interest in the Swedish model.

New ways of working

The meeting included a visit to Delta - a pilot project that has been underway since 1997. Keith Alsterlind runs SANNA: one of Delta's 10 activities, to help people with drug and alcohol addiction problems get back into work. "We stop people going round in circles and try and help them in a real way," he agrees. When the project started out, the different professionals involved had to find new ways of working together. "We didn't agree on much at all," he admits, but slowly people started to adapt their ways of working. In 2005, 25 of the 68 people in SANNA got jobs. Even if two-thirds were subsidised posts, they were none the less economically active, and paying taxes rather than dependent on welfare payments. "Without this cooperation we would not get such a good result. To help the weakest in society, we have proved it's a good way to work," affirms Keith Alsterlind.

Cecilia Abrahamsson, Delta's process facilitator, described how an activity develops out of an idea for responding to a specific need. Bringing people together in multidisciplinary teams creates new knowledge and skills, and also greater flexibility. Delta deals with around 4,000 clients a year, most if not all of them unemployed, and the aim is to get them 'job-ready'.

The review group agreed overwhelmingly that Delta is an innovative example of good practice, and stressed the need for continuity of funding to achieve results. Stronger cooperation needs time to take hold, through changing attitudes and working cultures.



Ideas for rehabilitation activities are implemented and evaluated in Delta, before possibly being adopted as permanent programmes.

Healthcare access - plugging the gaps

Universal access, high-quality service and sustainability - those are the main healthcare aims of the EU and its Member States. Certainly, there have been huge health improvements throughout Europe in recent decades. And yet, although access to healthcare is supposed to be equal and universal, big gaps still exist in practice. There are major differences in health status among the Member States, but also within them. In every EU country, those on higher incomes are likely to be healthier than those with limited means. Why, and what can be done about it?

Experts from ten EU countries met in Budapest on 17-18 January to seek some answers. This first peer review on healthcare issues was hosted by the Hungarian Ministry of Health, which is currently in the middle of major healthcare reforms. The Hungarian government believes that change is essential, notably because of the country's high morbidity and mortality rates; conflicts between the intentions of macro health policy and institutional interests; a lack of financial and professional transparency in the system, as manifested by widespread "under-the-table payments" for healthcare; and changing needs, due amongst other things to a rapidly ageing population.

The main purpose of the review was to take stock of the Hungarian government's chosen remedies. These include a new focus on areas such as oncology, cardiology, children's health and medical emergencies; the integration of long-term care with healthcare; and adjustments to hospital bed capacity. More controversially, "co-payments" will be introduced - patient contributions of just over one euro per visit to the doctor or per day in hospital. However, some four million people out of Hungary's population of ten million will be exempt from the charges.

Another hotly debated proposal, on which no decision had yet been taken at the time of the review, was the possible introduction of a multiple insurance system, with different insurance companies competing. A number of peer reviewers expressed doubts about this. One objection is that, in countries where health insurance is market-based, administrative costs consume up to 20% of the total healthcare budget, whereas under a single-insurer system, the corresponding figure is as low as 1.5%. However, the Hungarian Secretary of State anticipated that the administrative burden would represent only about half of the savings made through the



introduction of co-payments and, possibly, multiple insurance. Participants also wondered if price competition might not reduce the content of the basic health insurance package and if companies might not engage in "risk selection" by turning down the applicants who were most likely to require healthcare. The Secretary of State replied that all insurers would be required to offer a government-defined basic package and to accept all applicants.

On healthcare throughout Europe, the Budapest seminar raised a number of points which will be brought to the attention of the EU's Social Protection Committee. What emerged quite clearly is that true equality of access to healthcare entails more than simply ensuring equal treatment for all. So how can the needs of different socio-economic groups and different regions be met? What forms of outreach can get to the people who tend to remain outside the healthcare system? What can be done to counter the effects of the "inverse care law", a perverse relationship between the need for health care and its actual utilisation, which in essence says that those who most need medical care are least likely to receive it, while those with least need of health care tend to use health services more (and more effectively)? How can we tackle the situation where care capacity is developed where it is the least needed, whilst there remain serious limitations with regards to accessibility and quality of healthcare services provided where the needs are the greatest?? Can the market help? What role might be played by co-payments and financial incentives? What could be the role of care coordination?

In healthcare policy formulation, where should the line be drawn between stakeholders and lobbyists? How can services be reorganised to strengthen prevention? What potential does technology offer? How can waiting times be reduced? How can education, awareness and information be strengthened? How can data collection and monitoring be improved on health status, access and use by population groups? What should be the links to policies in other sectors - for example, on reducing unemployment and social exclusion? As some of the biggest healthcare provision gaps in Member States happen to be in border areas, is cross-border healthcare cooperation one possible solution? How can EU structural funds be used for health promotion and for filling infrastructure gaps in Europe's poorer regions? The debate has just begun.