Lebenslagen in Deutschland

Armuts- und Reichtumsberichterstattung der Bundesregierung

Forschungsprojekt

Vergleichende Analyse der Teilhabechancen in Europa

Social Inclusion in Europe

Final Report

European centre for
social welfare policy and research, Vienna

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„VERGLEICHENDE ANALYSE DER TEILHABECHANCEN IN EUROPA“

SOCIAL INCLUSION IN EUROPE

FINAL REPORT, 10 NOVEMBER 2011

EUROPEAN CENTRE FOR SOCIAL
WELFARE POLICY
AND RESEARCH,
VIENNA

EUROPEAN CENTRE · EUROPÄISCHES ZENTRUM · CENTRE EUROPÉEN
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Aims of the report

The research project aims to compile a comprehensive study on social inclusion in Europe, which would serve as the fourth edition of the "Armuts- und Reichtumsberichterstattung (ARB)" for the Deutsche Bundestag. The research project is commissioned and financed by the Bundesministerium für Arbeit und Soziales (BMAS).

The report describes social inclusion of the population of EU countries in various dimensions, including income, health, housing, education, social participation, and subjective well-being. It compares the situation of specific social groups, based on gender, age, and for some issues, migrant status. In contrast to many existing report, the focus is not be exclusively on those marginalized at the bottom, but we analyse the situation of those at the top. We explore how to conceptualize these "privileged" positions in terms of income, health care access, social participation and subjective well-being. Finally, the policy implications of the presented evidence is discussed, including best practices across selected European countries and policy areas, with policy recommendations for Germany.

About the European Centre

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Project team

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Zusammenfassung

Konzeptioneller Hintergrund

"Teilhabechancen" bezieht sich auf (soziale) Beteiligungsmöglichkeiten, die sowohl auf die Situation im Sinne von sozialer Teilhabe als auch auf die Chancen des Einzelnen oder von Gruppen auf eine solche Beteiligung verweisen. Oftmals wird der Begriff in Zusammenhang mit bestimmten Bereichen des Lebens (Politik, Beschäftigung, Bildung, Kultur) und bestimmten sozialen Gruppen (Frauen, Männer, ältere Menschen, Jugendliche, Behinderte, Migranten) verwendet.

Die Theorie der Chancengleichheit, sowie die theoretischen Arbeiten von Sen über „capabilities“ (Fähigkeiten, Verwirklichungschancen) stehen in einem engen konzeptionellen Zusammenhang zum Begriff der Chancen („opportunities“). Chancengleichheit (Equality Of Opportunities / EOP) bezieht sich dabei auf die Idee der "Nivellierung des Spielfeldes" und impliziert, dass der sozio-ökonomische Status, in den man hinein geboren wird keine Auswirkung auf die eigene Wettbewerbsaussichten haben sollte. Aus dieser Perspektive betrachtet, findet die Verbesserung der sozialen Teilhabechancen somit eine einfache Übersetzung in Chancengleichheits-Politik. Diese hat zum Ziel allen die gleichen Chancen zur Teilnahme an einem erfüllten Leben zu ermöglichen, frei von Zufällen in Bezug auf Geburt und Lebenslage, damit Menschen die gerechte Belohnung für ihre eigenen Bemühungen ernten können.

Der Nobelpreisträger Amartya Sen argumentiert, dass die "echte" Chancengleichheit durch gleiche Verwirklichungschancen erfolgen muss (capability approach; 1992, S. 7). Verwirklichungschancen sind die tatsächlichen Möglichkeiten die Menschen haben, jener Zustand ihres Seins, den sie fähig sind zu erreichen. Verwirklichungschancen umfasst die Möglichkeit ein Leben zu führen, das die „normale“ Länge dauert, also nicht verfrüht zu sterben; der Begriff umfasst außerdem die Möglichkeit zu haben in guter Gesundheit zu leben (einschließlich reproduktiver Gesundheit); ausreichend ernährt zu sein; eine angemessene Unterkunft haben; die Möglichkeit, Bindungen zu Dingen und Menschen aufzubauen und einiges mehr (Nussbaum 2000). Sen selbst verzichtet darauf, eine umfassende Liste der Verwirklichungschancen aufzustellen. Die Theorie der Verwirklichungschancen respektiert die Freiheit der Menschen (z. B. die Vielfalt ihrer Wahlentscheidungen und ihres Geschmacks) und berücksichtigt ihre Unterschiede in Bezug auf Fähigkeiten und Ausgangspositionen. Zum Beispiel, braucht eine körperbehinderte Person wahrscheinlich mehr Ressourcen als eine Person ohne körperlicher Beeinträchtigung, um das gleiche Maß an Verwirklichungschance ihrer Gesundheit und sozialer Teilhabe betreffend zu haben. Sens Arbeit hatte einen tiefgreifende Einfluss auf das Paradigma des „Human Development“, das darauf beruht, dass das „eigentliche Ziel menschlicher Entwicklung die Vergrößerung der Wahlmöglichkeiten ist." (UNDP 1991) Diese zusätzlichen Möglichkeiten umfassen politische Freiheit, garantierte Menschenrechte und Selbstachtung.

Soziale Eingliederung kann als eine *statische Situation* definiert werden: all diejenigen, die nicht ausgegrenzt sind, sind einbezogen, was normalerweise für die Mehrheit der Gesellschaft zutreffen sollte. Wir können uns soziale Eingliederung auch als einen *Prozess* denken der diejenigen, die marginalisiert sind, bei der Integration behilflich ist. Eine Politik der sozialen Eingliederung kann somit sicherstellen, dass Armut und Arbeitslosigkeit nur Übergangsphasen des Lebens bleiben. Eine solche Politik bedeutet mehr als die traditionelle soziale Sicherheit und Sozialhilfe, da sie (im Idealfall) eine Vielzahl von koordinierten politischen Bemühungen bietet, und sich nicht nur auf Einkommensmangel, sondern auch auf Verwirklichungschancen und andere Aspekte des Lebens, sowie die Wechselbeziehung zwischen diesen Teilbereichen des Lebens richtet. Eine Politik der sozialen Eingliederung kann auch *präventiven Charakter haben, da durch die* Bereitstellung eines

umfassenden sozialen Sicherheitsnetzes verhindert werden kann, dass Menschen ausgegrenzt werden.

Zwischen internationalen Organisationen hat die Verwendung von *Indikatoren des Wohlbefindens zur Messung sozialen Fortschritts bereits einen breiten* Konsens erreicht. Die OECD veranstaltete eine Reihe von internationalen Konferenzen zum Thema Messung und Förderung des gesellschaftlichen Fortschritts. Im Jahr 2007 stellte Eurostat Mittel bereit um die Messung des Wohlbefindens auf EU-Ebene zu ermöglichen. Die Bemühungen und Leistungen werden auf der "GDP and beyond" Eurostat-Website veröffentlicht.[1] Im Juli 2011 haben die Vereinten Nationen eine Resolution unter dem Titel "Glück: hin zu einem ganzheitlichen Ansatz von Entwicklung" angenommen. Diese fordert die Mitgliedstaaten auf, politische Maßnahmen zu setzen, um das Ziel nach mehr Glück und Wohlbefinden voranzutreiben.[2] Die Resolution hält des weiteren fest, dass das Bruttosozialprodukt "nicht dazu entworfen wurde das Glück und Wohlergehen der Menschen in einem Land zu messen und dieses daher nicht angemessen widerspiegelt".

Niedriges Einkommen und materielle Deprivation

Das Konzept der Armut in relativen anstelle von absoluten Begriffen umfasst jene, die ein Einkommen unterhalb einer bestimmten Schwelle im Verhältnis zum durchschnittlichen Einkommen in dem Land, in dem sie leben, haben. Die derzeitige Konvention in der EU zieht als Armutsgefährdungsschwelle 60% des durchschnittlich verfügbaren Äuquivalenzhaushaltseinkommen heran, das Unterschiede in der Größe und Zusammensetzung der Haushalte berücksichtigt (die Anpassung wird mit Hilfe der der modifizierten OECD-Skala durchgeführt).[3]

Neben der Armutsgefährdungsquote wird auch der Indikator der materiallen Deprivation herangezogen. Dieser ist ein absolutes Maß, basierend auf einem einzigen EU-weiten Standard, und variiert daher nicht zwischen den einzelnen Ländern. Deprivation wird im weiten Sinne aufgefasst als nicht in der Lage zu sein ein menschenwürdiges Leben zu führen und wird in Hinblick auf das Fehlen relevanter Güter und Dienstleistungen gemessen. Dieses Maß konzentriert sich auf "erzwungenen Mangel", wobei "erzwungen" impliziert, dass das Mangelnde etwas ist, was der Haushalt haben möchte, aber sich nicht leisten kann. Zum Beispiel ist eine Familie *nicht* benachteiligt wenn sie kein Auto hat weil sie keines haben will.

Etwa 16% der Bevölkerung in der gesamten Europäischen Union, sprich 80 Millionen Menschen, waren nach der EU-SILC Erhebung aus dem Jahr 2009 von Armut bedroht, hatten also nur ein Einkommen von weniger als 60% des Mittelwertes des Landes, in dem sie leben, zur Verfügung. Der betroffene Anteil variiert zwischen 9% und 26% in den einzelnen EU-Mitgliedstaaten. Am wenigsten von Armut betroffen waren Personen in der Tschechischen Republik, der Slowakei, den Niederlanden und Slowenien, und über dem Durchschnitt betroffen waren Personen in den baltischen Staaten, Bulgarien, Rumänien sowie den südlichen Ländern, Griechenland, Italien, Portugal und Spanien. Die Armutsgefährdungsquote in Deutschland blieb leicht unter dem EU-Durchschnitt (15,5% vs. 16,3%). Werden die Konfidenzintervalle der Schätzung berücksichtigt, so lag

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[1] http://epp.eurostat.ec.europa.eu/portal/page/portal/gdp_and_beyond/achievements

[2] UN News Centre: „Happiness should have greater role in development policy – UN Member States". http://www.un.org/apps/news/story.asp?NewsID=39084 . Access date: 21 October 21, 2011.

[3] Die Armutsgrenzen unterscheiden sich stark zwischen den einzelnen Ländern in Bezug auf die Kaufkraft die sie repräsentieren. Die durchschnittliche Armutsgrenze in den 12 Ländern, die der EU seit 2004 beigetreten sind, war nur etwa die Hälfte des Durchschnitts in den anderen 15 Mitgliedstaaten in Kaufkraft und noch viel weniger in Euro. In Deutschland, wurde die 2008 Armutsgrenze für einen Haushalt mit zwei Erwachsenen und zwei Kindern als 23.400 € berechnet, und für eine einzelne Person als 11.200 €.

die Armutsgefährdungsquote in Deutschland 2008 mit einer Wahrscheinlichkeit von 95% zwischen 15,1% und 15,9%.

Zwischen 2004 und 2008 sank der Anteil der von Armut bedrohten Bevölkerung in Irland, Polen, der Tschechischen Republik und der Slowakei, und ist wahrscheinlich auch in Ungarn und Portugal gesunken. Im Gegensatz dazu stieg der Anteil der von Armut Bedrohten in Dänemark, Deutschland, Finnland, Lettland, Luxemburg und Schweden. In den meisten Ländern gab es jedoch keine statistisch signifikante Veränderung in der Armutsgefährdungsquote innerhalb dieses Zeitraumes von 5 Jahren.

Frauen in den meisten EU-Ländern haben tendenziell ein höheres Armutsrisiko. Die Armutsgefährdungsquote der Frauen in der EU ist im Durchschnitt um 1,7 Prozentpunkte höher als jene der Männer. Auch in Deutschland besteht ein geschlechtsspezifischer Unterschied, der zwar sehr klein, jedoch dennoch statistisch signifikant ist.

Kinder und Personen im Alter von 65 Jahren oder älter sind in der EU in der Regel einem höheren Armutsrisiko ausgesetzt als die Bevölkerung im erwerbsfähigen Alter. *Deutschland* scheint in diesem Punkt eine Sonderstellung einzunehmen (nur Norwegen ist ähnlich), denn weder Kinder noch ältere Menschen sind von einem relativ hohen Armutsrisiko bedroht. Betrachtet man allerdings nur ältere Personen, die alleine leben, so ist das Armutsrisiko deutlich höher. Während Kinderarmut kein Thema in Deutschland zu sein scheint, sind junge Erwachsene überdurchschnittlich von Armut gefährdet.

Alleinerziehende und Menschen in Haushalten mit niedriger Arbeitsintensität haben ein Armutsrisiko von respektive 38% und 53%. Diese beiden sozialen Gruppen haben gleichzeitig auch häufiger mit materieller Deprivation zu kämpfen. Mit 20% und mehr liegen sie mehr als vier Mal höher als der nationale Durchschnitt. Dies lässt vermuten, dass diese Gruppen von langfristiger Armut betroffen sind, die auch ihr Konsumverhalten verändert hat.

Die Analyse der Kernziele der Strategie Europa 2020 legt nahe, dass insgesamt 107 Millionen Menschen in der EU nach mindestens einem der drei Indikatoren – von Armut bedroht, start depriviert oder in einem Haushalt mit niedriger Arbeitsintensität lebend - von Ausgrenzung bedroht sind. Etwa 6,5 Millionen Menschen oder 6% der gesamten Population, die als von Ausgrenzung bedroht definiert wurde, sind nach allen drei Indikatoren benachteiligt. Nur eine Minderheit scheint also unter schwerer kumulativer Benachteiligung zu leiden.

In Deutschland sind 13 Millionen Menschen von Armut bedroht, verglichen mit 7 Millionen, die in Haushalten mit niedriger Arbeitsintensität leben und 4 Millionen, die materiell depriviert sind. Beachten Sie jedoch, dass 7 von 13 Millionen Deutschen, die von Armut bedroht sind, *nicht* materiell depriviert oder *nicht* durch niedrige Arbeitsintensität charakterisiert sind, was auf möglicherweise kurzfristige Armut (im ersten Fall) oder auf Armut trotz Arbeit (im letzteren Fall), hindeutet. Etwa 1,5 Millionen Menschen sind nach allen drei Indikatoren von Ausgrenzung bedroht.

Die Ergebnisse der Clusteranalyse der drei Indikatoren zeigt vier Gruppen von Ländern innerhalb der EU. Deutschland, gemeinsam mit dem Vereinigten Königreich, Irland und Belgien werden durch einen überdurchschnittlichen Anteil an Haushalten mit niedriger Arbeitsintensität (12-24%), durch unterdurchschnittliche Anteile von Menschen mit schwerer materieller Deprivation (3-6%), und durch im EU-Durchschnitt liegende Armutsgefährdungsquoten, charakterisiert. Diese Gruppe kann daher auch als “ "Armut trotz Arbeit"-Länder genannt werden, welche am stärksten von niedriger Arbeitsintensität betroffen ist".

Ungleichheiten bei der Gesundheit

Die empirische Evidenz deutet auf eine klare Beziehung zwischen dem sozioökonomischen Status und gesundheitlichen Folgen, sowohl in Bezug auf den Gesundheitszustand als auch in Hinblick auf den Zugang zur Gesundheitsversorgung hin.

Höhere sozioökonomische Gruppen (höheres Bildungsniveau und Einkommen) neigen dazu, die *selbst wahrgenommene Gesundheit* systematisch besser einzuschätzen, einschließlich der subjektiven Gesundheit, Einschränkungen bei den täglichen Aktivitäten und chronischen Erkrankungen. Im Gegensatz dazu berichten die Angehörigen des unteren Einkommens-Fünftels in allen europäischen Ländern signifikant seltener von "sehr guter Gesundheit". In Deutschland zeigt sich die relative Benachteiligung der unteren Einkommensgruppen in allen Altersgruppen: Personen des untersten Einkommens-Fünftels erleben viel eher einen schlechten oder sehr schlechten Gesundheitszustand als andere Einkommensgruppen.

Es ist wichtig zu betonen, dass der länderübergreifende Vergleich der subjektiven Gesundheit durch kulturelle Faktoren beeinflusst wird. Deutschland gehört zu jenen Ländern, wo sich gezeigt hat, dass die Menschen ihren Gesundheitszustand bisher unterbewertet haben, während dänische und schwedische Befragten tendenziell ihre Gesundheit überschätzten (Jürges 2007). Die *durchschnittliche Lebenserwartung bei guter Gesundheit* (teilweise basierend auf der Selbsteinschätzung von Einschränkungen[4]) scheint in Deutschland weit unter dem EU-Durchschnitt zu liegen, obwohl Deutschland bei objektiveren Daten zur durchschnittliche Lebenserwartung (basierend auf Mortalität) relativ gut liegt. Dies scheint die deutsche Gewohnheit, die (subjektive) Gesundheit zu unterschätzen, widerzuspiegeln, anstatt tatsächlich einen im europäischen Vergleich schlechten Gesundheitszustand zu reflektieren.

Von Armut bedrohte Personen sehen sich auch öfters mit *Barrieren zum Zugang medizinischer Versorgung* konfrontiert. Selbstbehalte, Mangel an kostenlosem Transport oder Entfernungen zu den Diensten, sowie Wartezeiten (ohne Option, diese durch die Inanspruchnahme privater Dienstleistungen zu umgehen) stellen vor allem für Personen unterer Einkommensgruppen Einschränkungen dar. Im Durchschnitt der EU27 sind 8% des unteren Einkommens-Fünftels nicht in der Lage sich zahnärztliche Versorgung zu leisten weil sie diese als "zu teuer" betrachten.

Im Vergleich zu den meisten westeuropäischen Ländern hat *Deutschland einen relativ hohen Anteil von Personen im unteren Einkommens-Fünftel (5,8%) mit medizinischer Unterversorgung auf Grund der Selbstanteile bei medizinischen Gesundheitsleistungen.*.

Während *Wartezeiten* in den meisten EU-Mitgliedstaaten mit einem sehr niedrigen Problemen medizinischer Unterversorgung fast kein Thema sind, waren sie traditionell die wichtigsten Hindernisse für den Zugang in einigen anderen Ländern, wie Finnland und das Vereinigte Königreich (Huber et al. 2008). In Deutschland scheinen Wartezeiten kein besonderer Grund für medizinische Unterversorgung zu sein: Die geschätzten Raten sind 0,1% im Falle dentaler Probleme und 0,6% für medizinische Probleme im Allgemeinen.

Wohnraumunterversorgung und Zugang zu Dienstleistungen

Im Jahr 2009 waren schätzungsweise 30 Millionen Menschen, das sind 6% der Bevölkerung der EU27, von schwerer Wohnraumunterversorgung betroffen. Personen sind wohnraumunterversorgt, wenn sie in einer überfüllten Wohnung leben, die außerdem zumindest einen grundlegenden Qualitätsmangel aufweist ((entweder (1) ein undichtes Dach oder feuchte Wände, Böden, Fundamente oder verrottete Fensterrahmen oder Böden, oder (2) weder eine Badewanne, noch eine Dusche, noch eine Innentoilette, oder (3) zu dunkel). In Bezug auf Wohnraumunterversorgung teilt sich Europa in zwei Hälften, wobei vor allem Ost- und Südeuropa von diesem Problem betroffen ist. Deutschland ist mit einem Anteil von 2% eines jener Länder, welches von schwerer Wohnraumunterversorgung am wenigsten betroffen ist.

[4] Gesunde Lebensjahre werden nach der Sullivan-Methode berechnet, die Informationen über Mortalitäts- und Morbiditäts-Daten kombiniert (d.h. Einschränkungen bei den Aktivitäten wegen gesundheitlicher Probleme).

Im Jahr 2009 lebten 18% der Bevölkerung der EU27 in überbelegten Haushalten. Dieser objektive Indikator basiert auf der Anzahl der Zimmer, der Haushaltsgröße und -Zusammensetzung. Das Problem stellt sich viel häufiger in den osteuropäischen Ländern, mit Raten von 40 oder sogar 50% (in Ungarn, Rumänien und Lettland). Die niedrigsten Überbelegungsraten wurden in Zypern (1%) und in den Niederlanden (2%) verzeichnet. In Deutschland beträgt die geschätzte Rate 7%, ähnlich wie in Luxemburg oder im Vereinigten Königreich.

Von Armut bedrohte Personen leben häufiger in beengten Verhältnissen oder in einer Wohnung mit Qualitätsdefiziten. In Deutschland sind 22% der von Armut bedrohten Bevölkerungsgruppe überfüllten Bedingungen ausgesetzt. Ähnliche Raten herrschen auch in Norwegen, Luxemburg, Dänemark und Schweden vor. Diese Quoten mögen im Vergleich zu Osteuropa niedrig erscheinen, sind jedoch nach nationalen Normen relativ hoch, genauer gesagt im Vergleich zur Gesamtbevölkerung in etwa dreimal so hoch. So sind Deutsche im nationalen Durchschnitt „nur“ zu 7% von schwerer Wohnraumunterversorgung betroffen.

Die am stärksten betroffene soziale Gruppe in Deutschland sind junge Erwachsene, so leben 34% in überbelegten Haushalten und 14% in Wohnungen die schwere Qualitätsmängel aufweisen. In dieser Gruppe kann man allerdings teilweise von einem Lebenszyklus-Effekt sprechen, da anzunehmen ist, dass sich die Situation der jungen Leute mit Erreichung ihres Bildungsabschlusses möglicherweise verbessern wird. Alleinerziehende Eltern sind ebenfalls weitgehend von Überbelegung (25%) und schwerer Wohnraumunterversorgung (9%) betroffen. Diese beiden Haushaltstypen leben tendenziell in Wohnungen die zu Marktpreisen vermietet werden, daher hat es eindeutig mit Erschwinglichkeit zu tun. Andere soziale Gruppen mit überdurchschnittlicher Häufigkeit von Überbelegung und Qualitätsmängel sind von Armut bedrohte, große Familien (jene mit 3 + Erwachsenen und jene mit 3 + Kindern), und Einwanderer außerhalb der EU. MieterInnen mit einer freien Unterkunft oder einer subventionierten Miete haben in Deutschland eher Erfahrungen mit Überbelegung.

Ein Vergleich der selbst wahrgenommen finanziellen Belastung der Haushalte mit den Ergebnissen der objektiven Indikatoren zeigt, dass typischerweise die selbst wahrgenommene finanzielle Belastung viel höher ist als die objektiv gemessene. In Deutschland nehmen 20% der Bevölkerung ihre gesamten Wohnkosten (einschließlich Hypothektilgungen) als eine schwere Bürde wahr.

Etwa jede fünfte Person in der EU27 berichtet von Schwierigkeiten in Hinblick auf den *Zugang zu öffentlichen Verkehrsmitteln*.[5] Der Zugang zu öffentlichen Verkehrsmitteln ist insbesondere für Gruppen mit niedrigem Einkommen wichtig, da sie sich weniger wahrscheinlich ein Auto und dessen Erhaltung leisten können, und er ist lebenswichtig für Pendler um den Arbeitsplatz erreichen zu können. In 12 von 27 Ländern, darunter Deutschland, hat die von Armut bedrohte Bevölkerung *keine* relativ höhere Häufigkeit von "großen Schwierigkeiten" im Zugang zu öffentlichen Verkehrsmitteln als die Gesamtbevölkerung, was eher beruhigend ist für die Agenda der sozialen Eingliederung. Personen mit Problemen in Deutschland sind vor allem Personen, die im ländlichen Gebiet leben und auch größere Familien.

Norwegen, das Vereinigte Königreich und Zypern sind am wenigsten von Schwierigkeiten beim *Zugang zu Post- und Bankdienstleistungen* (2-8%) betroffen. Deutschland, mit einer Quote von 21%, befindet sich auf dem Niveau des EU27 Durchschnitts. Es gibt eine gewisse Korrelation mit dem Status “niedriges Einkommen”. In den meisten Ländern der EU, darunter auch in Deutschland, haben Menschen mit Einkommen auf Armutsniveau eher Schwierigkeiten mit dem Zugang zu Post- und Bankdienstleistungen.

[5] Die Zugänglichkeit der Dienste wird als physikalischen und technischen Zugang erhoben (z. B. Entfernung, Ausrüstung für Personen mit körperlicher Behinderung), sowie anhand der Öffnungszeiten und eines entsprechenden Zeitplans, aber nicht in Bezug auf Qualität, Preis und Ähnliches mehr.

Soziale Isolation

Unsere Analyse, die sich auf dem European Social Survey mit 46.000 Personen in 24 Ländern stützt, zeigt, dass soziale Isolation in Deutschland im internationalen Vergleich vergleichsweise gering ist. Nach unseren Schätzungen haben etwa 5% der deutschen Bevölkerung niemand mit dem sie persönliche Angelegenheiten besprechen können. In etwa der Hälfte der Länder in unserer Stichprobe erreicht dieser Anteil 10%, mit einem Spitzenwert von 29% in Rumänien. Alternative Indikatoren weisen ebenfalls darauf hin, dass Deutschland nach europäischen Maßstäben gut funktioniert. 7% der Bevölkerung trifft Freunde, Verwandte oder Kollegen seltener als einmal pro Monat oder nie (und nur 1% "nie"). Auch nach dem speziellen Modul zur sozialen Teilhabe der EU-SILC 2006 Erhebung hatten 5% der Deutschen keinen Verwandten, Freund oder Nachbar für Hilfe zur Verfügung (Lelkes 2010).

Es gibt klare soziale Muster die sich über die Länder hinweg zeigen. Bezahlte Arbeit und ehrenamtliche Tätigkeit tragen tendenziell zu einer guten Sicherung sozialer Netzwerke bei, weil die TeilnehmerInnen in diesen Netzwerken wahrscheinlich weniger isoliert sind. Es gibt Hinweise auf ein sehr ausgeprägtes Altersmuster, welches im Besonderen Senioren beeinflusst. Deutschland scheint hier eine Ausnahme zu bilden, da nur 6% der älteren Menschen berichten, dass sie niemanden haben, um persönliche Angelegenheiten zu besprechen. Gruppen mit niedrigem Einkommen leben in allen Ländern häufiger isoliert. In Deutschland, leben Personen im unteren Einkommensfünftel 1,7 mal häufiger isoliert als Personen im oberen Einkommensfünftel. Des weiteren sind auch "Minderheitengruppen" (diejenigen, die angeben, dass sie in ihrem Land unter Diskriminierung leiden) häufiger von sozialer Isolation betroffen.

In Deutschland geht Arbeitslosigkeit mit einer stärkeren sozialen Isolation einher, während junges Alter und höhere Bildung soziale Isolation eher verhindern können. 16% der Arbeitslosen haben keine(n) enge(n) Freund/Freundin, und 10% von ihnen haben sehr seltene persönliche Kontakte. Soziale Isolation, gemessen als begrenzte soziale Kontakte, ist sehr verbreitet unter Menschen mit Behinderung (diejenigen, die in ihren täglichen Aktivitäten "sehr behindert" sind), mehr als doppelt so häufig als in der Allgemeinbevölkerung. Faktoren wie hohes Alter, Inaktivität oder in Ost-Deutschland zu leben sind weitere Faktoren, die häufiger mit eingeschränkten sozialen Kontakten verbunden sind. Alle diese Unterschiede wurden überprüft und waren statistisch signifikant.

Im Fall von Deutschland mahnen die Akkumulation von sozialer Isolation und Arbeitslosigkeit zur Vorsicht. Fast jedeR sechste Arbeitslose behauptet, dass er/sie niemanden hat, mit dem er/sie intime und persönliche Angelegenheiten besprechen kann. Dies, kombiniert mit dem psychischen Stress im Zusammenhang mit der Arbeitslosigkeit, macht sie mit hoher Wahrscheinlichkeit anfälliger für psychische Belastungen, die auch körperliche Folgen für die Gesundheit haben können. In weiterer Folge kann dies ihre Arbeitsfähigkeit oder auch ihre Beteiligung an sozialen Aktivitäten wie etwa Freiwilligenarbeit oder Pflege zu Hause (Kinderbetreuung oder Langzeitpflege) stark beeinträchtigen.

Subjektives Wohlbefinden: "Elend"

Einschätzungen des Gesamtwohlbefindens verwenden häufig Daten zu selbst berichtetem Glück und selbst berichteter Zufriedenheit mit dem Leben insgesamt. In dieser Art der Messung, gewichten und beurteilen die Menschen ihre spezifische Zusammensetzung an Lebensumständen und -bedingungen. Somit informiert dieses Maß auch über die Kluft zwischen objektiven Lebensbedingungen und der eigenen Bewertung dieser Situationen durch die Menschen. Letzteres wird auch weitgehend von den Aspirationen der Menschen beeinflusst werden.

Die Politik kann keinen Einfluss auf das Alter oder Geschlecht der Menschen nehmen, noch kann sie das so genannte Match-Making (“Zusammenpassen”) für die Ehe durchführen, auch wenn es die Menschen im Durchschnitt glücklicher machen würde. Was sie aber offensichtlich bei den

Determinanten des Glücks auf der individuellen Ebene beeinflussen kann, sind Einkommensungleichheit, Bildung, Beschäftigung, einschließlich der Qualität von Beschäftigung. Unsere empirische Analyse zeigt, dass die allgemein verwendeten Indikatoren der sozialen Ausgrenzung, einschließlich Arbeitslosigkeit, geringem Einkommen, schlechter Gesundheit und sozialer Isolation, eine negative Auswirkung auf das subjektive Wohlbefinden haben.

Die Arbeitslosenquote hat eine klare kausale Wirkung und macht Menschen unglücklich. Dieser Effekt auf das Glück ist groß, und geht über die reine negative Wirkung des Einkommensverlusts im Zusammenhang mit der Arbeitslosigkeit hinaus. Eine Politik zur Reduzierung von Arbeitslosigkeit daher eine deutliche Wirkung im Sinne einer Steigerung des allgemeinen Wohlbefindens.

Unter Verwendung von GSOEP-Daten, finden Schwarze und Haerpfer (2007), dass der durchschnittliche Deutsche der Ungleichheit abgeneigt ist. Die Wirkung der Ungleichheit auf das subjektive Wohlbefinden unterscheidet sich nach dem Einkommensniveau und der politischen Ideologie des Individuums (Alesina et al. 2004). Ungleichheit "schmerzt", denn Menschen bewerten ihre eigene Situation im Vergleich zu anderen (Clark, Frijters et al. 2008). Die Reduzierung der Einkommensungleichheit führt somit wahrscheinlich zur Steigerung des gesamten gesellschaftlichen subjektiven Wohlbefindens. Dies trifft allerdings nur auf lange Sicht zu. Ein (sehr unwahrscheinlicher) einmaliger Transfer von Einkommen von den Reichen zu den Armen, auch wenn es politisch und sozial machbar wäre, würde das Wohlbefinden insgesamt voraussichtlich verringern. Der Grund dafür liegt in der Asymmetrie: Einkommensverlust schmerzt mehr als die Freude über Einkommenszuwachs.

Höhere Bildungsabschlüsse vermindern die Wahrscheinlichkeit von psychischem Elend, wobei dieser Effekt vor allem indirekten Einfluss hat: durch Lebensführung, einschließlich besserer Gesundheitskenntnisse und höherem Verdienst. Bildung ist eindeutig ein Weg zur Verbesserung der langfristigen Chancen im Leben und der Lebensqualität. Die aktuellen Daten erlauben keine weiteren Aussagen über das Verhältnis von subjektivem Wohlbefinden und der spezifischen Art und Weise von Bildung. Wir kommen jedoch eindeutig zu der Schlussfolgerung, dass eine Politik welche auf die Steigerung der Bedürfnisse nach Wohlbefinden ausgerichtet ist, inhärent bildungspolitische Maßnahmen beinhalten sollte.

Die Ergebnisse unterstreichen auch die Bedeutung der Integration ethnischer Minderheiten. Ungeachtet der Messprobleme bei der Identifizierung dieser Gruppen scheint ein selbsternannter Status als ethnische Minderheit eindeutig mit niedrigerem subjektiven Wohlbefinden zu korrelieren.

Soziale Isolation kann nicht direkt durch politische Maßnahmen abgeschafft werden, da die Menschen in ihrer Lebensführung autonom sind, aber sie kann beeinflusst werden. Der Erwerb sozialer Kompetenzen könnte zum festen Bestandteil der formalen Bildung und der nicht-lehrplanmäßigen Aktivitäten von Schulen werden. Weiters könnten Anreize zur ehrenamtlichen Tätigkeit oder, auf institutioneller Ebene, zur Unterstützung von NGOs, Vereinen und Clubs, soziale Verbundenheit fördern. Im höheren Alter spielen die Struktur und die Qualität der Langzeitpflege eine wichtige Rolle. Das seelische Wohlbefinden muss, neben dem körperlichen Wohlbefinden, integraler Bestandteil solcher Dienste werden.

Soziale Kontakte sind klare Glücksverstärker. Das Problem ist, dass armutsgefährdete Personen und Arbeitslose tendenziell weniger soziale Kontakte haben (wie in den Kapiteln 6 und 10 gezeigt), diese Gruppen befinden sich somit in einem Kreislauf der Benachteiligung. Die Armen leiden, weil sie arm sind, und sie leiden noch mehr, weil sie weniger soziale Kontakte haben. Und weil sie leiden (sie haben eine geringe Zufriedenheit), haben sie weniger wahrscheinlich soziale Kontakte (sie haben weniger wahrscheinlich die Energie und Motivation um auf Andere zuzugehen), was letztlich auch dazu beitragen könnte, dass sie arm bleiben (da soziales Kapital die Marktchancen oder die Hilfe bei der Suche nach einem guten Job verbessern kann). Wie lässt sich dieser Kreislauf der Benachteiligung durchbrechen? Eine Möglichkeit könnten „personalisierte Glücksstrategien“ sein, die die Bewusstseinsbildung erhöhen und die Autonomie und Präferenzen der Individuen respektieren.

Diese "personalisierten Glücksstrategien" könnten einen Anreiz für die Zusammenarbeit verschiedener AkteurInnen wie beispielsweise dem Arbeitsamtpersonal, SozialarbeiterInnen und TherapeutInnen bieten. Die Strategien könnten Aus- und Weiterbildungsmöglichkeiten, Teilnahme an Peer-Gruppen (Lernen, Sport, Ehrenamt), oder auch Familien- oder persönliche Therapien umfassen, da oftmals sehr persönliche Faktoren hinter dem Scheitern in der Gesellschaft stehen. “Action for Happiness”, eine eingetragene Wohltätigkeitsorganisation im Vereinigten Königreich,[6] initiierte eine soziale Bewegung, wobei es eine sehr intelligente Nutzung der neuen sozialen Medien gab (Facebook, Twitter, und auch Aufrufe an Menschen, um Teil einer Internet-Gemeinschaft zu werden). Sie bietet Unterstützung für diejenigen, die sich unwohl fühlen: Beratung für depressive oder selbstmordgefährdete Menschen in einer leicht zugänglichen Sprache, praktische Ratschläge über die Arten vorhandener Unterstützungsangebote, darunter Gesprächstherapien, Medikamente, fachärztliche Versorgung oder Notfallversorgung.

Spitzeneinkommen

Der weltweite Reichtum ist sehr ungleich verteilt. Im Jahr 2002 hatten die reichsten 10 Prozent der *Weltbevölkerung* um 120-mal höhere *Einkommen* als die ärmsten 10 Prozent. Darüber hinaus besitzt das reichste Viertelprozent so viel *Reichtum* wie der Rest der Weltbevölkerung.

Deutschland ist eines der europäischen Länder mit der höchsten Einkommenskonzentration und wird nur von dem Vereinigten Königreich (aus 23 untersuchten Ländern) übertroffen. Laut einer aktuellen Studie von Atkinson et al. (2011), welche die Konzentration der Bruttoeinkommen innerhalb von Ländern analysiert, reicht der Anteil der *Top 1 Prozent* von 5 Prozent in den Niederlanden bis 11 Prozent in Deutschland bis zu mehr als 17 Prozent in den Vereinigten Staaten. Der Unterschied zwischen dem Top 1 Prozent und dem Top 0,1 Prozent hebt die *Ungleichheit innerhalb der Gruppe der Reichen selbst* hervor. Die *obersten 0,1 Prozent* in *Deutschland* besitzen 4 Prozent des gesamten Bruttoeinkommens.

Eine andere Studie, basierend auf dem “Deutschen Sozio-ökonomischem Panel”, findet eine höhere Einkommenskonzentration in Deutschland: Die reichsten ein Prozent besitzen 20 Prozent des Gesamteinkommens in *Deutschland* (Grabka & Frick 2007: 668). Das SOEP verwendet eine weiter gefasste Definition von Einkommen, die auch Immobilien, Finanzanlagen, Geschäfts-Vermögenswerte und Sachanlagen umfasst.

Bei der Exploration langfristiger Trends bei den Anteilen der Top-Einkommen finden Atkinson, Piketty und Saez (2011), dass die meisten Länder eine eher bescheidene Zunahme seit dem Zweiten Weltkrieg nach einem starken Rückgang in der ersten Hälfte des 20. Jahrhunderts erlebt haben. Die Autoren identifizieren vier Länder-Gruppen, die auf den geographischen und kulturellen Ähnlichkeiten in der Entwicklung der Anteile von Top-Einkommen beruhen.

Deutschland gehört zu der zweiten Gruppe von *mitteleuropäischen Länder*n (zusammen mit Frankreich, der Schweiz und den Niederlanden) sowie Japan. Im Vergleich zu den westlichen englischsprachigen Ländern, folgt die Entwicklung der Anteile der Top-Einkommen einer L-Form, beginnend mit einem relativ hohen Anteil am Anfang des 20. Jahrhunderts, gefolgt von einem relativ steilen Abfall bis zur Nachkriegszeit und seitdem relativ stabilen Anteilen. Deutschland hatte einen Top-Einkommens-Anteil von fast 20 Prozent in 1900. Nach einer kurzen Phase des Anstiegs ging der Anteil während der Nachkriegszeit auf 11 Prozent zurück und blieb seitdem ziemlich stabil zwischen neun und 11 Prozent liegen (die letzten Jahre sind nicht in der Datenbank für Deutschland enthalten).

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[6] Der Vorstand umfasst Prof. Richard Layard, London School of Economics, Geoff Mulgan, Gründer von Demos und früherer Direktor der Government's Strategy Unit, Leiter Politik in Büro des Ministerpräsidenten, und Nic Marks, Gründer des Center for Well-being at the New Economics Foundation und andere. Website: www.actionforhappiness.org

Langfristige Trends deuten auf eine Umstrukturierung der Einkommen hin, mit der wachsenden Bedeutung von Arbeitseinkommen im Vergleich zu Kapitaleinkünften. Während die Einkommensstruktur 1984-2000 in Deutschland relativ stabil geblieben ist, hat sie sich vor kurzem bemerkenswert geändert: Der Anteil der Kapitaleinkünfte und der Einkommen aus selbständiger Tätigkeit ist gestiegen. Dies führte zu einer Aufwärtseinkommensmobilität der mittleren Einkommensgruppen, die bis zu den Eliten mit hohen Einkommen reichte.

Zusammengehörigkeit: aktive politische und soziale Teilhabe

Vertrauen. 14% der deutschen Bevölkerung sagt, dass man den meisten Menschen vertrauen kann, was in etwa dem durchschnittlichen Wert in unserer Stichprobe von europäischen Ländern entspricht. In Schweden, Finnland, Norwegen und Dänemark, berichten 30% oder mehr Menschen von einem hohen Maß an Vertrauen. In den meisten Ländern berichten Personen mit hohem Einkommen eher von einem hohen Maß an Vertrauen. In Deutschland sagen 19% des oberen Einkommens-Fünftels, dass sie den meisten Menschen vertrauen können, im Gegensatz zu 12% des unteren Einkommens-Fünftels womit das Verhältnis 1,5 beträgt.

Neben Personen mit hohem Einkommen, sagen in Deutschland auch Personen mit hohem Bildungsniveau eher, dass man den meisten Menschen vertauen kann. Es gibt eine signifikant niedrigere Häufigkeit von sehr vertrauensvollen Menschen unter Arbeitslosen und Ostdeutschen.

Soziale Kontakte. In Deutschland trifft 9% der Bevölkerung jeden Tag Freunde, Verwandte oder Kollegen, und 29% mehrmals in der Woche. Dieser Wert liegt etwas unter dem Durchschnitt in unserer Stichprobe von europäischen Ländern. Im Gegensatz zu den Nachbarn ist der deutsche Wert niedriger als in den "westlichen" Nachbarländern (Frankreich, die Niederlande, Belgien, Dänemark und der Schweiz), aber höher als beim östlichen Nachbarn Polen. Ältere Menschen unterscheiden sich nicht wesentlich von der mittleren Altersgruppe (im Alter 30 bis 64): Der Anteil der Menschen mit intensiven sozialen Kontakten ist insgesamt etwa gleich in der Mehrheit der Länder. Dies deutet darauf hin, dass, während soziale Isolation häufiger bei älteren Menschen auftritt, ein großer Anteil dieser Altersgruppe sozial sehr engagiert bleibt.

In Deutschland scheinen sich ältere Menschen, Einwohner Ostdeutschlands, die nicht erwerbstätige Bevölkerung und Menschen mit Hochschulbildung weniger häufig in sozialen Kontakten zu engagieren. Auf der anderen Seite, scheinen Arbeitslose, Personen mit geringer Bildung und junge Erwachsene eher intensive soziale Kontakte zu haben. Vergleicht man diese Zahlen mit jenen zur sozialen Isolation (seltene oder gar keine Treffen) bietet sich ein interessantes soziales Profil von sozialen Kontakten. Die Situation der Arbeitslosen ist polarisiert. Unter den Arbeitslosen kommen sowohl soziale Isolation und intensive soziale Kontakte häufiger vor, bei großen Unterschieden in der sozialen Vernetzung dieser Gruppe. Gut ausgebildete Personen scheinen den goldenen Mittelweg zu bevorzugen: Sie haben eher weniger oft intensive persönliche Sozialkontakte mit Freunden oder Verwandten, und parallel dazu, sind sie auch weniger wahrscheinlich sozial isoliert. Diese Gruppe verwendet wohl eher alternative, nicht-personenbezogene Methoden der persönlichen Interaktion, einschließlich E-Mails oder sozialen Medien.

Politische Partizipation. Deutschland hat einen relativ hohen Anteil politisch aktiver Bevölkerung im europäischen Vergleich. Über ein Viertel der Deutschen haben in einer Organisation oder Vereinigung gearbeitet und etwa eine von drei Personen hat in den letzten 12 Monaten eine Petition unterzeichnet oder boykottiert bestimmte Produkte. Das Tragen einer Anstecknadel bzw. eines Abzeichens ist nicht besonders beliebt in Deutschland, nur 5% der Bevölkerung tun dies.

Die Cluster-Analyse der Indikatoren für politische Partizipation klassifiziert Deutschland als ein Land mit einer relativ hohen politischen Partizipation (zusammen mit Frankreich, der Schweiz und Dänemark in einer Ausprägung und in einer Gruppe mit Belgien, Dänemark und den Niederlanden in einer anderen), wenn auch etwas hinter der Spitzengruppe bestehend aus Finnland, Norwegen und

Schweden. Osteuropa (Bulgarien, Ungarn, Slowakei, Polen, Estland, Slowenien, Rumänien, Lettland) und einige Mittelmeerländer (Zypern, Griechenland, Portugal, Spanien – je nach Auswahl der Variablen politischer Partizipation) bilden eine Gruppe niedrigen politischen Engagements.

Personen mit hohem Einkommen nehmen eher an politischer Aktivität jeglicher Art teil als jene mit niedrigem Einkommen. In Deutschland ist der Unterschied besonders hoch in Bezug auf Kontaktaufnahme mit einem Politiker oder Arbeiten in einer politischen Partei oder Bürgerinitiative. Die höhere Beteiligung von Personen mit hohem Einkommen könnte durch ihren im Durchschnitt höheren Bildungsgrad und damit einhergehend ein größeres Streben nach Einflussnahme auf politische Ergebnisse, trotz der höheren Opportunitätskosten für Freizeitaktivitäten, erklärt werden. In Deutschland ist beispielsweise die oberste Einkommensgruppe (im Vergleich zu Personen mit niedrigem Einkommen) bei zeitaufwendigen Aktivitäten wie das Arbeiten in einer politischen Partei oder Bürgerinitiative relativ aktiv, mit fünffach höheren Beteiligungsraten.

Es gibt ausgeprägte Unterschiede nach Bildungsstand. In einer großen Zahl von Ländern, darunter Bulgarien, Ungarn, Polen, der Tschechischen Republik und Rumänien, ist das politische Engagement (gemessen als zwei oder mehr Arten von Aktivitäten, ausgenommen Unterzeichnung einer Petition) von Personen mit niedrigem Bildungsstand praktisch gleich Null. Dies deutet darauf hin, dass diese Gruppen abseits der Politik stehen und wenig Vertrauen und Motivation haben, um politische Entscheidungen zu beeinflussen. Die niedrige Beteiligung könnte außerdem auf das kommunistische Erbe dieser Länder zurückzuführen sein, welches eine schwache Zivilgesellschaft hinterlassen hat. Im Gegensatz zu diesen Ländern haben Menschen mit niedrigem Bildungsniveau in den erstgereihten drei nordischen Ländern eine Beteiligungsrate von 15% und darüber.

In Deutschland ist die politische Tätigkeit von Personen mit hohem Bildungsstand eine der höchsten in Europa, mit jedeR Dritte ist an mehreren Formen politischer Aktivität beteiligt. Es gibt jedoch eine große soziale Kluft, da das politische Engagement bei Menschen mit niedrigem Bildungsniveau mit nur 8% eher schwach ist. Obwohl dieser Wert immer noch über jenen osteuropäischer Länder liegt, ist er deutlich niedriger als jener in den nordischen Ländern. In Bezug auf die sozialen Unterschiede in Deutschland, zeigt sich, dass Gruppen mit hohem Einkommen und hoher Bildung sich eher an politischen Aktivitäten beteiligen. Im Gegensatz dazu spielen viele von sozialer Ausgrenzung bedrohte Gruppen, einschließlich der Arbeitslosen, Personen mit geringer Bildung und Personen mit niedrigem Einkommen eine kleine Rolle bei dem Versuch, die Auswirkungen der Politik auf ihr Leben zu beeinflussen. Ebenso bleibt das politische Engagement der Ostdeutschen, der nicht erwerbstätigen Bevölkerung, der älteren Menschen, und auch das der Frauen unter dem nationalen Durchschnitt.

Folgerungen für die Politik. Wie kann Politik soziale Kooperation und soziales Engagement fördern? Vertrauen lässt sich indirekt beeinflussen. Transparenz und Rechenschaftspflicht von öffentlichen Institutionen, PolitikerInnen und politischen EntscheidungsträgerInnen spielt eine wichtige Rolle bei der Verbesserung des Vertrauens in das politische System als solches. Ausreichende Informationen über die Funktionsweise dieser Institutionen sind auch wichtig sowohl als Teil der Kommunikationsstrategie dieser Körperschaften aber auch als Teil von Schullehrplänen. Darüber hinaus könnten Lehrpläne der Schulen und Erwachsenenbildung, welche soziale Kompetenzen und soziale Zusammenarbeit fördern, erheblich zur Verbesserung der individuellen Fähigkeit beitragen, um in den Gemeinschaften und sozialen Netzwerken zu funktionieren. Finanzielle und nicht-finanzielle Anreize für ehrenamtliche Tätigkeiten können das Verhalten auch beeinflussen, zumindest auf längere Sicht. Viele dieser sozialen Muster sind tief in die Kultur eingebettet, so dass einige dieser Veränderungen Zeit und konsequente politische Anstrengungen verlangen. Der jüngste politische Fokus auf Lebensqualität, einschließlich der Anerkennung des Wertes von Freizeit (zusätzlich zu den produktiven Tätigkeiten am Arbeitsplatz), Freizeitaktivitäten und sozialen Kontakten ist ein wichtiger Schritt in diese Richtung. Zusätzlich zu den verschiedenen Ebenen und Bereichen der Regierung, spielen ArbeitgeberInnen und repräsentativen Organe der ArbeitnehmerInnen in dieser Hinsicht auch eine wichtige Rolle.

Subjektives Wohlbefinden: "Glückseligkeit"

Die empirischen Analysen legen nahe, dass wir mehr darüber wissen, was Menschen unglücklich macht als über das, was sie glücklich macht. Arbeitslosigkeit, Behinderung, ethnischer Minderheiten-Status und niedriges Einkommen verringern tendenziell die Wahrscheinlichkeit hoher Zufriedenheit. Die Wirkung von Faktoren die Wohlbefinden induzieren (intensive Sozialkontakte, politisches Engagement, hohes Einkommen und hohe Bildung) ist hingegen kleiner und häufig nicht statistisch signifikant für bestimmte Länder. So enthüllen diese sozialen Kategorien wenig über Glück erzeugende Faktoren.

In Deutschland korreliert Arbeitslosigkeit sehr stark mit niedrigem Wohlbefinden. Die Beziehung scheint stärker als in anderen Ländern zu sein. Wie zuvor gezeigt, haben 38% der Arbeitslosen ein sehr niedriges Niveau an Zufriedenheit und sind nur zu 7% sehr zufrieden. Die Arbeitslosen sind damit die am deutlichsten unzufriedene soziale Gruppe in Deutschland (unter den hier analysierten Gruppen). Dies kann durch die hohe Arbeitslosigkeit und die lange Dauer der Arbeitslosigkeit erklärt werden. Auf Grund unserer psychologischen Neigung, „schmerzt“ der Verlust früherer Ansprüche auf Sozialleistungen mehr als nie welche gehabt zu haben, dies wird in der psychologischen Literatur auch häufig als „Besitztumseffekt oder "Status quo bias" (siehe auch die Diskussion in Kapitel 7) bezeichnet. Die Glücksforschung zeigt, dass die negativen Auswirkungen von Arbeitslosigkeit über den reinen Einkommensverlust hinausgehen und betont sowohl die kurzfristigen psychologischen Kosten als auch den langfristigen Narben-Effekt, der sogar nach der Wiedereinstellung noch vorherrschen kann. Arbeitslosigkeit scheint das Selbstwertgefühl zu senken und sich auch nachteilig auf soziale Netzwerke auszuwirken (Kapitel 6). Basierend auf unseren Erkenntnissen und der Literatur über Wohlbefinden, sollte demnach die Verringerung der Arbeitslosigkeit und die Erhöhung der Wiederbeschäftigungschancen sowie die schnellere Wiederbeschäftigung oberste Priorität auf der deutschen politischen Agenda haben.

Niedriges Einkommen und Behinderung gehen nicht unbedingt mit geringerem subjektiven Wohlbefinden einher. 15% der Menschen mit einer Behinderung, welche ihre täglichen Aktivitäten erheblich erschwert, geben selbst an, sehr zufrieden zu sein. Obwohl diese Zahl unter dem nationalen Durchschnitt bleibt, zeigt sie, dass manche Menschen trotz ihrer einschränkenden Umstände Freude an ihrem Leben finden können. Wie? Aktivitäten und Beziehungen können eine "Exit-Strategie" ins Glück schaffen da diese großen Einfluss auf die Zufriedenheit haben, mehr als Einkommen oder äußere Umstände. Um Menschen mit Behinderung eine aktivere Teilhabe zu ermöglichen, müssen mehr Möglichkeiten für soziales Engagement, ehrenamtliche Arbeit, geschätzte Freizeitaktivitäten und zu guter letzt Zugang zur Beschäftigung geschaffen werden. Die Bereitstellung flexibler und entgegenkommender Beschäftigungsmöglichkeiten ist fair und wirkt sozial integrativ und würde darüber hinaus, so ist zu erwarten, die persönliche Lebenszufriedenheit erhöhen.

Ostdeutsche haben ein systematisch geringeres subjektives Wohlbefinden. Noll und Zweck meinen, "das Vertrauen in die Leistung der wohlfahrtsstaatlichen Institutionen und das Vertrauen in die politischen und rechtlichen Systeme scheinen entscheidend dafür zu sein, die Unterschiede bei den SWB-Raten zwischen West- und Ostdeutschen zu erklären" (2010, S. 24).

Die Menschen spielen selbst eine wichtige Rolle bei der Bestimmung ihres Glücks. Neben der individuellen Fähigkeit, ihre Lebensumstände (z. B. Bemühungen einen Job zu finden, ein Haus zu kaufen) und Aktivitäten (wie viel Zeit verbringe ich mit Freunden) zu beeinflussen, können sie ihr Wohlbefinden durch die Interpretation von Lebensereignissen weitgehend verändern (siehe z. B. Lyubomirsky 2008). Die westliche Neurowissenschaft hat nun bestätigt, was fernöstlicher Weisheit schon lange bekannt war: Glück ist eine Fertigkeit, die wir lernen können. Auf der anderen Seite wollen die Menschen nicht gesagt bekommen, was gut für sie sei, vor allem nicht von ihren politischen Führern. Die Schaffung von Anreizen, Informationen und einer allgemeinen gesellschaftliche Dynamik können jedoch letztlich zu einer Änderung von Normen und Verhaltensweisen beitragen. Soziale Bewegungen die auf individuellem Engagement basieren,

weisen auch einen Weg, wie Richard Layard, der Befürworter der “Aktion für Glück”, einer jüngeren britischen Nichtregierungsorganisation, argumentiert.

Was ist die Rolle der Regierungen bei der Förderung des Glückes der Bürger? Soziale Institutionen haben einen systematischen Einfluss auf Glück. Indikatoren für das Wohlbefinden ermöglichen es Regierungen, die Auswirkungen ihrer Programme auf das Wohlbefinden direkt zu bewerten. Dafür sollten diese Indikatoren aber eine klare Rolle in der politischen Entscheidungsfindung spielen, mit einem eindeutigen kausalen Zusammenhang zwischen Politik und Ergebnissen. In Gegensatz zum Vereinigten Königreich oder Frankreich wo die Verwendung von Indikatoren für das Wohlergehen im Vordergrund der jüngsten und laufenden politischen Bemühungen steht, hat das Thema noch keine politische Priorität in Deutschland gewonnen. Es gibt also viel Spielraum für eine verstärkte Nutzung von Indikatoren für das Wohlergehen in Deutschland bei der politischen Entscheidungsfindung.

Frühkindliche Bildung und Betreuung: Barrieren beim Zugang zu einer guten Startposition ins Leben

Die ökonomische Forschung über die Schlüsselrolle des Umfelds der frühen Kindheit und der Familie ist überzeugend, und steht im Einklang mit den jüngsten Erkenntnissen aus den Neurowissenschaften und der Entwicklungspsychologie. In einer umfassenden Überprüfung wobei die volkswirtschaftlichen Kosten und Nutzen des gesamten Portfolios von potentiellen Maßnahmen zur Verbesserung von Humankapital in der Wirtschaft (einschließlich Investitionen in frühkindliches Lernen und in jugendliches Lernen, in Ausbildungsprogramme für freigesetzte Arbeitskräfte, Steuervorteile und Schulsubventionen) verglichen wurden, kommt James Heckman (2000) zu dem Schluss, dass eine Politik, die die Bedeutung frühkindlicher Bildung und Betreuung erkennt, sowohl effektiv als auch kosteneffizient ist. Programme zur frühkindlichen Förderung mögen teuer erscheinen, berücksichtigt man jedoch das breite Spektrum zukünftiger Vorteile für die Geförderten selbst, aber vor allem auch für die Gesellschaft als solches, stellt diese Form der präventiven Sozialpolitik eine wertvolle Investition und Kostenersparnis dar. Weitere Argumente zur Unterstützung und Ergänzung des familiären Umfelds finden sich auch in der vergleichenden Sozialpolitik und Bildungssoziologie. Forschungsergebnisse zeigen, dass ein nicht funktionierendes familiäres Umfeld schwerwiegender als das Versagen von Schulen auf Probleme im Zusammenhang mit der emotionalen Entwicklung und dem Bildungserfolg von Kindern wirkt.

Aus diesen Ergebnissen lassen sich wichtige Vorgaben für die staatliche Politik ableiten. Bei den Familien selbst anzusetzen könnte ein effektiverer Weg zur Verbesserung schulischer Leistungen sein als etwa direkte Ausgaben für "Standard"-Schulinputs wie Lehrergehälter, Qualität der Lehrer, Klassengröße, und Ausgaben für SchülerInnen und Schulausstattung. Dies ist um so wichtiger angesichts des zunehmenden Bewusstseins, dass Investitionen in Bildung zum Zeitpunkt des Regelschulalters oft unerwartet wirkungslos sind.

Ungeachtet positiver jüngster politischen Veränderungen kann *Deutschlands Abschneiden* im internationalen Vergleich in Bezug auf Inputs als auch Erfolgen von FBFB-Politiken *im besten Fall als durchschnittlich* beschrieben werden – schlechter, jedenfalls, als die Leistung der nordischen Länder. Ganz allgemein, *geben die nordischen Ländern eindeutig das beste Modell bewährter Praxis in Bezug auf FBFB-Politik ab*, denn sie bieten in einem umfassenden Sinn die besten Chancen gleicher Startpositionen ins Leben für alle Kinder, unabhängig von den sozioökonomischen Umständen bei ihrer Geburt und den Umständen ihrer frühen Kindheit.

Im Bereich *sozialer Wirkungen, sprich in Bezug auf Kinderarmut,* schneidet Deutschland (8,3%) in internationaler Perspektive relativ gut ab, wie der elfte Rang in einer 34-Länder OECD-Stichprobe belegt. Dennoch ist die Kinderarmutsrate deutlich höher als jene in Dänemark (3,7%), Finnland (4,2%), Norwegen (5,5%), Schweden (7%) und Österreich (6,2%). Während der Anteil der Alleinerziehenden in Deutschland relativ gering ist (5,9%), gibt es eine große Kluft zwischen den

Armutsquoten von Alleinerzieherhaushalten (36,2%) und jenen von Paarfamilien mit Kindern (5,8%). Gleichzeitig, finden sich auch die höchsten Beschäftigungsquote bei Müttern von kleinen Kindern wieder in den nordischen Ländern wie Dänemark (76,5%), Island (84,8%) und Schweden (82,5%). Deutschland (63,1%) liegt auf halbem Weg zwischen den genannten nordischen Ländern und dem EU-weiten niedrigsten Niveaus in Südeuropa und im postkommunistischen Europa.

In Bezug auf die *politischen Input-Indikatoren* wie zum Beispiel die gesamten öffentlichen Ausgaben für FBFB Einrichtungen sind alle fünf nordischen Staaten, sowie Frankreich und Belgien unter den Spitzenreitern. Deutschland gibt im Vergleich weniger als die Hälfte dieser Ländergruppe aus (0,4% des BIP). Wichtiger und potentiell noch beunruhigender: Deutschland gibt besonders wenig für Kinderbetreuungseinrichtungen in der jüngsten (0-2) Altersgruppe aus: 0,1% des BIP, im Vergleich zu dem EU-weit höchsten Niveau von 0,6% in Schweden, 0,7% in Island und 0,8% in Dänemark.[7] Die niedrigen Ausgaben für die entscheidende Phase jüngster Kindheit spiegelt sich auch in den Teilnahmeraten der FBFB-Einrichtungen wider. Deutschland entspricht hier einem weitverbreiteten internationalen Muster, das relativ niedrige Teilnahmeraten bei Kindern im Alter von 0-2 (19%) und gleichzeitig sehr hohen Teilnahmeraten bei Kindern im Alter von 3-5 (89%) aufweist. Es versteht sich von selbst, dass die Verfügbarkeit von preiswerten und qualitativ hochwertigen Kinderbetreuungseinrichtungen (und Nutzungsquoten) wichtige zusätzliche Effekte hätte, da durch die Bereitstellung geeigneter Betreuungseinrichtungen die Vereinbarkeit von Beruf und familiären Verpflichtungen der Mütter (Stichwort "Babies und Bosse") erst möglich und dadurch die Erwerbsbeteiligung von Müttern erhöht werden würde. Indirekt würde außerdem sowohl die Abhängigkeit von Sozialhilfe als auch Kinderarmut verringert werden. Neben den indirekten Effekten, ist jedoch besonders wichtig zu betonen, dass wirtschaftliche und soziologische Daten zeigen, dass diese jüngste der jungen Altersgruppen gerade die ist, die am ehesten direkt von staatlichen Investitionen profitiert würden.

Es gibt zwingende Beweise für die Befürwortung von staatlichen Investitionen in den frühen Lebensjahren. Dennoch neigen EU-und OECD-Länder immer noch dazu, mehr für vorschulische Dienstleistungen auszugeben als für eine wirkliche frühkindliche Betreuung, welche auf jene Altersgruppe abzielt, in der Interventionen wahrscheinlich effektiver wären (Abb. 3.5 und 3.6). In der Tat belaufen sich die verbindlichen Staatsausgaben für frühe Kinderbetreuung auf nur 0,1 Prozent des BIP in Ländern wie der Slowakei, Deutschland und den Niederlanden, aber auf *sechs, sieben und acht Mal so viel* in den nordischen Ländern wie Schweden, Island und Dänemark. Wenn ein Ziel jedoch auch darin besteht, die Erwerbstätigkeit von Müttern zu aktivieren, so müssen die Preise für Kinderbetreuung billiger werden. Auch hier zeigt sich wieder die Vorreiterrolle nordischer Modelle. Darüber hinaus lassen sich in Bezug auf die Qualität von Vorschulprogrammen eine Reihe von expliziten politischen Vorgaben aus der kumulativen Evidenz von FBFB-Pilotprogrammen ableiten (Barnett 2002):

1. Die Klassengröße und der Kind-Lehrer-Schlüssel müssen niedrig gehalten werden.
2. Lehrer müssen hoch qualifiziert sein, mit mindestens Bachelor-Abschluss und mit Fachausbildung in Früherziehung, und sie müssen gut bezahlt werden.
3. Die Lehrpläne müssen intellektuell reich und weit genug sein, um den Entwicklungsbedarf der Kinder in allen Bereichen ansprechen zu können.
4. Programme müssen eine aktive Partnerschaft mit den Eltern implizieren und auf deren Bedürfnisse, wie etwa deren Bedarf an Kinderbetreuung, berücksichtigen.
5. Programme sollten nicht später als mit drei Jahren beginnen.
6. Die Ressourcen sollten in erster Linie auf benachteiligte Kinder konzentriert werden.

[7] Beachten Sie jedoch, dass eine wichtige neue Politik dies durch die Beschleunigung der Expansion der Kinderbetreuungsplätze für Kinder unter drei Jahren beseitigen will. So soll bis 2013 der Deckungsgrad für Kinder von 0-3 Jahren auf 35 Prozent angestiegen sein, und ab 2013 wird jedes Kind vom ersten Geburtstag an das Recht auf einen Kinderbetreuungsplatz haben (Kinderförderungsgesetz 2008 BGBl; Leitner 2010).

Natürlich hat bisher kein Land exakte Kopien von den hier untersuchten FBFB Pilotprogrammen auf wirklich flächendeckender Basis umgesetzt. Die nordischen Staaten wie Dänemark, Schweden und Finnland sind die herausragenden Modelle bewährter Praxis die es zu befolgen gilt, denn sie haben *bereits* Programme wie die "Perry" Vorschule oder "Head Start" auf nationaler Ebene umgesetzt. Durch die Bereitstellung von öffentlich geförderter Tagesbetreuung mit geringen Klassengrößen und hohen Teilnahmeraten (sogar sehr junger Kinder), wird es Müttern ermöglicht aktiv am Erwerbsleben teilzunehmen wodurch eine langfristige Abhängigkeit vom sozialen Netz verringert und die Steuerbasis vergrößert wird. Des weiteren, ist auch die Armut unter Kindern und bei Alleinerziehenden deutlich niedriger als in anderen Wohlfahrtssystemen, während die Erwerbsbeteiligungsraten der Mütter deutlich höher sind.

Die Teilnahmeraten von Kindern im Vorschulalter (3-5) in den EU-Ländern variieren von unter 60 Prozent in den angelsächsischen Ländern (Australien, Kanada, USA) und in Kroatien, Griechenland, Polen und der Schweiz, zu nahezu umfassend (über 90 Prozent) in Belgien, Estland, Frankreich, Island, Italien, Neuseeland, Slowenien, Spanien, Schweden und dem Vereinigten Königreich. Bedeutsamer ist jedoch, *dass die Teilnahmeraten für die kritische Altersgruppe – Kinder zwischen 0 und 2 Jahren – überall deutlich niedriger sind mit Ausnahme der nordischen Länder. Die Teilnahmeraten von Kindern im Alter zwischen 0 und 2 Jahren reichen* von fast null Prozent in den postkommunistischen Ländern, rund 10 Prozent in Griechenland und Österreich, bis zu mehr als 40 Prozent in Frankreich und Island. Nur in den Niederlanden erreichen die FBFB Teilnahmeraten ein Niveau von fast 50 Prozent, liegen damit jedoch immer noch hinter den nordischen Ländern: Schweden 60 Prozent und Dänemark 70 Prozent. Ein weiteres Merkmal nordischer Modelle ist, dass fast alle jüngeren Kinder in einer Betreuungseinrichtung mit garantiertem Zugang zu qualitativ hochwertiger ganztägiger subventionierter Betreuung (Esping-Andersen 2009) untergebracht sind, im Unterschied zu individueller Betreuung wie sie beispielsweise in Frankreich den Regelfall darstellt. Belgien, Slowenien und die vier nordischen Staaten sind die einzigen EU-Länder, die einen staatlichen Anspruch auf Kindertagesbetreuung vor 3 Jahren bereitstellen. *Und nur in den nordischen Ländern gibt es politische Maßnahmen, um sicherzustellen, dass es keine Lücke zwischen dem Ende des Elternurlaubs und dem Beginn eines FBFB-Anspruchs gibt.* In Summe haben Länder wie Schweden und Dänemark deutlich das beste allgemeine politische Modell zur Erhöhung des Humankapitals und ermöglichen durch Investitionen in FBFB bereits im frühen Alter Chancengleichheit.

Gesundheitswesen

Im Allgemeinen bietet Deutschland im Vergleich zu anderen EU-Mitgliedstaaten ein sehr umfassendes Gesundheitsfürsorgesystem. Allerdings gibt es auch in sehr gut organisierten Wohlfahrtsstaaten nach wie vor Ungleichheiten und eine Reihe von Menschen sehen sich beim Zugang zu Gesundheitsleistungen nach wie vor mit Barrieren konfrontiert. Kapitel 13 gibt einen Überblick über bewährte Praktiken aus einer Reihe von ausgewählten europäischen Ländern.

Das kürzlich eingeführte obligatorische universelle Krankenversicherungssystem in Deutschland zielt darauf ab, die aktuelle Zahl der Menschen ohne Deckung zu reduzieren. Lücken in der *Absicherung durch die Gesundheitsfürsorge* kann es jedoch immer noch für jene Menschen geben, die nicht in der Lage, sind, die organisatorischen Barrieren zu überwinden (z. B. administrative Verfahren für die Registrierung bei einer Krankenkasse) bzw. ihre Rechte und Pflichten nur mangelhaft kennen. Es ist daher wesentlich, dass Informationen über das Recht auf Krankenversicherung sowie über die Pflichten und Verwaltungsverfahren leicht zugänglich sind, insbesondere für jene Gruppen, die von sozialer Ausgrenzung bedroht sind. Zu diesen Gruppen gehören Personen mit niedrigem Bildungsniveau, Analphabeten und Personen mit sprachlichen Barrieren sowie andere gefährdete Gruppen, wie beispielsweise Menschen mit psychischen Problemen. Es muss daher festgestellt werden, welche Gruppen daran scheitern, einen regulären Versicherungsstatus zu bekommen und daher besonderer Unterstützung bedürfen, um Zugangsbarrieren zu beseitigen.

Im Vergleich zu anderen EU-Mitgliedstaaten stellt Deutschland ein eher großzügiges Gesundheitssystem in Bezug auf niedrige *Selbstbehalte* zur Verfügung. Da Selbstbehalte armutsgefährdete Personen im Besonderen treffen, könnten Ausnahmen für Menschen mit niedrigem Einkommen die finanzielle Belastung ausgleichen und den Zugangs zur Gesundheitsversorgung fördern. Allerdings gibt es bei manchen Diensten Lücken, wie z. B. bei Prothesen und Sehhilfen, die von den Patienten fast vollständig abgedeckt werden müssen. Besonders ältere Personen sehen sich oft mit hohen Kosten für Gesundheitsdienstleistungen konfrontiert und sind nicht in der Lage, die Gesamtkosten für diese Hilfsmittel selbst zu decken. Der jüngste Anstieg der Zuzahlungen für Arzneimittel hat vor allem jene Menschen mit einem umfangreichen Bedarf an Medikamenten getroffen, wie zum Beispiel Patienten mit chronischen Krankheiten (welche wiederum eher ältere Personen sind). Die Einführung einer klaren Höchstgrenze bei der Kostenteilung, wie für Finnland dargestellt, würde helfen, finanzielle Engpässe zu vermeiden und das Armutsrisiko besonders für diese Gruppen verringern.

Die Bereitstellung der vollständigen Abdeckung von *Transportdiensten* zu und von Gesundheitseinrichtungen (insbesondere für Kinder) wäre ein Weg, Alleinerziehende und von Armut bedrohte kinderreiche Familien zu unterstützen.

Um regionale und Stadt-Land-Unterschiede zu verringern hat sich gezeigt, dass die Kombination der Bemühungen aller involvierten AkteurInnen bei der Bewältigung des gemeinsamen Abbaus von Zugangsbarrieren zur Gesundheitsfürsorge zielführend war. Insbesondere bei der Beseitigung von Ungleichheiten in der Bereitstellung von Gesundheitsdiensten in ländlichen Gebieten kann es hilfreich sein, sich von Beispielen gelungener Politik aus Finnland und Spanien inspirieren zu lassen, wo die Zusammenarbeit auf lokaler Ebene dabei geholfen hat, finanzielle Engpässe und unzureichende professionelle Ressourcen zu überwinden.

Die Verteilung von Gesundheitsleistungen bleibt ein wichtiger Bereich, um Chancengleichheit beim Zugang zur Gesundheitsversorgung in Deutschland zu erreichen. Vor allem die erhebliche Diskrepanz in der Verteilung der Ärzte zwischen (ländlichen) östlichen und westlichen Teilen des Landes muss in den kommenden Jahren gelöst werden. Anreize für Ärzte und andere Gesundheitsberufe könnten dabei helfen, die östlichen Regionen für MitarbeiterInnen im medizinischen Bereich attraktiver zu machen.

Arbeitsmarktchancen für ältere ArbeitnehmerInnen

Die Arbeitsmarktbeteilungschancen älterer Personen (55-64) in Deutschland haben sich seit 2004 und seit den 2005 Hartz-Reformen nach jahrzehntelanger Stagnation sehr deutlich verbessert. Die Erwerbsquoten erreichten 61 Prozent im Jahr 2009, ein Niveau, das Deutschland vor kurzem zum zweitbesten Land in unserer Fünf-Länder-Stichprobe (Deutschland, Schweden, Finnland, Niederlande und Österreich) machte, an zweiter Stelle nach Schweden (bei 74 Prozent) und knapp vor Finnland (59 Prozent). Zusammen mit den Niederlanden, erreichte Deutschland im Jahr 2007 das EU Stockholm Ziel (Erhöhung der Beschäftigungsquote von Personen im Alter von 55 bis 64 auf 50% bis 2010) , vor Österreich, aber nach Schweden (2001) und Finnland (2004). Starker Ausdruck dieser vergleichenden Erfolgsquote ist, dass Deutschland im vergangenen Jahrzehnt als Hochrisiko-Arbeitsmarkt für arbeitslose ältere ArbeitnehmerInnen galt, denn sowohl die Arbeitslosenquote (bei 8 Prozent) älterer Personen, als auch die langfristigen Arbeitslosenquoten (über 5 Prozent) ist die höchste in der Stichprobe. Es gibt also Bedarf für eine Politik, die einen besseren Zugang zur Erwerbsbeteiligung für ältere Arbeitslose herbeiführen kann.

In Bezug auf Alter-Lohn-Profile, zeigt sich in Deutschland, im Gegensatz zu Finnland und Schweden (beide Länder zeigen relativ flache Profile im Karriereverlauf) ein Zick-Zack-Kurs. Frauen holen mit Unterbrechungen die Männer fast ein, nur um später wieder im Karriereverlauf zurückzufallen. Das Ergebnis ist, dass die geschlechtsspezifischen Unterschiede in der Altersgruppe 60-64 in Deutschland

relativ groß sind – in unserer Stichprobe am größten, dicht gefolgt von den Niederlanden und Österreich, mit den steilsten Alter-Lohn-Profilen sowohl für Männer *als auch* für Frauen. Während solche steilen Alter-Lohn-Profile einen starken Anreiz für ArbeitnehmerInnen bieten, an ihren aktuellen Jobs festzuhalten, stellen sie gleichzeitig starke Hürden für die Beschäftigungsfähigkeit älterer ArbeitnehmerInnen dar. Aus politischer Sicht folgt daraus, dass die Verringerung von steilen Alter-Lohn-Profilen für ältere ArbeitnehmerInnen im öffentlichen Sektor wünschenswert wäre um das politische Ziel der Aktivierung älterer ArbeitnehmerInnen voranzutreiben.

Ebenso gibt es Hinweise darauf, dass ein hohes Maß an Kündigungsschutz Unternehmen daran hindert, ältere ArbeitnehmerInnen einzustellen und viele ältere ArbeitnehmerInnen in den *un*freiwilligen Vorruhestand zwingt (z. B. Dorn und Souza-Posa 2010) gehen. Aus politischer Sicht würde die Verringerung des Kündigungsschutzpegels, wo möglich (z. B. im öffentlichen Sektor), somit wahrscheinlich zu höheren Arbeitsmarktaktivierungsraten unter älteren ArbeitnehmerInnen führen, besonders in Kombination mit Reformen die einen frühzeitigen Rentenantritt weniger attraktiv gestalten.

Insgesamt scheinen negative Anreize, wie die Schließung von Wegen in die Frühverrentung und in die Erwerbsunfähigkeitsrente, wie in Deutschland, Schweden und Finnland in den letzten Jahren umgesetzt, am meisten wirksam zu sein bei der Erhöhung der Erwerbsbeteiligung von älteren ArbeitnehmerInnen, wenn auch manchmal auf Kosten höherer Langzeitarbeitslosigkeitsraten.

Darüber hinaus können dynamische Arbeitsmärkte mit kooperativen Beziehungen zwischen ArbeitgeberInnen (und ihren Organisationen) und ArbeitnehmerInnen (und ihren Organisationen) eine große Hilfe sein. Ein herausragendes Beispiel aus jüngster Zeit ist in diesem Zusammenhang das "deutsche Arbeitsmarktwunder" während und nach den späten 2000er Jahren, welches aller Wahrscheinlichkeit nach eher auf die Umsicht und Flexibilität der ArbeitgeberInnen als auf staatliche Maßnahmen zurückzuführen ist. Wie Burda und Hunt (2011) nachweisen, erlebte Deutschland einen noch tieferen Rückgang des BIP in dieser Rezession als die USA, dennoch gab es wenig Beschäftigungsverlust. Burda und Hunt argumentieren, dass die Zurückhaltung der ArbeitgeberInnen bezüglich Neueinstellungen während der vorangehenden Expansion – zum Teil durch die Vermutung, dass diese nicht andauern würde –, der Hauptgrund für die herausragende deutschen Beschäftigungsleistung in der Rezession war. Darüber hinaus waren die Lohnzurückhaltung seitens der ArbeitnehmerInnen und die breite Einführung von Arbeitszeitkonten, die es den ArbeitgeberInnenn ermöglichte, Zahlungen für Überstunden zu vermeiden, wenn die Stunden pro MitarbeiterIn den Standardstunden über ein bestimmtes Zeitfenster entsprachen, ebenfalls wichtige Faktoren. So waren die Arbeitszeitkonten ein wesentlicher Faktor um Kündigungen zu verhindern. Das Ergebnis war dass, während die Kürzungen von Stunden pro ArbeitnehmerIn während der Rezession insgesamt erheblich waren, die Reduzierung von Guthaben auf Arbeitszeitkonten die traditionelle staatlich geförderte Kurzarbeit ersetzte.

Executive Summary

Conceptual background

"Teilhabechancen" refers to (social) participation opportunities, referring to both the situation in terms of social participation and the opportunities of individuals or groups for such participation. Its current use tends to refer to particular domains of life (politics, employment, education, culture) and to particular social groups (women, men, the elderly, the young, the disabled, the migrants).

The mentioning of opportunities ("Chancen") creates a conceptual link to the theory on *equality of opportunities*, and to the theoretical work of Sen on *capabilities*. Equality of opportunities (EOP) refers to the notion of 'levelling the playing field'. It implies that the socio-economic status into which one is born ought to have no impact on one's competitive prospects. From this perspective, improving social participation opportunities (Teilhabechancen) has thus a straightforward translation into EOP policy: it means the effort to allow everyone the very same chance to take part in a full life, unencumbered by accidents of birth and circumstance, and to subsequently reap the just reward of their own efforts.

The Nobel laureate Amartya Sen argues that the 'real' equality of opportunities must be through *equality of capabilities* (1992, p. 7). Capabilities are thus the real opportunities people have, the actual state of being they are able to achieve. Basic capabilities include the ability to live to the end of a human life of normal length, not dying prematurely, being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter, being able to have attachments to things and people outside ourselves; and many others (Nussbaum 2000). Sen himself refrains from giving a comprehensive list of capabilities. The capabilities theory respects people's freedom (e.g. the diversity of their choices and tastes) and takes into account people's differences in terms of abilities and starting positions. A disabled person, for example, may need a larger amount of resources to achieve the same level of capabilities for health and for social participation as someone without physical impairment. Sen's work had a profound impact on the human development paradigm, which proclaims that "the real objective of development is to increase people's choices." (UNDP 1991) These additional choices include political freedom, guaranteed human rights and self-respect.

Social inclusion may be defined as a *static situation*: all those who are not excluded are included, which should normally hold for the majority of the society. We may also think of social inclusion as a *process,* helping to integrate those who are on the margins. Social inclusion policies can thus ensure that the poverty and joblessness remain only transitory phases of life. These policies imply more than traditional social security and social assistance schemes, as they (ideally) offer a variety of coordinated policy efforts, focusing not only on income shortage, but also on employability and other aspects of life, and the interrelationship between these marginal aspects of life. Social inclusion policies can also be *preventive*: not letting people to be excluded by providing an overall safety net.

The use of *well-being indicators* as measures of social progress has reached a consensus among the main international organizations. The OECD hosted a series of international conferences on Measuring and Fostering the Progress of Societies. In 2007, Eurostat committed funding to explore the measurement of well-being at EU level. The efforts and achievements are summoned under the "GDP and beyond" Eurostat website[8]. In July 2011 the United Nations accepted a resolution titled "Happiness: towards a holistic approach to development", and "invited Member States to pursue public policy steps that would better capture the importance of pursuing happiness and well-being in

[8] http://epp.eurostat.ec.europa.eu/portal/page/portal/gdp_and_beyond/achievements

development." [9] The resolution also notes that the GDP "was not designed to and does not adequately reflect the happiness and well-being of people in a country".

Low income and material deprivation

The concept of poverty defined in relative rather than absolute terms, with those who have a level of income below a certain threshold in relation to average income in the country in which they live. The convention in the EU at present is to take the threshold as 60% of median household disposable income measured on an equivalised basis to allow for differences in the size and composition of households (using the OECD modified scale as the means of adjustment)[10].

The indicator of material deprivation, on the other hand, is an absolute measure, based on a single EU-wide standard, and does not vary across countries. Deprivation is interpreted in the wide sense of not being able to live a decent life, and is measured in terms of a lack of relevant goods and services. This measure focuses on "enforced lack", where "enforced" implies that the item is something that the household would like to have, but cannot afford. For example, a family is *not* deprived if they do not have a car because they do not want to have one.

Some 16% of the population were at risk of poverty across the European Union according to EU-SILC survey carried out in 2009, in the sense of having income below 60% of the median of the country in which they live, a total number of 80 million. The proportion concerned varied between 9% and 26% across EU Member States. It was lowest in the Czech Republic, Slovakia, the Netherlands, and Slovenia, and above average in the Baltic States, Bulgaria, Romania and the southern countries, Greece, Italy, Portugal and Spain. The at-risk-of-poverty rate in Germany remains slightly below the EU average (15.5% vs. 16.3%). Taking into account the confidence interval of the estimate, the at-risk-of-poverty rate in Germany is estimated to be between 15.1% and 15.9% with a 95% probability.

Between 2004 and 2008, the proportion of population at risk of poverty declined in Ireland, Poland, the Czech Republic and Slovakia, and is likely to have declined in Hungary and Portugal. In contrast, the proportion at risk of poverty increased in Denmark, Germany, Finland, Latvia, Luxembourg and Sweden. In the majority of countries there was no statistically significant change in the at-risk-of-poverty rate over the 5 years.

Women tend to face a higher risk of poverty in most EU countries. The at-risk-of-poverty rate for women is 1.7 percentage points higher than that for men in the EU on average. There is a very small, although statistically significant gender difference in Germany as well.

Children and the people aged 65 or over are typically exposed to a higher risk of poverty than the working-age population across the EU. *Germany* appears to be unique in the EU (only Norway is similar), in the sense that neither children nor the elderly suffer from relatively high poverty risks. If we focus on elderly who live alone, there is a significantly higher poverty risk. While child poverty does not appear to be an issue in Germany, young adults face above average poverty risk.

Single parents and people living households with low work intensity face a poverty risk of 38% and 53%, respectively. These social groups have the highest prevalence of severe material deprivation as well, with 20% or over, which is over four times as high as the national average. This suggests that these groups are affected by long term poverty, which alters their consumption patterns.

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[9] UN News Centre: „Happiness should have greater role in development policy – UN Member States". http://www.un.org/apps/news/story.asp?NewsID=39084 . Access date: 21 October 21, 2011.

[10] The poverty thresholds differ greatly across countries in terms of the purchasing power they represent. The average poverty threshold in the 12 countries which have entered the EU since 2004 was only around half the average in the other 15 Member States in purchasing power terms and much less in terms of Euro. In Germany, the 2008 poverty threshold for a two-adult and two-children household was calculated to be 23,400 euros, and for a single person, 11,200 euros.

The analysis of the headline targets of the Europe 2020 Strategy suggests that overall 107 million people in the EU are at risk of exclusion according to at least one the three key indicators (being at risk of poverty, severely deprived or living in households with very low work intensity). Some 6.5 million people, or 6% of the total defined to be at risk of exclusion, are deprived according to all three indicators. Only a minority appear to suffer from severe cumulative disadvantage.

In Germany, 13 million people are at risk of poverty, compared to 7 million who live in households with low work intensity and 4 million who are materially deprived. Note, however, that 7 out of 13 million Germans at risk of poverty are *not* materially deprived or *not* characterized by low work intensity, suggesting possibly short term poverty (in the former case) or in work poverty (in the latter case). About 1.5 million people are at risk of exclusion according to all three indicators.

We explored the natural grouping of the three indicators of social exclusion at a country level across the EU. We identified four country clusters. Germany, together with the UK, Ireland and Belgium are characterized by an above-average share of low work intensity rates (12-24%), below average share of people suffering from severe material deprivation (3-6%), and at-risk-of-poverty rates around the EU average. This group can be called ""work-poor" countries, affected most by low work intensity".

Health inequalities

The empirical evidence suggests a clear relationship between socio-economic status and health outcomes, both in terms of health status and access to health care.

Higher socio-economic groups (higher educational attainment and income) tend to have systematically better *self-perceived health*, including subjective health, limitations in daily activities and chronic conditions. In contrast, those belonging to the bottom income quintile are significantly less likely to report "very good health" in all European countries. In Germany, the relative disadvantage of lower income groups is prevalent for all age groups: those belonging to the lowest income quintile are far more likely to experience bad or very bad health than other income groups.

Note that the cross-country comparison of subjective health is hindered by cultural factors. Germany is among those countries, where people have previously been shown to under-rate their health state, whereas Danish and Swedish respondents had a tendency to over-rate their health (Jürges 2007). The *average healthy life expectancy* (based partly on self-assessed limitations[11]) appears to be far below EU average in Germany, although the more objective data on the average life expectancy (based on mortality) Germany performs relatively well. This appears to reflect the German attitude to underrate (subjective) health, rather than actual poor health status in European comparison.

Individuals at risk of poverty are also more likely to be affected by *barriers of access to health care.* Co-payments, lack of free transportation or distances to services, as well as waiting times (with no option to bypass them by making use of private services) impose constraints especially on people in lower income groups. On average across the EU27, 8% of the bottom income quintile group are not able to afford dental care because they find it "too expensive".

In comparison to most Western European countries, *Germany* has relatively high rates *of unmet needs due to out-of-pocket expenses* for medical health services among the bottom income quintile (5.8%).

While *waiting times* are almost no issue in many countries with very low levels of unmet needs in most EU Member States, they have traditionally been the main barriers to access in some other countries, like Finland and the UK (Huber et al. 2008). In Germany, waiting times do not appear to be

[11] Healthy life years are calculated using the Sullivan method which combines information on mortality and morbidity data (i.e. limitations in activities because of health problems).

a significant reason for unmet medical needs: the estimated rates are 0.1% in case of dental needs and 0.6% for medical needs in general.

Housing deprivation and access to services

In 2009, an estimated 30 million people, 6% of the EU27 population suffered from severe housing deprivation. This is defined as living in a dwelling which is both overcrowded and has at least one fundamental quality shortage (either (1) a leaking roof or damp walls, floors, foundations or rot in window frames or floor; or (2) neither a bath, nor a shower, nor an indoor flushing; or (3) too dark). There is a major geographical divide across Europe, with highest rates of deprivation in Eastern and Southern Europe. Germany, with its rate of 2%, is one of the countries least affected by severe housing deprivation.

In 2009, 18% of the EU27 population lived in overcrowded conditions, which is an objective indicator based on the number of rooms, household size and composition. The problem is much more prevalent in Eastern European countries, with rates of 40, or even 50% (Hungary, Romania, and Latvia). The lowest percentages were recorded in Cyprus (1%) and the Netherlands (2%). In Germany, the estimated rate is 7%, which is about the same as in Luxembourg or in the UK.

The population at risk of poverty is more likely to live in overcrowded conditions or in a dwelling with quality shortfalls. In Germany, 22% of the population at risk of poverty is exposed to overcrowded conditions. Similar rates prevail in Norway, Luxembourg, Denmark, and Sweden. These rates may appear low compared to Eastern Europe, but they are relatively high in national standards, with a difference of about threefold compared to the total population. In Germany, 7% of those at risk of poverty suffer from severe housing deprivation.

In Germany, jobless young adults are the most disadvantaged group in terms of overcrowding (34%) and housing quality shortfalls (14%), signalling partly a life cycle effect. Single parents are also largely affected by overcrowding (25%), and by severe housing deprivation (9%). Both of these household types tend to live in dwellings rented at market price, so it is clearly related to affordability. Other social groups with above average prevalence of overcrowding and quality shortfalls include those at risk of poverty, large families (those with 3+ adults and those with 3+ children), and migrants from outside the EU. Tenants with a free accommodation or subsidized rent are more likely to experience overcrowding in Germany.

We compared the households' perceived financial burden related to their actual overburden. Typically, the prevalence of self-perceived housing cost overburden is much higher than that measured by the objective indicator. In Germany, 20% of the population perceive their total housing costs (including mortgage payments) as a heavy burden.

About one in five persons in the EU27 report difficulties with *access to public transport*[12]. Access to public transport is particularly relevant for low income groups, as they are less likely to afford a car and its maintenance, and it is vital for commuting, for having access to jobs. In 12 out of 27 countries, including Germany, the population at risk of poverty does *not* have a relatively higher prevalence of "great difficulties" with public transport than the total population, which is rather reassuring for the social inclusion agenda. In Germany, people living in rural areas and also large families are likely to experience difficulties or great difficulties in accessing public transport.

Norway, the UK and Cyprus are the least affected by difficulties in *access to postal and banking services* (2-8%). Germany, with its rate of 21%, is at the level of the EU27 average. There is some

[12] The accessibility of the services is assessed in terms of physical and technical access (e.g. distance, equipment for respondents with physical disability), and opening hours, appropriate timetable, but not in terms of quality, price and similar aspects.

correlation with low income situation. People with poverty level of incomes are more likely to have difficulties with access to postal and banking services across most countries of the EU, including Germany as well.

Social isolation

Our analysis, based on the European Social Survey with 46000 individuals across 24 countries, suggests that social isolation in Germany is comparatively low by international comparison. According to our estimates, about 5% of the German population have no one to discuss personal matters. In about half of the countries in our sample, this ratio reaches 10%, and it peaks at 29% in Romania. Alternative indicators also suggest that Germany performs well by European standards. 7% of the population meets friends, relatives or colleagues less often than once a month or never (and only 1% "never"). Similarly, according to the EU-SILC 2006 special module on social participation, 5% of the Germans were not able to ask any relative, friend or neighbour for help (Lelkes 2010).

There are clear social patterns recurring across countries. We found that paid work and voluntary work tend to be good safeguards of social networks, as people engaged in any of these are less likely to be isolated. There is evidence of a very pronounced age pattern, affecting old age people in particular. Germany appears to be an exception here, with only 6% of the elderly reporting that they have no one to discuss personal matters with. Low income groups tend to be more isolated across all the countries. In Germany, the ratio is 1.7 between the bottom and the top income quintile group. "Minority groups" (those who feel that they suffer from discrimination in their country) are also more likely to suffer from social isolation.

In Germany, unemployment is associated with greater social isolation, while young age and higher education is associated with lower prevalence of social isolation, according to the both alternative indicators used in our analysis. 16% of the unemployed have no close friend, and 10% of them have very rare personal contacts. Social isolation, measured in terms of limited social contact, is very high among the disabled (those who are "hampered a lot" in their daily activities), over twice as more frequent than among the general population. Old age, inactivity or living in East Germany are also associated with a higher prevalence of limited social contacts. All these differences were tested and found to be statistically significant.

In case of Germany, the accumulation of social isolation and unemployment warrants for caution. Almost one out of six unemployed claims that they have no one to discuss intimate and personal matters with. This, combined with the mental stress related to unemployment, is likely to make them more prone to psychological hardship, which may well have physical health consequences as well. All this may greatly impair their ability to re-enter the labour market or even to engage in meaningful social activities such as volunteering or home care (child care or long term care).

Subjective well-being: "misery

Overall assessments of well-being tend to use self-reported happiness and self-reported satisfaction with life as a whole. In these measures, people weight and assess their specific set of life circumstances and conditions. Thus, this measure also provides information on the gap between objective living conditions and people's own evaluation of these situations. This latter will also be largely affected by people's aspirations.

Politicians cannot influence the age or gender of people, neither can they perform match-making for marriage, even if it tends to make people happier on average. What they can obviously influence among the individual level determinants of happiness, is income inequality, education, employment, including the quality of employment. Our empirical analysis highlights that the generally used

indicators of social exclusion, including joblessness, low income, bad health and social isolation, have a negative impact on people's subjective well-being.

The unemployment was shown to have a clear causal effect, making people unhappy. This effect on happiness is large, and it goes beyond the pure negative effect of income loss related to becoming unemployed. Policies reducing unemployment are expected to have a clear effect in raising overall well-being.

Using GSOEP data, Schwarze and Haerpfer (2007) find the average German to be inequality averse. The effect of inequality on subjective well-being differs by the income level and the political ideology of the individual (Alesina et al. 2004). Inequality "hurts" as people tend to evaluate their own situation compared to others (Clark, Frijters et al. 2008). Reducing income inequalities is thus likely to increase total societal subjective well-being . This may hold, however, only on the long run. Note, that a (most unlikely) one-off transfer of incomes from the rich to the poor, even if it was politically and socially feasible, is expected to decrease total well-being. The reason is an asymmetry: income loss hurts more than the joy related to income gains.

Higher educational attainment reduces the chances of mental misery, and much of this effect comes in indirect ways: through lifestyles, including better health literacy, higher earnings. Education, however, is clearly a way of improving long term life chances and the quality of life. The current data does not allow us to state more on the relationship of subjective well-being and the specific types and methods of education. We, however, can clearly conclude that a policy focus on increasing total well-being needs to inherently include education policy measures.

The findings also highlight the importance of integrating ethnic minorities. Despite the measurement difficulties of identifying these groups, self-proclaimed ethnic minority status seems to be clearly correlated with lower subjective-well-being.

Social isolation may not be directly abolished by policy measures, given people's autonomy in leading their lives, but can be influenced. Acquiring social competences could be an inherent part of formal education and the extra-curricular activities offered by schools. Incentives provided to people for doing voluntary work, or at an institutional level, support to NGOs, voluntary associations and club can enhance social connectedness. In an old age, the structure and quality of long term care play a major role as well. The mental well-being needs to be an integral part of the objectives of these services, in addition to physical well-being.

Social contacts are clear happiness boosters. The problem is that the poor and the unemployed tend to have less of these (as shown in Chapters 6 and 10), so these groups may suffer from a circle of disadvantage. The poor suffer, because they are poor, and they suffer even more, because they have less social contacts. And because they suffer (they have low satisfaction), they are less likely to have social contacts (they are less likely to have the energy and motivation to reach out to others), which might ultimately also contribute to them staying poor (as social capital can enhance business opportunities or help with finding a good job). How to break this cycle of disadvantage? Awareness raising helps, with "personalised happiness strategies", which also respect the autonomy and preferences of individuals.

These "personalised happiness strategies" may evoke the collaboration of e.g. labour office professionals, social workers and mental health professionals. These strategies could include training and education options, providing participation in peer groups (learning, sports, volunteering), or perhaps family or personal therapy as well, as often these most personal factors stand behind the failure to succeed in society. Action for Happiness, a Registered Charity in the UK[13], initiated a social

[13] The Board includes Prof. Richard Layard, London School of Economics, Geoff Mulgan, founder of Demos and previous director of Government's Strategy Unit, Head of Policy in Prime Minister's office, and Nic Marks, the founder of the Center for Well-being at the New Economics Foundation, and others. Website: www.actionforhappiness.org

movement, making a very intelligent use of new social media (Facebook, twitter, and also engaging people to sign up and be part of an internet community). It includes support for those who feel unwell: they offer advice for those who are depressed or suicidal in an easily accessible language, and give practical advice on the types of support available, including talking therapies, medicines, specialist care or emergencies.

Top incomes

Global wealth is very unequally distributed. In 2002, the richest 10 per cent of the *world population* had 120 times higher *incomes* than the poorest 10 per cent. Moreover, the richest 0.25 per cent owns as much *wealth* as the rest of the world population.

Germany is found to be one of the European countries with the highest income concentration, superseded only by the United Kingdom (out of the 23 countries analysed). According to a recent study by Atkinson et al. (2011), analysing the concentration of gross incomes within countries, the share of the *top 1 per cent* ranges from 5 per cent in the Netherlands, to 11 per cent in Germany, up to more than 17 per cent in the United States. The difference between the top one per cent and the top 0.1 per cent highlights the *inequality within the rich themselves*. The *top 0.1 per cent* in *Germany* owns 4 per cent of the total gross income.

An alternative study, based on the German Socio-Economic Panel Study (SOEP), finds a higher income concentration in Germany: the richest one per cent owns 20 per cent of the total income in *Germany* (Grabka & Frick 2007: 668). The SOEP uses a broader definition of income, which covers real estate property, financial assets, business assets and tangible assets as well.

Exploring long term trends in top income shares, Atkinson, Piketty and Saez (2011) find that most countries have experienced rather modest increase since World War II following a sharp decrease in the first half of the 20th century. The authors identify four country clusters based on the geographic and cultural similarities in the evolution of top income shares.

Germany belongs to the second group of *Middle European countries* (together with France, Switzerland and the Netherlands) as well as Japan. In comparison to the Western English speaking countries, the evolution of top income share follows an L-shape, starting with a relatively high share in the beginning of the 20th century, followed by a relatively steep decrease till the post-war period and since then relatively stable shares. Germany had a top income share of almost 20 per cent in 1900. After a short period of increase, shares went down to 11 per cent during post war period and stayed rather stable between nine and 11 per cent since then (more recent years are not included in the database for Germany).

Long term trends suggest a restructuring of incomes, with the rising importance of labour income compared to capital income. While the income structure remained rather stable in 1984-2000 in Germany, it has changed remarkably recently: the share of capital incomes and self-employment incomes has risen. This resulted an upward income mobility among middle-income groups, who up to the high-income elites.

Connected: active political and social participation

Trust. 14% of the German population says that most people can be trusted, which is about the average value in our sample of European countries. In Sweden, Finland, Norway and Denmark, 30% or more people report a high level of trust. High income individuals are more likely to report a high level of trust in most countries. In Germany, 19% of the top fifth income group say that they can trust most people, in contrast to the 12% of the bottom fifth income group, so the ratio is 1.5.

In Germany, those with high incomes or with high level of education are more likely to say that most people can be trusted. There is a significantly lower prevalence of highly trusting people among the unemployed and the East Germans.

Social contacts. In Germany, 9% of the population meets friends, relatives or colleagues every day, and 29% meets them several times a week. This value is somewhat below the average in our sample of European countries. In contrast to neighbours, the German value is lower than that in the "Western" neighbouring countries (France, Netherlands, Belgium, Denmark and Switzerland), but higher than in the Eastern neighbour Poland. The elderly do not differ much from the middle age category (aged 30 to 64): the share of people with intense social contacts is about the same in the overall majority of countries. This suggests that while social isolation occurs more frequently among the elderly, a large share of this age group remains very engaged socially.

In Germany, the elderly, East German residents, the inactive population, and people with tertiary education are less likely to be engaged in frequent social contacts. On the other hand, the unemployed, those with low education, and young adults are more likely to have intense social contacts. Comparing these figures with those on social isolation (rare or no meeting) provides an interesting social profile of social contacts. The situation of the unemployed is polarised. Both social isolation and intense social contacts are more prevalent among the unemployed, showing great variation in the social networking of this group. Highly educated people seem to prefer a golden middle way: they are less likely to have intense social personal contacts with friends or relatives, and in parallel, they are also less likely to be socially isolated. This group is probably more likely to use alternative, non-personal methods of personal interaction, including e-mails or social media.

Political participation. Germany has a relatively large politically active population in a European comparison. Over one in four Germans have worked in an organization or association and about one in three persons signed a petition or boycotted certain products during the past 12 months. Wearing a campaign badge is not particularly popular in the country, with only 5% of the population doing so.

The cluster analysis of political participation indicators classifies Germany as a country with a relatively high political participation (together with France, Switzerland and Denmark in one specification and in a group with Belgium, Denmark, and the Netherlands in another), although somewhat behind the top group of Finland, Norway and Sweden. Eastern European (Bulgaria, Hungary, Slovakia, Poland, Estonia, Slovenia, Romania, Latvia) and some Mediterranean countries (Cyprus, Greece, Portugal, Spain – depending on the selection of political participation variables) constitute a group with low political engagement.

High income individuals are more likely to take part in political action of any sort than those on low incomes. In Germany, the difference is particularly high with respect to contacting a politician or working in a political party or action group. The higher participation of high income people may be explained by their higher education on average and thus the greater aspiration to influence policy outcomes, despite the higher opportunity cost of free time activities. In Germany, for example, the top income group is relatively active (compared to those on low incomes) in time intensive activities such as working in a political party or action group, with fivefold participation rates.

There are pronounced differences by educational attainment. In a large number of countries, including Bulgaria, Hungary, Poland, the Czech Republic and Romania, the political engagement (measured as two or more types of activities, excluding signing a petition) of low educated groups is practically zero. This suggests that these groups are abstinent from politics and have little trust and motivation to influence political decisions. This may be due to the Communist inheritance of these countries, which left behind a weak civil society. In contrast to these countries, people with low education levels have a participation rate of 15% or over in the top three Nordic countries.

In Germany, the political activity of highly educated people is one of the highest in Europe, with over one out of three people being involved in several political activities. There is, however, a major social

gap, as the political engagement is rather weak among those with low education levels, reaching only 8%. Although it surpasses the rates of Eastern-European countries, it is substantially lower than that of the Nordic countries.

With respect to social differences within Germany, we found that high income and highly educated groups are more likely to engage in political activities. In contrast, many groups at risk of social exclusion, including the unemployed, those with low education and low income play a little role in trying to influence politics affecting their lives. Similarly, the political engagement of East Germans, inactive population, the elderly, and also that of women remains below the national average.

Policy implications. How can politics promote social cooperation and social engagement? Trust can be influenced indirectly. Transparency and accountability of public institutions, politicians and policy-makers plays a major role in enhancing trust in the political system as such. Adequate information on the functioning of these institutions is also vital, both as part of the communication strategy of these bodies, but also as part of the school curricula. In addition, school curricula and adult education that promote social skills and social cooperation may greatly enhance individuals's ability to function in communities and social networks. Financial and non-financial incentives for voluntary work are also likely to affect behavior, at least on the longer run. Many of these social patterns are deeply imbedded in the culture, so some of these changes may need time and consistent policy effort. Recent policy focus on the quality of life, including the acknowledgement of the value of free time (in addition to productive activities at the workplace), free time activities and social contacts is a vital step in this direction. In addition to the various levels and branches of government, employers and the representative bodies of employees also play a major role in this respect.

Subjective well-being: "bliss"

The empirical analysis suggests that we have more knowledge on what makes people unhappy than what makes them happy. Unemployment, disability, ethnic minority status and low income tend to reduce the probability of being very satisfied. The effect of well-being inducing factors (intense social contacts, political engagement, high income, and high education) is smaller and often not statistically significant for certain countries. Thus, these social categories reveal little on happiness inducing factors.

In Germany, unemployment is very strongly correlated to low well-being. The relationship seems to be stronger than in other countries. As shown earlier, 38% of the unemployed report a very low level of satisfaction and only 7% are very satisfied. The unemployed are thus the most dissatisfied social group in Germany (among those groups analysed here). This may be explained by the high levels of unemployment and the long duration of unemployment. Losing previous entitlement to social benefits "hurts" more than never having it, due to our psychological bias, also called as the "endowment effect" or "status quo bias" (see also the discussion in chapter 7). Happiness research highlights that the negative effects of unemployment go beyond that of pure income loss, and highlight the psychological costs on the short run, as well as a long term scarring effect, which prevails even after reemployment. Unemployment seems to lower self-esteem and be detrimental to social networks as well (chapter 6). Thus, based upon our findings and the well-being literature, reducing unemployment and increasing the probability and speed of reemployment would clearly be on the forefront of the German policy agenda.

Low income, disability is not necessarily related to lower subjective well-being. 15% of people with disability that severely hampers their daily activities say themselves to be very satisfied. Although this figure remains below the national average, it highlights that some people can find joy in their lives despite their limiting circumstances. How? Activities and relationships can provide an "exit strategy" into happiness, as these determine much of it, more than income or external circumstances. The active inclusion of these groups needs to entail more opportunities for social

engagements, voluntary work, valued free time activities, and last, but not least, access to employment. Providing flexible and accommodating employment opportunities is fair and socially inclusive, and is also expected to increase personal life satisfaction.

East Germans have a systematically lower level of subjective well-being. According to Noll and Zweck, the "confidence in the performance of welfare state institutions and trust in the political and legal system seem to be crucial to explain the differences in SWB levels between West and East Germans" (2010, p. 24).

Individuals themselves play a major role in determining their own happiness. In addition to individual's ability to influence their life circumstances (e.g. making efforts to find a job, buying a house) and actions (how much time to spend with friends), they can largely alter their well-being by the interpretation of life events (see e.g. Lyubomirsky 2008). Western neuroscience has now confirmed what Eastern wisdom has known for a long time: happiness is a skill we can learn. On the other hand, people do not want to be told what is good for them, especially not by their political leaders. Providing incentives, information and a general social momentum, however, may ultimately contribute to changing norms and behavior. Social movements based on individual commitment may also be a way forward, as argued by Richard Layard, the proponent of the Action for Happiness, a recent British non-governmental organization.

What is the role of governments, in promoting the happiness of citizens? Social institutions systematically influence happiness. Well-being indicators enable governments to evaluate the welfare effects of their programs directly. For this, however, there has to be a clear role of these indicators in the policy-making cycle, with a clear causal link between a policy and its outcome.In contrast to the UK or France, where the use of well-being indicators are in the forefront of recent and ongoing policy efforts, this issue has not yet gained political priority in Germany. There is thus much scope for an increased use of well-being indicators in Germany across the policy-making cycle.

Early childhood education and care: barriers in access to good starting points in life

The economic research on the key role of early childhood and family environments is compelling, and it is consistent with recent evidence from neuroscience and developmental psychology. In a major review comparing the economic costs and benefits of the entire portfolio of potential policies to improve human capital in the economy (including investment in early childhood learning and in adolescent learning, training programs for displaced workers, tax benefits, and schooling subsidies), James Heckman (2000) concludes that high intensity early childhood education and care (ECEC) policies are both effective and highly cost-efficient. Early childhood social policies may seem expensive, but when taking into account the wide range of future benefits both to participants and to society at large, these preventive social policies are a great investment and cost-saving. The case for strengthening and complementing family environments is further bolstered by evidence from comparative social policy and the sociology of education. These bodies of research indicate that failing family environments may be more important than failing schools in explaining the problems related to the emotional development and educational success of children.

Important prescriptions for public policy follow from this evidence. Efforts directed toward families may be a more effective way of improving school performance than direct expenditures on 'standard' schooling inputs such as teacher salaries, teacher quality, class size, and spending on pupils and school equipment. This is even more important given the increasing awareness that investments in education at 'normal' school ages are often unexpectedly ineffective.

Positive recent policy changes notwithstanding, *Germany's performance can be described as average* at best in international comparison as regards both inputs and outcomes on ECEC policies - worse,

certainly, than the performance of the Nordic countries. More generally*, the Nordic countries clearly represent the best practice model on ECEC policies* as they comprehensively offer the best chances of equal starting points in life to all young children, irrespective of the socio-economic circumstances of their birth and early childhood circumstances.

As regards *social outcomes*, Germany (8.3%) does perform relatively well in international perspective when it comes to child poverty, as it occupies the eleventh rank out of a 34-country OECD sample. Yet these are much higher child poverty levels than in Denmark (3.7%), Finland (4.2%), Norway (5.5%), Sweden (7%), and Austria (6.2%). While the share of single parent families is relatively low in Germany (5.9%), there is a large gap between the poverty rates of single parent households (36.2%) and those of couple families with children (5.8%). In the same vein, highest levels of employment among mothers of young children are again found in Nordic countries such as Denmark (76.5%), Iceland (84.8%) and Sweden (82.5%). Germany (63.1%) is situated midway between these Nordic levels and the EU-wide lowest levels in Southern Europe and post-communist Europe.

In terms of *policy input indicators* such as total public spending on ECEC services, the EU-wide top seven consist of *all five Nordic countries*, as well as France and Belgium. Germany spends less than half as much as this group (0.4% of its GDP). More crucial and potentially more worrying still: Germany spends particularly little on the childcare services in the very youngest (0 to 2) age group: 0.1% of its GDP, as compared to EU-wide highest levels of 0.6 percent in Sweden, 0.7 percent in Iceland and 0.8 percent in Denmark.14 This marginal focus on the crucial youngest-young age group is also evident in attendance rates for ECEC services, where Germany closely follows larger international patterns, as it combines relatively low attendance levels for children aged 0-2 (19%) with very high attendance levels for children aged 3-5 (89%). Needles to say, increasing the availability of low-cost and high-quality childcare facilities (and take-up rates) would have important add-on effects through the ways in which, by reconciling work and family obligations of mothers ('babies and bosses') they could increase mothers' labour market participation rates and indirectly therefore could reduce both welfare dependency levels and child poverty rates. But in addition to these indirect effects, the reason why these low 0-2 attendance figures are particularly worrying is that mounting economic and sociological evidence indicates that this youngest-young age group is precisely the one most likely to benefit directly from state investment.

There is compelling evidence for advocating state investment in the earlier years. Yet, EU and OECD countries today still tend to spend more on pre-primary school services than on truly early-childhood care services which target the age group where intervention is likely to be more effective (Figures 3.5 and 3.6). In fact, state spending commitments on early childcare amount to only 0.1 percent of GDP in countries such as Slovakia, Germany and the Netherlands, but to *six, seven and eight times as much* in Nordic countries such as respectively Sweden, Iceland and Denmark. Second, if we are to activate the employment of mothers, we need to reduce the prices of childcare. Here again the Nordic countries show the lead. Moreover, concerning the quality of preschool programs, a number of explicit policy prescriptions follow from the cumulative evidence on ECEC pilot programs (Barnett 2002):

- Class sizes and child-teacher ratios must be kept low.
- Teachers must be highly qualified, with at least a bachelor's degree and with specialized training in early education, and must be paid well.
- Curricula must be intellectually rich and sufficiently broad to address children's developmental needs in all domains.

[14] Note, however, that a major new policy aims to remedy this by speeding up the expansion of childcare places for children under three. Thus, by 2013 the coverage rate for children aged 0–3 should have risen to 35 percent, and from 2013 onwards every child will have the right to a childcare place from its first birthday (Kinderförderungsgesetz 2008 BGBl; Leitner 2010).

- Programs must engage in an active partnership with parents and accommodate their needs, including their needs for childcare.
- Programs should start no later than age three.
- Resources should be focused primarily on disadvantaged children.

Of course, no country thus far has implemented exact copies of the ECEC pilot programs studied here on a truly nation-wide scale. The EU Nordic countries such as Denmark, Sweden and Finland are the outstanding best practice models to follow, as they effectively *already* apply Perry Preschool or Head Start-type programs on a national scale. By providing publicly subsidized day-care with low class sizes and realizing high attendance rates even for very young children, they actively enable mothers to work, thereby reducing long-term welfare dependency, and enlarging the tax base. Poverty among children and among single-parent families is much lower than in other welfare regimes, whereas mothers' labour market participation rates are significantly higher.

Attendance rates for pre-primary school age children (aged 3-5) in EU countries vary from under 60 percent in Anglo-Saxon countries (Australia, Canada, USA) and Croatia, Greece, Poland, and Switzerland, to near-universal (over 90 percent) in Belgium, Estonia, France, Iceland, Italy, New Zealand, Slovenia, Spain, Sweden and the UK. But importantly, *attendance rates for the truly crucial age group - children aged between 0 and 2 – are much lower everywhere except for the Nordic countries*, ranging from close to zero in post-communist countries and around 10 percent in Greece and Austria to over 40 percent in France and Iceland. Only in the Netherlands do ECEC attendance rates reach a level close to 50 percent for the very young children, while they reach over 60 percent in Sweden and over 70 percent in Denmark. And only in the Nordic countries are nearly all young children placed in centre-based care (as opposed to individual carers, as in France), with guaranteed access to high-quality full-day subsidized care (Esping-Andersen 2009). Belgium, Slovenia and the four Nordic states are the only EU countries that provide a state entitlement to ECEC before age 3. *And only in the Nordic countries are policies designed so as to ensure there is no gap between the end of parental leave and the start of an ECEC entitlement*. In sum, countries such as Sweden and Denmark clearly provide the best overall policy model for increasing human capital, and thereby equality of opportunity early in life, through investment in ECEC.

Health care

In general, Germany provides a very comprehensive health care system in comparison with other EU Member States. However, health inequalities are prevailing even in very well-organised welfare states and a number of people are still facing barriers of access to health services. Chapter 13 provides a review of good practices from a number of selected European countries.

The recently introduced mandatory universal health insurance system in Germany aims to reduce the prevailing number of people without coverage. Gaps in *health care coverage,* however, may still appear for those people who are not able to tackle the organisational barriers (such as administrative procedures for registering with an insurance fund) or who lack understanding of their duties and rights. It is therefore essential that information on the right to health insurance coverage as well as on obligations and administrative procedures is easily accessible, in particular for those groups who are at risk of social exclusion. These groups include people with low educational attainment, the illiterate and those facing language barriers as well as other vulnerable groups, such as people with mental health problems. It thus needs to be therefore evaluated which groups fail to obtain a regular insurance status and special support should be provided to eliminate access barriers.

In comparison to other EU Member States, Germany offers a rather generous health system in terms of low *co-payments.* As co-payments affect the poor in particular, exemptions for people with low income ease the financial burden and promote access to health care. However, gaps can be found in case of some services, such as dental prosthesis and visual aids, which have to be covered by patients

almost completely. Especially older persons often already face high expenses for health services and may not be able to cover the total cost for these medical aids by themselves. The recent rise in co-payments on pharmaceuticals has affected especially those people with an extensive need for medicaments, such as patients with chronic diseases (which again are more likely to be older persons). Introducing a clear cost sharing ceiling, like the one presented for Finland, would help avoid financial constraints and reduce the risk of poverty particularly for these groups.

The provision of full coverage of *transportation services* to access health care services (especially for children) would be one way to support lone parents and larger families at risk of poverty.

Similarities found in successful national policy measures in terms of reducing *regional and rural-urban inequalities*, were to combine efforts of all players involved in addressing the common aim of reducing access barriers to health care. Particularly when addressing inequalities in the provision of health services in rural areas, it may be helpful to be inspired by examples of good policies from Finland and Spain, where collaborations on a local level have helped to overcome short-comings of financial nature and professional resources.

Distribution of health services will remain one key area to achieve equity in access to health services in Germany. Particularly the substantial discrepancies in the distribution of physicians between (rural) Eastern and Western parts of the country will be an issue to be solved in the coming years. Incentives offered to physicians and other health professionals may help Eastern regions to become more attractive for employees in the medical field.

Labour market chances for older workers

The labour market participation chances of older workers (55-64) in Germany have very markedly improved since 2004 and the 2005 Hartz reforms after decade-long stagnation. Activity rates reached 61 percent in 2009, a level which recently established Germany as the second highest achiever in our five-country sample, second only to Sweden (at 74 percent) and just above Finland (59 percent). Together with the Netherlands, Germany reached the 2001 EU Stockholm target to increase the employment rate of persons aged 55 to 64 up to 50 per cent in 2007, ahead of Austria but after Sweden (2001) and Finland (2004). One strong qualifier to this comparative success rate is that Germany stands out as a high-risk labour market for unemployed older workers over the past decade, with both the highest unemployment rate (at 8 percent) and, more worryingly, the highest long-term unemployment rate (at above 5 percent) in the sample. Thus, there is a need for policies which provide a better access to labour market participation for older unemployed workers.

In terms of age-wage profiles, unlike Finland and Sweden (flat profiles over the career cycle) Germany tells a tale of a zigzag gender race: women intermittently almost catch up with men, only to fall back later on in the career cycle. As a result, in the age category 60-64, gender gaps are relatively wide in Germany – the widest in our sample, far closely followed by the Netherlands and Austria, which has by far the steepest age-wage profiles for both men *and* women. While such steep age-wage profiles are a strong incentive for workers to hold on to their current jobs, they represent strong hurdles for the employability of older workers. From a policy viewpoint, it follows that reducing steep age-wage profiles for older workers in the public sector would be desirable if activating older workers is a policy priority.

Similarly, there is evidence that high levels of employment protection regulation prevent companies from hiring older workers and force many older workers to go into *in*voluntary early retirement (e.g. Dorn and Souza-Posa 2010). From a policy viewpoint, reducing of employment protection levels where possible (e.g. in the public sector) would thus be likely to lead to higher labour market activation levels among older workers, especially if combined with stronger disincentives for early retirement.

All in all, negative incentives, such as closing down pathways into early retirement and disability retirement, implemented in Germany, Sweden and Finland in recent years, appear to be most effective in increasing labor market participation of older workers, albeit sometimes at the cost of higher levels of long-term unemployment.

In addition, dynamic labour markets with cooperative relations between employers (and their organizations) and employees (and their organizations) can be a major help. A standout recent example here is the 'German employment miracle' during and after the late 2000s, which was in all likelihood more due to employer prudence and flexibility rather than state measures. As Burda and Hunt (2011) point out, Germany experienced an even deeper fall in GDP in this recession than the United States, yet it experienced little employment loss. Burda and Hunt argue that employers' reticence to hire in the preceding expansion, partly due to a belief the expansion would not last, was the main cause for the outstanding German employment record during the recession. In addition, wage moderation on the part of employees and the widespread adoption of working time accounts, which allow employers to avoid overtime pay if hours per worker average to standard hours over a window of time, were also significant factors. Working time accounts, for instance, provided disincentives for employers to lay off workers in the downturn. As a result, whereas overall cuts in hours per worker were severe during the recession, reduction of working time account balances substituted for traditional government-sponsored short-time work.

I. Conceptual background

1. Conceptual framework and current political setting

Orsolya Lelkes[15]

"Teilhabechancen" refers to (social) participation opportunities, referring to both the situation in terms of social participation and the opportunities of individuals or groups for such participation. Its current use tends to refer to particular domains of life (politics, employment, education, culture) and to particular social groups (women, men, the elderly, the young, the disabled, the migrants).

The term does not seem to have a simple English equivalent. "Social participation", which comes close to the literal translation of "Teilhabe" tends to be used in a narrower sense, referring to social contacts, social and political activities (e.g. helping others, volunteering, voting). "Teilhabechancen" comes closest perhaps to the widely used notion of "social inclusion". Both "Teilhabechancen" and "social inclusion" reflect individual and social processes and not only the outcomes of these processes (e.g. being marginalized). Both are multidimensional in the sense that they consider a range of life domains.

In the German academic literature, the sociological concept of "Lebenslage" may be also regarded as a conceptual underpinning of "Teilhabechancen". "Lebenslage" refers to life circumstances and the opportunities open for individuals or social groups. The phrase itself originates from Marx and Engels, who used it in their description of the situation of the proletariat[16].

The mentioning of opportunities ("Chancen") creates a conceptual link to the theory on equality of opportunities, and to the theoretical work of Sen on capabilities.

Fairness in processes: equality of opportunity

Equality of opportunities (EOP) refers to the notion of 'levelling the playing field'. It implies that individuals with the same talent and ambition ought to have access to the same positions and chances in life. Differently formulated, it implies that the socio-economic status into which one is born ought to have no impact on one's competitive prospects. Following seminal theoretical contributions by the political philosophers such as John Arneson and G.A. Cohen, the political economist John Roemer (1998) proposed a first policy-relevant definition and operationalization of EOP. The starting point is the need to separate the influences on any relevant outcome a person experiences into those of *circumstances* and those of *effort*. Circumstances are attributes of the person's environment for which s/he should ideally not be held responsible, whereas effort is seen as an individual choice variable for which s/he should be held responsible. An EOP policy can then be defined as any state intervention that (aims to) ensure that all persons who make the same effort end up with the same outcome, regardless of their circumstances – this is the idea of 'leveling the playing field.'

From this perspective, improving social participation opportunities (Teilhabechancen) has thus a straightforward translation into EOP policy: it means the effort to allow everyone the very same chance to take part in a full life, unencumbered by accidents of birth and circumstance, and to subsequently reap the just reward of their own efforts. In other words, EOP policy aims to compensate persons for their deficits in circumstances, in order to make only effort count with regard to the outcome they achieve. For instance, if a child studies poorly for lack of effort and as a result of that ends up in a bad job, he would have no case to appeal for compensation. If in contrast a

[15] With contribution from Pieter Vanhuysse

[16] Karl Marx/Friedrich Engels: Manifest der Kommunistischen Partei, first published in London in 1848, a recent publication e.g. is by Nikol Verlag in September 2009.

child is born in a poor or dysfunctional family, and as a result of *that* ends up in a bad school and thereafter in a bad job – that should be compensated for by the state. Clearly, taxation is one policy tool that can be used to create or improve EOP. As we argue below, schooling and more generally human capital investment is one of the key policies that can be used in a particularly cost-efficient and goal-effective way in order to level the playing field for all citizens early on in the life cycle.

Thus, EOP's focus is on the "rules of the game" rather than on outcomes as such. What should be equal however? A conceptual framework is provided by Amartya Sen, although he deliberately refrains from providing an operational definition of the "objective good".

Fairness of outcomes: Sen's capabilities theory

The Nobel laureate Amartya Sen argues that the " 'real' equality of opportunities must be through equality of capabilities" (1992, p. 7). Capabilities are thus the real opportunities people have, the actual state of being they are able to achieve. Basic capabilities include the ability to live to the end of a human life of normal length, not dying prematurely, being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter, being able to have attachments to things and people outside ourselves; and many others (Nussbaum 2000).

The notion of capabilities thus involves an element of freedom, as it does not necessarily mean that people want these states of being, or that they actually experience them. A typical example is that of the capability of being adequately nourished: a person who has this capability may still choose to fast for religious or health reasons. For a policy-maker, the main issue is whether the person has the capability of being nourished or not.

The capabilities theory thus respects people's freedom (e.g. the diversity of their choices and tastes) and takes into account people's differences in terms of abilities and starting positions. A disabled person, for example, may need a larger amount of resources to achieve the same level of capabilities for health and for social participation as someone without physical impairment. It had a profound impact on the human development paradigm, which proclaims that "the real objective of development is to increase people's choices." (UNDP 1991) These additional choices include political freedom, guaranteed human rights and self-respect. The 2010 Human Development Report states this refined definition clearly:

> *"Human development is the expansion of people's freedoms to live long, healthy and creative lives; to advance other goals they have reason to value; and to engage actively in shaping development equitably and sustainably on a shared planet. People are both the beneficiaries and drivers of human development, as individuals and in groups.*
>
> *Thus stated, human development has three components:*
>
> - *Well-being:* expanding people's real freedoms— so that people can flourish.
> - *Empowerment and agency:* enabling people and groups to act—to drive valuable outcomes.
> - *Justice:* expanding equity, sustaining outcomes over time and respecting human rights and other goals of society." (UNDP 2010, p. 22)

This definition thus includes opportunity freedoms (choices, capabilities) and process freedoms (such as agency and democratic practices), but also refers to justice (equity) and constraints (shared planet).

It is, however, exactly this element of freedom, which turned out to be rather difficult to capture for most of the empirical research: how to measure living conditions, quality of life, which are not experienced, but would be available to an individual? Therefore, many studies focus on the so-called *functionings*, which are actual states of beings, in other words, individual level outcomes. The added

value of such research compared to “traditional” poverty analysis is that it moves away from the exclusive use of income or resources, and adds a number of further dimensions of human life. Capabilities theory could also be regarded as a theoretical underpinning to notions of social exclusion or social inclusion.

Social inclusion, social exclusion: two sides of the same coin?

We might think of social inclusion as a static situation: all those who are not excluded are included, which should normally hold for the majority of the society. We may also think of social inclusion as a process, helping to integrate those who are on the margins. Social inclusion policies can thus ensure that the poverty and joblessness remain only transitory phases of life. These policies imply more than traditional social security and social assistance schemes, as they (ideally) offer a variety of coordinated policy efforts, focusing not only on income shortage, but also on employability and other aspects of life, and the interrelationship between these marginal aspects of life. Social inclusion policies can also be preventive: not letting people to be excluded by providing an overall safety net. We might well assume that the determinants of social exclusion and social inclusion overlap, but are not identical. This issue will be explored further on in the empirical sections of the paper.

Social exclusion is sometimes defined (1) as a lack of certain “final outcome” or states, or (2) as the lack of resources. The first type of definition is applied for instance by the researchers of the Centre for Analysis of Social Exclusion (CASE) (Burchardt et al., 2002, 30, 32. o.): “*an individual is socially excluded when he/she would like to but cannot participate in the generally accepted activities of the society in which he or she lives”.* Accordingly, social exclusion is, for example, where an individual would like to have a job, invite guests or go to vote, but he or she cannot do so. Social exclusion is therefore a state involving the existence of any one or several of the problems listed above. Poverty, low schooling standards or a poor state of health are only viewed in this approach as causes leading to exclusion, though their significance is unquestionable. Preference is given by the European Union to the second approach, focusing on the lack of resources. The majority of the social indicators that were approved during the Belgian Presidency at the Laeken summit in 2001 are income based, including various poverty and income inequality measures.

While the majority of social indicators actually measure social exclusion, the political terminology of the European Union clearly favours social inclusion or social cohesion. This appears to put an emphasis on emphasising the policy efforts for inclusion.

In the European Union strategic policy making, social cohesion became a key element of the Lisbon strategy. “Europe 2020” also highlights “inclusive growth”, next to “smart” and “sustainable growth” as part of its three priorities (European Council, 2010). Three of the five EU headline targets, which are now to be translated into national targets, include the promotion of social inclusion, by increasing employment, raising educational enrollment, and by lifting at least 20 million people out of the risk of poverty or exclusion. These targets will be monitored by the Laeken indicators. (All indicators are presented on the EUROSTAT website.)

Box 1.1: The 5 targets for the EU in 2020

To measure progress in meeting the Europe 2020 goals, **5 headline targets** have been agreed for the whole EU. This limited set of EU-level targets is being **translated into national targets** in each EU country, reflecting different situations and circumstances.

1. Employment: 75% of the 20-64 year-olds to be employed
2. R&D / innovation
3. Climate change / energy
4. Education: reducing school drop-out rates below 10% at least 40% of 30-34–year-olds completing third level education
5. Poverty / social exclusion: at least 20 million fewer people in or at risk of poverty or exclusion

Source: European Commission, http://ec.europa.eu/europe2020/targets/eu-targets/index_en.htm

As shown above, political priorities reinforce the scientific work in clarifying and operationalising new concepts of social fairness and vica versa. Much has happened on the international arena. What do we know about national politics? We briefly highlight the case of Germany, Austria and the United Kingdom.

Social inclusion in national politics

The German government program[17] does not mention social participation opportunities (Teilhabechancen). Participation (Teilhabe) is mentioned related to certain social groups, including the elderly (p. 40), migrants (p. 49) and migrant women (p. 51) and related to certain policy areas, such as health care provision (p. 33), and access to culture (p. 55). The text makes a distinction between participation, employment and training ("Wir wollen generationenübergreifende Projekte ermöglichen und für sinnvolle Teilhabe-, Beschäftigungs- und Weiterbildungsmaßnahmen für die Älteren nach ihrer aktiven Berufstätigkeit sorgen." p. 40), which implies that the term participation does not necessary include labour market participation or enrollment in education as such in the political discourse. Social participation (Teilhabe) is mentioned next to responsibilities as well with respect to migrants ("Erfolgreiche Integration bedeutet für uns: Identifikation mit unserem Land, gleichberechtigte Teilhabe und Verantwortung." p. 49).

In addition, current German politics highlights the participation opportunities (Teilhabechancen) of the disabled. Currently, an action plan is being prepared under the leadership of the Bundesministeriums für Arbeit und Soziales, for the national implementation of the UN Convention on the rights of disabled people, effective since 2009. According to official statistics, the number of disabled in Germany reaches 8.7 million, more than 10% of the citizens[18].

The Austrian government program[19] includes similar references to the issue of participation („Teilhabe"). Participation opportunities (Teilhabechancen) is mentioned once, referring to the older generation:

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[17] Wir haben die Kraft. Gemeinsam für unser Land. Regierungsprogramm 2009 – 2013 http://www.cdu.de/doc/pdfc/090628-beschluss-regierungsprogramm-cducsu.pdf

[18] Source: http://www.bundesregierung.de/nn_1264/Content/DE/Artikel/2011/04/2011-04-12-menschen-mit-behinderungen-teilhabe-verwirklichen.html

[19] Regierungsprogramm 2008-2013. Gemeinsam für Österreich. Link: http://www.austria.gv.at/DocView.axd?CobId=32965

„Teilhabechancen der älteren Generation an modernen Informationstechnologien, an der Wissensgesellschaft und soziale Teilhabe sowie die Mobilität der SeniorInnen in allen Lebensbereichen forcieren." (p. 168)

Participation (Teilhabe) is mentioned related to certain social groups, including migrants (p. 107), the elderly (p. 168), low income groups (p. 188), related to certain aspects of the society including participation in the knowledge and information society (Wissens- und Informationsgesellschaft), access to culture (esp. to national museums, p. 231), and finally, related to a fairness principle of redistribution, calling for a fair share of the income growth for agricultural family businesses (p. 69).

In Austria, the issue is also widened to access to culture and arts. A pilot project by the Armutkonferenz provides escort to people in need who accompany them to a concert, an exhibition or a theatre play, thus enabling people with intellectual or mental impairments, but also migrants, receive an opportunity to have access to these cultural goods. [20]

UK Government Program[21] with its much shorter length of 35 pages, makes no mention of "social exclusion", "social inclusion" or "social participation". "Participation" is mentioned once in the context of democratic participation in the National Health Service. "Opportunity" is mentioned also in the context of democratic involvement of the public to the legislation process. The binding social objective refers to poverty, child poverty in particular, and states that "We will maintain the goal of ending child poverty in the UK by 2020". (p. 19.)

Parallel to these developments, the booming interest in *happiness and well-being indicators* highlights a changing approach to measuring and monitoring human progress. The increasing ecological concerns also underline the search for alternative indicators to resources (GDP, income).

Well-being: a new paradigm of measuring social outcomes

The availability and methodological progress of large-scale datasets measuring subjective well-being opened perspectives for a greater policy use of these issues. In 2004, a group of prominent social scientists have called for the establishment of well-being accounts, arguing that "well-being should become a primary focus of policymakers, and that its rigorous measurement is a primary policy imperative" (Diener and Seligman 2004, pp. 1-2). They added that "national well-being indicators of well-being are needed not only because well-being is an important outcome in itself, but also because well-being is so often a cause of other valued outcomes, such as worker productivity and rewarding relationships" (ibid). Policy-makers were at the same time also receptive to these issues, both at an international and national level.

Alternative ways of measuring social progress has moved high up on the agenda of international organizations. The OECD hosted a series of international conferences on Measuring and Fostering the Progress of Societies. The Istambul World Forum in 2007 culminated with a declaration by the OECD, the European Commission, the Organisation of the Islamic Conference, the United Nations, the UN Development Programme and the World Bank affirmed the United Nations and the World Bank confirming their "commitment to measuring and fostering the progress of societies in all dimensions, with the ultimate goal of improving policy making, democracy and citizens' wellbeing"[22]. In the same

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[20] "Pilotprojekt Social Assistance Service von Hunger auf Kunst und Kultur", see:
http://www.armutskonferenz.at/index.php?option=com_content&task=view&id=251&Itemid=243

[21] The Coalition: our programme for government.
http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_187876.pdf

[22] OECD link on the Istambul World Forum:
http://www.oecd.org/document/51/0,3343,en_21571361_31938349_37115187_1_1_1_1,00.html

year, 2007, Eurostat committed funding to explore the measurement of well-being at EU level. The document discussing the feasibility of well-being indicators was published in 2010, and the efforts and achievements are summoned under the "GDP and beyond" Eurostat website[23].

In July 2011 the United Nations accepted a resolution titled "Happiness: towards a holistic approach to development", and "invited Member States to pursue public policy steps that would better capture the importance of pursuing happiness and well-being in development."[24] The resolution notes that the GDP indicator "was not designed to and does not adequately reflect the happiness and well-being of people in a country," and "unsustainable patterns of production and consumption can impede sustainable development."

Bhutan, which for many years has used gross national happiness as an indicator of national progress, convened a panel discussion on the September 2011 session of the UN[25]. In a strong and critical speech, the prime minister called nations for a renewed paradigm of social progress:

> *"Humanity is in need of a clear vision that will transcend the diversity of our cultures, thoughts and circumstances and bind all of us together. We need a different development paradigm, one that is guided by such a vision; one that is holistic, sustainable, inclusive and humane. Such a vision can take civilization forward and enable it to sustain the progress it has made and must make."*

Bhutan, together with the UNDP, the Earth Institute of Columbia University, leading scientists and thinkers on the subject of the science and economics of happiness will present a set of policy recommendations in the spring of 2012 before the Rio+20 summit[26].

Box 1.2: Themes that appear in the well-being work

Source: ONS (2010) Measuring well-being. Consultation document. Office for National Statistics, London

[23] http://epp.eurostat.ec.europa.eu/portal/page/portal/gdp_and_beyond/achievements

[24] UN News Centre: „Happiness should have greater role in development policy – UN Member States". http://www.un.org/apps/news/story.asp?NewsID=39084 . Access date: 21 October 21, 2011.

[25] Speech of the prime minister of Bhutan at the General Assembly of the United Nations, September 23, 2011. http://gadebate.un.org/66/bhutan . Access date: 21 October 21, 2011.

[26] United Nations Conference on Sustainable Development, 4-6 June 2012.

The UK Government committed to creating "a new indicator set, which is more outcome focused" already in 2005. The recently published sustainable development indicator publication already includes a set of well-being measures (Department for Environment, Food and Rural Affairs 2010). The current government appears to have maintained this commitment. The Office for National Statistics started a national debate in November 2010 on measuring progress and on the development of appropriate measures, consulting organisations, businesses as well as individuals. This phase had the closing date of 15 April 2011[27]. Then, a range of subjective well-being indicators will be included in the Integrated Household Survey (HIS), including measurements of happiness, life satisfaction and purpose in life. Next to the efforts of the government, the New Economics Foundation (nef), a "think-and-do-tank" had been a pioneer with its Well-being Manifesto in 2004 and its easily accessible visualisation of well-being accounts, with a doubtless impact on politics and research internationally as well[28]. The *nef* recommends the following areas where government could take action to promote well-being (2004, p. 8):

1. Measure what matters: produce a set of national well-being accounts.
2. Create a well-being economy: employment, meaningful work and environmental taxation.
3. Reclaim our time through improving our work-life balance.
4. Create an education system to promote flourishing.
5. Refocus the health system to promote complete health.
6. Invest in early years and parenting.
7. Discourage materialism and promote authentic advertising.
8. Strengthen civil society, social well-being and active citizenship.

In 2008, the French President Nicolas Sarkozy set up a Commission on the Measurement of Economic Performance and Social Progress, including Joseph Stiglitz (President of the Commission), Amartya Sen (Advisor) and Jean Paul Fitoussi (Coordinator)[29]. The aim of the "Stiglitz Commission" has been to identify the limits of GDP as an indicator of economic performance and social progress; to consider what additional information might be required for the production of more relevant indicators of social progress; to assess the feasibility of alternative measurement tools, and to discuss how to present the statistical information in an appropriate way. The Commission has concluded that well-being is multidimensional and "at least in principle" the following dimensions need to be considered simultaneously (Stiglitz, Sen and Fitoussi 2009):

i. Material living standards (income, consumption and wealth);
ii. Health;
iii. Education;
iv. Personal activities including work
v. Political voice and governance;
vi. Social connections and relationships;
vii. Environment (present and future conditions);
viii. Insecurity, of an economic as well as a physical nature .

The Stiglitz Commission report highlights that both subjective and objective indicators are essential for the evaluation of the quality of life. The currently agreed common list of social indicators at the EU level consists overwhelmingly of objective indicators, with subjective health as an exception. There is clearly much room for expansion in this respect. Given the stated political priorities and

[27] Website with more information: http://www.ons.gov.uk/about/consultations/measuring-national-well-being/index.html

[28] http://www.neweconomics.org/publications/well-being-manifesto-flourishing-society

[29] http://www.stiglitz-sen-fitoussi.fr/en/index.htm

ongoing conceptual work in the EU institutions, subjective indicators will be on the rise in the near future.

Indicators measuring social inclusion, social participation and well-being thus represent a move away from simple income-based measures such as poverty or income inequality and measure *social outcomes.* In sum, based on the emerging consensus among policy-makers and social scientists, we can conclude that the new indicators measuring social progress should include

- *a portfolio of indicators,* rather than just say a single measure (e.g., poverty);
- *non-monetary aspects of life*, focusing on social outcomes, rather than just resources (e.g. incomes);
- *subjective* (self-assessed) measures as well in addition to objective ones.

In the following report, we will also use a series of indicators, including low income and material deprivation, early childhood education and care, health inequalities, housing and neighbourhood problems, social isolation and social participation, subjective well-being.

Table 1.1: Dimensions of social indicators used in the report

Dimension	Social groups at the bottom	Social groups at the top
Income	Low income and material deprivation	Income, wealth
Education	Early childhood education and care: barriers in access	-
Health	Health inequalities, barriers in access to public health care	Health care privileges
Housing	Housing and neighbourhood problems	-
Social participation	Social isolation	Political and social participation
Subjective well-being	"Misery"	"Bliss"

These indicators are inherently related to the issue of equity or social justice, the distribution of resources across people and across social groups. What are we distributing, however? How big is the cake? Strongly related issues are the total available amount of resources, with an increasing awareness of the limits of (natural) resources and the efficient use of these resources. Political choices are often highlighted as a trade-off between efficiency and equity. There is often, however, a win-win situation, where the promotion of equity increases efficiency as well. Typical examples are early childhood education or preventive health care, which will be discussed later in more depth.

II. „On the margin“ empirical analysis

2. Low income and material deprivation

Orsolya Lelkes, Katrin Gasior

The calculations are based on the EU-SILC 2009 (Community Statistics on Income and Living Conditions). The EU-SILC organised under a Framework Regulation of the European Parliament and the Council (N°1177/2003), is now the reference source for statistics on income and living conditions.

The EU-SILC 2009 covers all of the 27 member states, plus Iceland and Norway. Malta is included for the first time[30]. The sample size varies between 9,283 (Cyprus) and 51,196 (Italy) individuals. The reference population of EU-SILC is all private households and their current members residing in the territory of the state at the time of data collection. Persons living in collective households and in institutions are generally excluded from the target population. The information on incomes refers to the period between 1st January and 31st December 2008 (the income reference year) in all the countries but Ireland (moving income reference period) and the UK (survey year)[31].

The concept of poverty defined in relative rather than absolute terms, with those who have a level of income below a certain threshold in relation to average income in the country in which they live. The people concerned are conventionally defined as being at risk of poverty, or of social exclusion, since given their relative level of income they may not be able to enjoy the standard of living that most people in the country in question are able to. The convention in the EU at present is to take the threshold as 60% of median household disposable income measured on an equivalised basis to allow for differences in the size and composition of households (using the OECD modified scale as the means of adjustment). The level of the threshold, however, is not the only issue for debate in this regard. Other issues concern the fact that income is defined in cash terms and excludes for the most part income and benefits in kind (such as production for own consumption or social services provided free of charge or on a subsidized basis) and is measured in annual terms, which means that neither accumulated wealth nor the possible fluctuation in income from year to year is taken into account even though both tend to affect living standards.

The indicator of material deprivation, on the other hand, is an absolute measure, based on a single EU-wide standard, and does not vary across countries. Deprivation is interpreted in the wide sense of not being able to live a decent life, and is measured in terms of a lack of relevant goods and services. This measure focuses on “enforced lack”, where “enforced” implies that the item is something that the household would like to have, but cannot afford. For example, a family is *not* deprived if they do not have a car because they do not want to have one. The possession of the item does not necessary imply ownership, it may be rented or provided on loan. Thus, a rented car is also taken into account, and a family with a rented car is not regarded to be deprived on this front. Are people who cannot afford a car regarded to be deprived in Europe? No, it is a necessary but not a sufficient criterion. The EU definition of material deprivation refers to enforced lack of four items out of nine, and the items on this list include rather basic ones such as paying rent and utility bills or eat meat, fish or a protein equivalent every second day or having a washing machine.

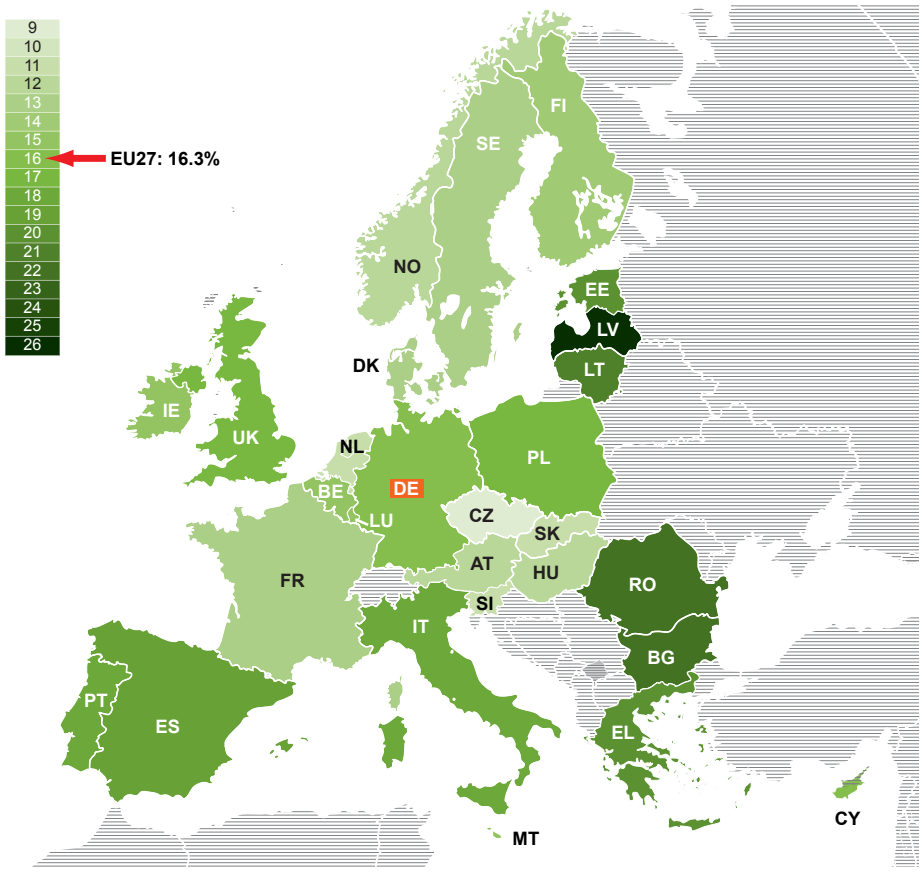
[30] Aggregate information on Malta was available on the Eurostat website, but micro data was not released for researchers.

[31] In Ireland it is a moving twelve month period immediately preceding the time of data collection/compilation for each respondent or unit in the survey, and in the UK it is the survey year 2009.

Risk of poverty in EU Member States

Some 16% of the population were at risk of poverty across the European Union according to EU-SILC survey carried out in 2009, in the sense of having income below 60% of the median of the country in which they live, a total number of 80 million. The proportion concerned varied between 9% and 26% across EU Member States. It was: lowest in the Czech Republic, Slovakia, the Netherlands, and Slovenia, and above average in the Baltic States, Bulgaria, Romania and the southern countries, Greece, Italy, Portugal and Spain. The at-risk-of-poverty rate in Germany remains slightly below the EU average (15.5% vs. 16.3%).

Figure 2.1: At-risk-of-poverty rates across the EU, 2008 income year



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.

The figures for the risk of poverty are normally presented as single values. But since they are based on the information collected from only a sample of households, they are inevitably subject to a margin of error, even if the sample concerned is intended to be representative of the population of the country. The size of these margins of error depends to a large extent on the size of the sample, i.e. the number of people surveyed relative to the population of the country. It is important to take explicit account of these margins of error when assessing differences between countries or changes over time, otherwise there is a danger of reaching misleading conclusions. In particular, differences arising from these margins of error can be confused with real differences in the figures. To avoid this, 'confidence intervals', representing the margin of error, can be calculated around the risk of poverty figure, which indicate the range within which the true Figure is likely to lie.

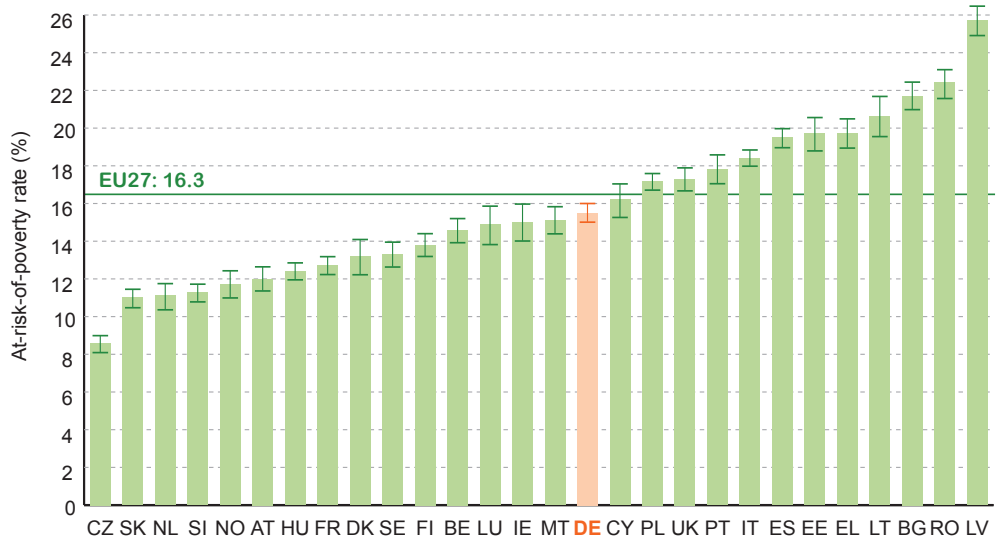
Calculating a conventional 95% confidence interval for each country (meaning that there is a 95% probability of the true figure being within the calculated range) indicates an average range of about 1 percentage point around the at-risk-of-poverty figure rate within which the true figure is likely to lie

(Figure 2.2). The at-risk-of-poverty rate in Germany is estimated to be between 15.1% and 15.9% with a 95% probability.

Country rankings thus need to take into consideration the confidence intervals of the estimates and should not be simply based on the "point" estimates. For example, the population at risk of poverty in Germany is 15.0% if simply calculated from the EU-SILC data, while in Ireland it is 15.5%. But once the confidence intervals are taken into account, the two figures are not statistically different and it is not possible to say that one is higher or lower than the other.

On the other hand, the countries with the lowest and highest levels of poverty in Europe seem to be clearly distinct from the other countries. The proportion of the population at risk of poverty in the Czech Republic, which is the lowest in the EU, is lower than that in Slovakia, the second lowest, even taking account of confidence intervals, and the same is true of Romania, which has the second highest proportion, as compared with Latvia, which has the highest.

Figure 2.2: Proportion of population at risk of poverty across the EU, 2008 income year

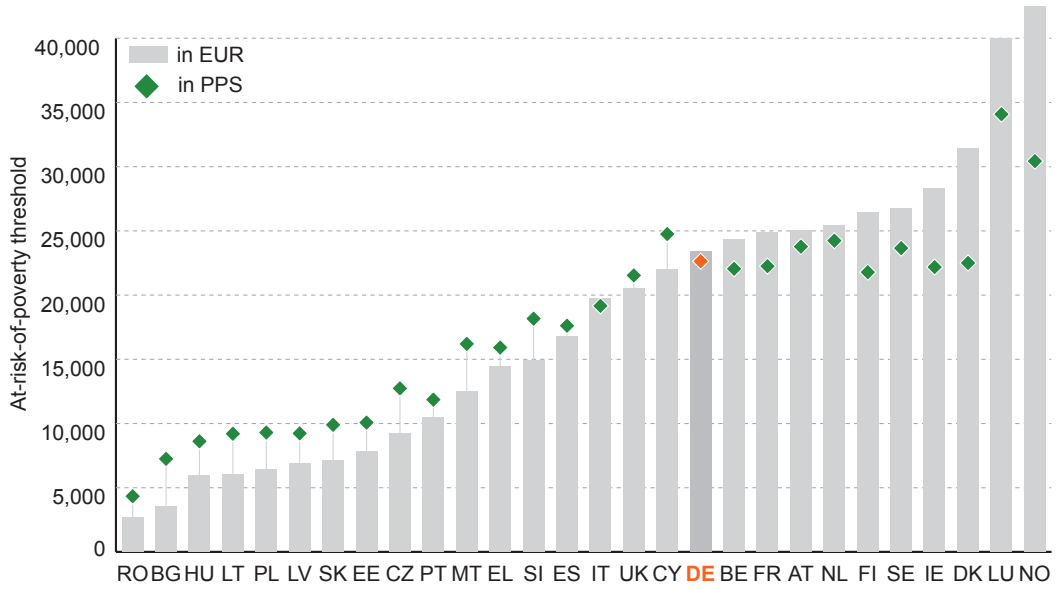


Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.

Since the risk of poverty is a relative measure which is country-specific, the poverty thresholds differ greatly across countries in terms of the purchasing power they represent (Figure 2.3). The average poverty threshold in the 12 countries which have entered the EU since 2004 was only around half the average in the other 15 Member States in purchasing power terms and much less in terms of Euro.

In Germany, the 2008 poverty threshold for a two-adult and two-children household was calculated to be 23,400 euros, and for a single person, 11,200 euros. Below this amount of annual income households are regarded to be at risk of poverty according to the standard European at-risk-of-poverty indicator.

Figure 2.3: Monetary value of the at-risk-of-poverty threshold for households of two adults with two children under 14, in EUR and PPS, 2008 income year



Source: EU-SILC 2009 – version March 2011, retrieved from EUROSTAT database (Extracted on 28-04-2011).

The estimation of trends in at-risk-of-poverty rates over the long-term is problematic in the EU because of the absence of a consistent data source[32]. The consistent, EU-wide dataset, EU-SILC now enables the estimation of poverty trends with a time period of five years for 25 Member countries, although data for Bulgaria and Romania are available only for a shorter period. For a few countries, a time period of 7 years is also available[33]. Even for a consistent data set, it is necessary to calculate confidence intervals in order to obtain a meaningful indication of changes in the population at risk of poverty over this period.

Between 2004 and 2008, the proportion of population at risk of poverty declined in Ireland, Poland, the Czech Republic and Slovakia, and is likely to have declined in Hungary and Portugal (see Figure 2.4). While, however, it has been a declining trend throughout all these years in the Czech Republic and Ireland, there has been a stagnation in the Slovak Republic and Poland. The drop in the at-risk-of-poverty rate in the UK may be a measurement error, given that the official poverty figures based on an alternative survey with a larger sample size do not confirm it. According to the Family Resources Survey, the percentage of people below 60% of median income (before housing costs) remained at a level of 18% in 2008, unchanged compared to previous years (Adams et al., 2011).

In contrast, the proportion at risk of poverty increased in Denmark, Germany, Finland, Latvia, Luxembourg and Sweden (Figure 2.4). There is also a small increase in Malta over this period. The small increase in Italy from 2004 to 2006 has reversed in 2007. In the majority of countries there was no statistically significant change in the at-risk-of-poverty rate over the 5 years.

The rates fluctuated upwards and downwards in some countries, most strikingly in Sweden, Latvia and Hungary. In Latvia, poverty risks remained the largely increased level in 2008. The major rise between 2006 and 2007 was partly due to the rise in the threshold[34], which increased by 44% in terms of Euros and by 32% in PPS terms. This was much more than in the other Baltic States (17-22% in PPS terms – see the section on the change in at-risk-of-poverty rate anchored in 2004). The at-risk-

[32] Poverty trends for the period since 1995 were set out and discussed in Ward et al. (2009).

[33] EU-SILC 2003 was launched in the following six countries: BE, DK, IE, EL, LU, and AT.

[34] Threshold value for households with two adults with two children younger than 14 years.

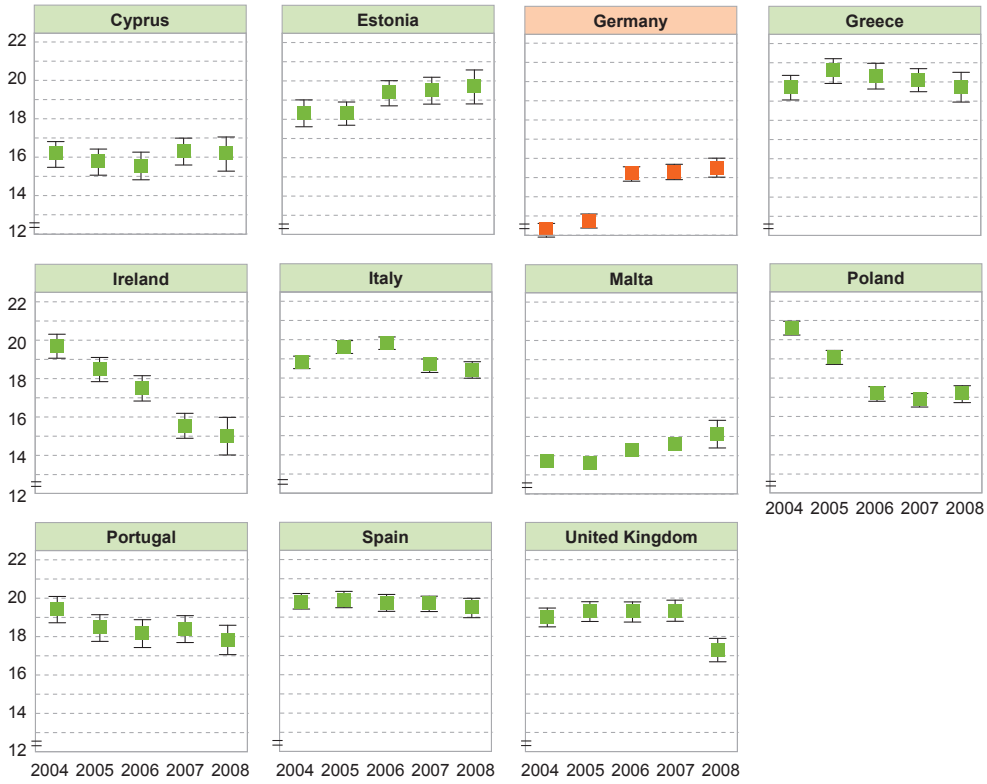
of-poverty rates in Hungary and Germany in 2005 are subject to measurement errors (the former being overestimated, the latter underestimated)[35].

Figure 2.4: Change in at-risk-of-poverty rate, 2004-2008 income year, including confidence intervals of estimates

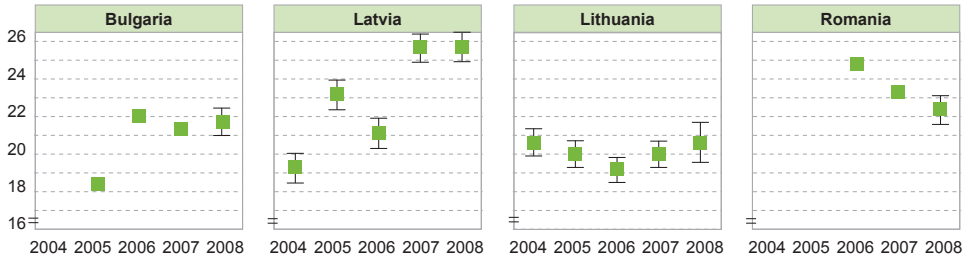
Countries with relatively low at-risk-of-poverty rates (below 15% in 2008)

[35] See Ward el al (2009, p. 44). For Germany, see Frick and Krell (2009) who point out differences between the EU-SILC and the German panel study (SOEP), both in terms of the level and trend in risk-of- poverty rates. They argue that the EU-SILC is affected by sample bias and methodological problems (e.g. rather than face-to-face interview, it was conducted as a postal survey), and that it under-represents the migrant population due to the exclusive use of German as a language in the questionnaire. One of the main issues of comparability, related to the sampling method has been resolved already. Starting with EU-SIlC 2008, the survey is now based on a random sample (during a transition period until 2007, part of the German sample was obtained through a representative quota sample) (Pressemitteilung des Statistischen Bundesamtes Nr. 457 vom 27.11.2009: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/2009/11/PD09_457_634).

Countries with medium level risk of poverty (15-20% in 2008)



High level of poverty (more than 20% in 2008)



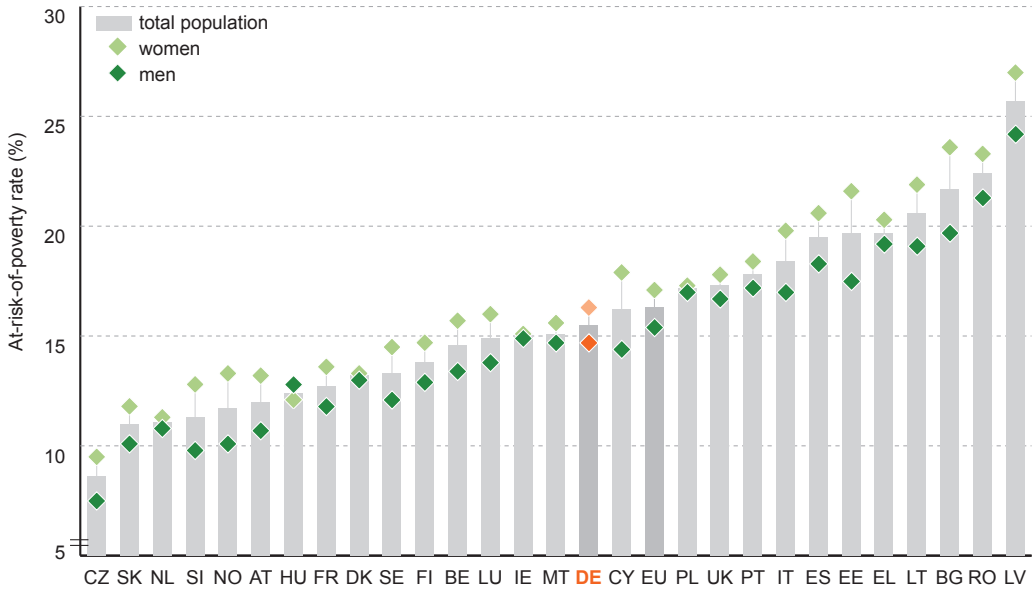
Source: Own calculations based on EU-SILC 2005-2009 datasets.
Notes: Data for Malta 2004-2007, Bulgaria 2005-2007, Romania 2006-2007 and France 2007 are retrieved from EUROSTAT database.

At-risk-of-poverty rates by gender

Women tend to face a higher risk of poverty in nearly all EU countries, with the exception of Denmark, Hungary, Ireland and Poland, as shown by Figure 2.5. The at-risk-of-poverty rate for women is 1.7 percentage points higher than that for men in the EU on average. The gender difference is the highest in Bulgaria, Estonia and Cyprus, reaching 3 percentage points or more. This gender difference is evident across all age groups, but is especially large among young adults (aged 18-24) and the elderly (aged 65 or more). Women under 25 are more likely to be enrolled in education than men, a larger proportion of whom already tend to be in work. Later on, women generally spend less time in employment than their male counterparts because of taking care of children and/or caring for elderly family members. They are also more likely to work part-time and, on average, earn less over their working life. This, however, does not raise the risk of poverty substantially, as most women share households with men and, therefore, the income which comes into the household, whoever is responsible for generating it. It does, however, show up in later years.

Women are more likely to live longer, and because of this, to live alone, which for those in retirement tends to push down their income. In addition, their lower lifetime earnings tend to reflected in lower pension entitlement.

Figure 2.5: Risk of poverty in EU Member States by gender, 2008 income year



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.

At-risk-of-poverty rates by age

Children and the elderly are typically exposed to a higher risk of poverty than the working-age population across the EU. Countries vary, however, in the relative disadvantage of these age groups as compared to each other. In 10 out of 27 countries, the risk poverty among the children is higher than the poverty of any other age group (Figure 2.6).

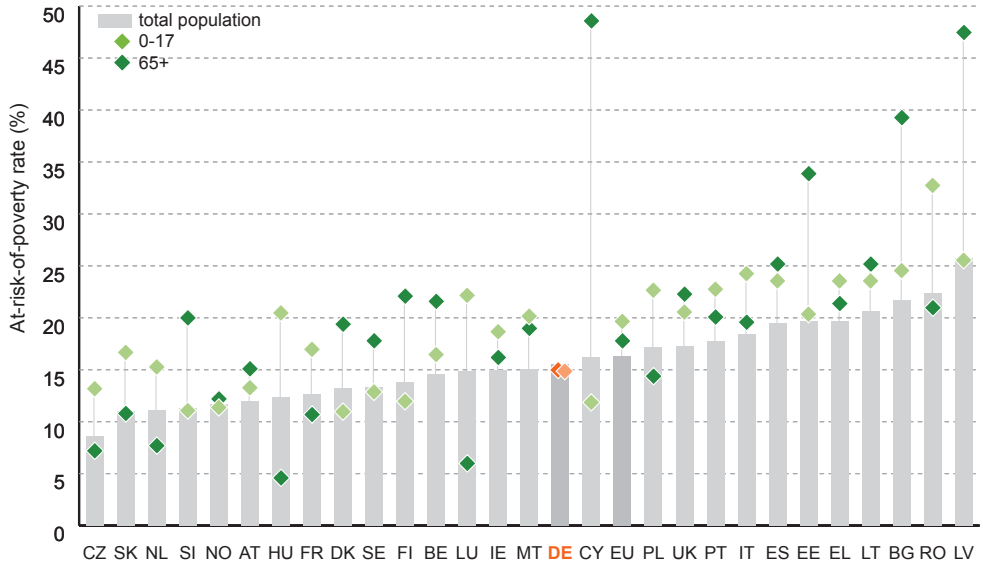
Children are the age group with the highest risk of poverty in many countries of the Centre and East of Europe – the Czech Republic, Hungary, Poland, Romania and Slovakia – as well as in Italy, Portugal and Ireland. The risk among children is highest in Romania, reaching 33%.

In 10 out of 27 countries, the elderly have the highest risk of poverty. In Bulgaria and Estonia, at least one in three of those aged 65 or over are at risk of poverty, while in Cyprus and Latvia, it is about one in two. At the other extreme, in Hungary and Luxembourg, the risk of poverty is low among the elderly (5-6%).

There is some relationship between the overall risk of poverty and the age groups which are most affected. In countries with a relatively low overall risk, children or young adults are more likely to be at risk than other age groups, while in those with a high overall risk, the elderly tend to have the highest risk.

Germany appears to be unique in the EU (only Norway is similar), in the sense that there is no difference between the poverty risk of children, elderly and the total population.

Figure 2.6: Risk of poverty of the elderly (65+) and children (0-17) compared to the total population, 2008 income year



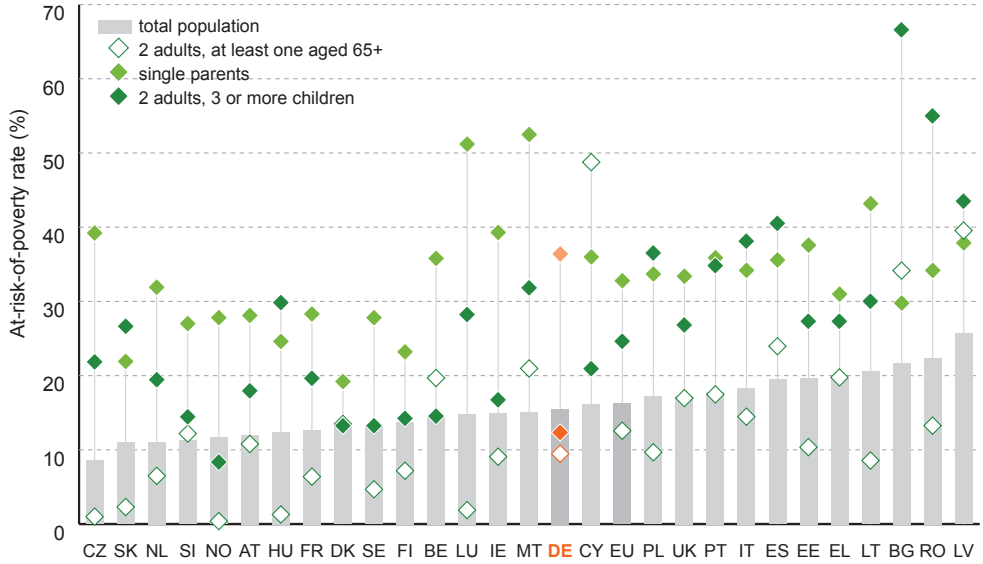
Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.

At-risk-of-poverty rates by household composition

The risk of poverty rises significantly with the number of dependent children in the household, in particular for those with three or more children (see Table A.1 in the annex). The risk of poverty among families with two children tends to be generally higher than those with one child, and is significantly higher among those with three or more children. The risk for the latter is 30% or over in Italy, Spain, Portugal, Lithuania, Latvia, Hungary, Poland and Slovakia and over 50% in Bulgaria and Romania. By contrast, the risk of poverty for large families is relatively small compared to the (national) average in Germany.

Lone-parent households are particularly prone to a risk of poverty in most countries, with poverty rates ranging from 20% to 54%. In the majority of the countries, one in three or more of such households is at risk of poverty, with the highest rates in the Czech Republic, Ireland, Lithuania, Latvia and Malta. Note that there was a major fall in the poverty risk of single parents in the UK from 44% in 2007 to 35% in 2008.

Figure 2.7: Risk of poverty in EU Member States by selected household types, 2008 income year



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.

The risk of poverty rises significantly with the number of dependent children in the household, in particular for those with three or more children (see Figure 2.7). The risk of poverty among families with two children tends to be generally higher than those with one child, and is significantly higher among those with three or more children. The risk for the households with two adults and three or more children is 30% or over in Italy, Portugal, Spain, Malta, Hungary, Lithuania, Latvia, and Poland, and over 50% in Bulgaria and Romania. By contrast, the risk of poverty for large families is relatively small in Germany, Belgium, Denmark, Finland, Ireland, Slovenia, Norway and Sweden.

Lone-parent households are particularly prone to a risk of poverty in most countries, with poverty rates ranging from 20% to 54%. In the majority of the countries, one in three or more of such households is at risk of poverty, with the highest rates in Ireland, Lithuania, Latvia, Malta, Luxembourg and the Czech Republic.

Elderly couples tend to have a low poverty risk in the majority of countries. In Germany, the at-risk-of poverty rate of elderly couples is below the national average rate (14% compared to 16%). They belong to a high risk group only in Malta (with a poverty rate reaching 50%), and two of the Baltic States: Latvia and Lithuania.

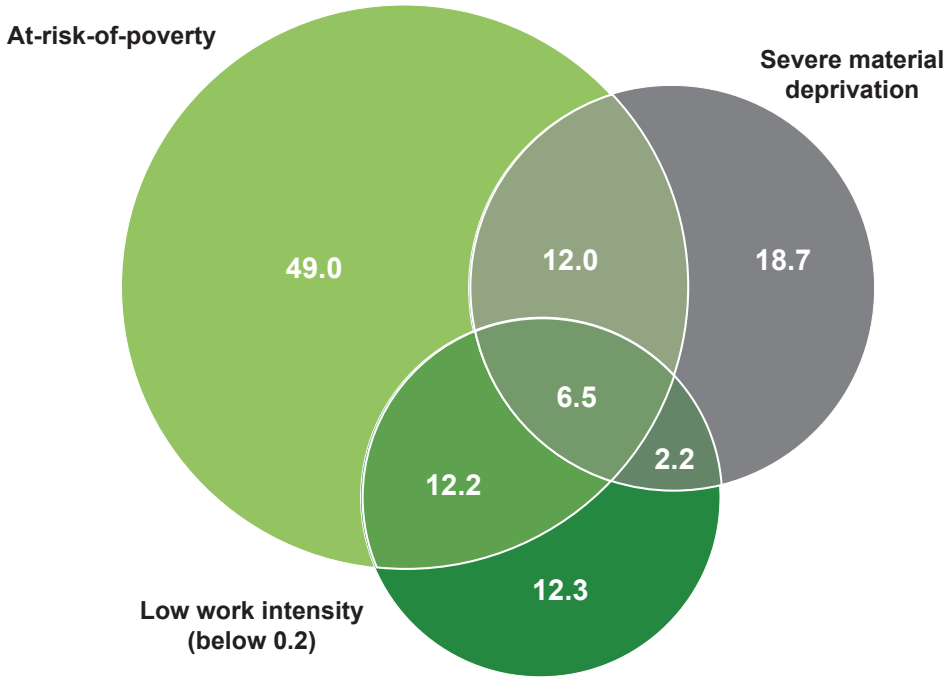
Relationship between indicators of poverty, deprivation and work intensity

One of the headline targets of the Europe 2020 Strategy is to lift at least 20 million people out of the risk of poverty or exclusion. The indicator used is a combination of three indicators: people living in households with very low work intensity, those at risk of poverty and those experiencing severe material deprivation. The overlap between these three indicators is illuminating.

The EU-SILC for 2009 suggests that that overall 107 million people in the EU are at risk of exclusion according to at least one these indicators (being at risk of poverty, severely deprived or living in households with very low work intensity).

The largest group among these is those with income below 60% of the national median – some 80 million people as against 39 million who are materially deprived and 33 million who live in households with low work intensity (Figure 2.8).

Figure 2.8: Overlap between those at risk of poverty, severe material deprivation and low work intensity, number of people (millions) in EU27, 2009



Source: Own calculations based on EU-SILC 2009 data – version of 1 March 2011
Notes: At-risk-of-poverty = Persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers).
Low work intensity = People living in households with very low work intensity are people aged 0-59 living in households where the adults work less than 20% of their total work potential during the past year.
Severe material deprivation = Severely materially deprived persons have living conditions severely constrained by a lack of resources, they experience at least 4 out of 9 following deprivations items: cannot afford i) to pay rent or utility bills, ii) keep home adequately warm, iii) face unexpected expenses, iv) eat meat, fish or a protein equivalent every second day, v) a week holiday away from home, vi) a car, vii) a washing machine, viii) a colour TV, or ix) a telephone.

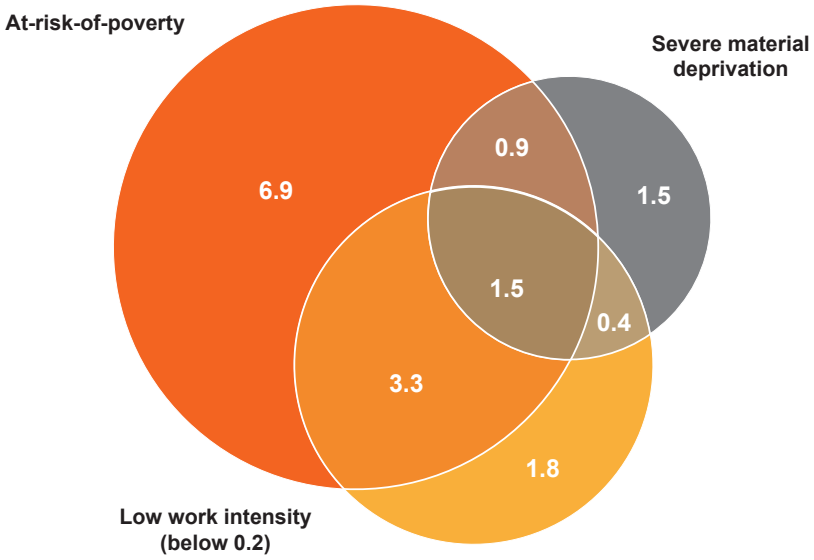
Some 6.5 million people, or 6% of the total defined to be at risk of exclusion, are deprived according to all three indicators. Only a minority, therefore, can be defined as suffering from severe cumulative disadvantage.

There is limited overlap between the measures of the risk of poverty and severe material deprivation three fourth (80% of the former are not severely materially deprived). The main reason is that the former indicator is based on country-specific thresholds, while the latter uses the same criterion across EU countries. As a consequence, material deprivation captures absolute rather than relative income differences across countries, and is highest in the lowest income countries.

The majority of working-age people who live in households with low work intensity tend to be at risk of poverty. On the other hand, only one quarter of those at risk of poverty are affected by low work intensity (note that those of 60 and over are excluded).

There is a stronger relationship between low work intensity and the risk of poverty than between low work intensity and severe material deprivation. Low work intensity affects earnings and therefore incomes but may be only a temporary phenomenon. Material deprivation is more likely to reflect purchasing power over the longer-term (since it includes possession of consumer durables which may have been purchased in the past when the household had a higher income level).

Figure 2.9: Overlap between those at risk of poverty, severe material deprivation and low work intensity, number of people (millions) in Germany, 2009



Source: Own calculations based on EU-SILC 2009 data – version of 1 March 2011
Notes: see Figure 2.8.

In Germany, 13 million people are at risk of poverty, compared to 7 million who live in households with low work intensity and 4 million who are materially deprived (Figure 2.9). Some 1.5 million people are at risk of exclusion according to all three indicators.

Thus, the most encompassing out of these three headline indicators of social exclusion is that of poverty. It identifies the largest population group and the majority of those who are materially deprived or live in low work intensity households have poverty levels of incomes. Note, however, that 7 out of 13 million Germans at risk of poverty are not materially deprived or characterized by low work intensity, suggesting short term poverty (in the former case) or in work poverty (in the latter case).

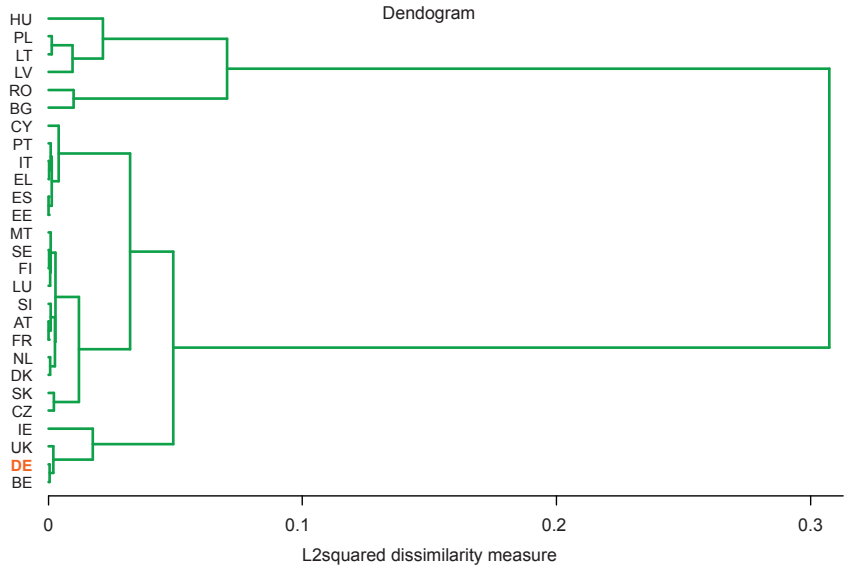
Country clusters of social exclusion indicators

We explored the natural grouping of the three indicators of social exclusion at a country level across the EU. At a larger level, we find a cluster of six East-European countries (Hungary, Poland, Lithuania, Latvia, Bulgaria and Romania) and the rest of the EU. On a more detailed level, we can identify four country groups (see Figure 2.10).

- In the first group, with Hungary, Poland, Latvia and Lithuania, countries tend to be characterized by high rates of (severe) material deprivation and poverty risk (12-21% and 12-26%, respectively). Hungary is somewhat distinct from the other three countries (which are actually geographical neighbours), with a relatively worse work intensity and material deprivation indicators and somewhat better poverty risk measure than the others.
- The second “resource-poor” cluster, with Bulgaria and Romania, suffer from an extremely high extent of (severe) material deprivation (27-37%).
- The third cluster of “better than average” countries includes a large number of heterogeneous countries which perform above the EU average in most indicators.
- The fourth group, with Germany, the UK, Ireland and Belgium are characterized by an above-average share of low work intensity rates (12-24%), below average share of people suffering

from severe material deprivation (3-6%), and at-risk-of-poverty rates around the EU average (see Table 2.1). The weakness of these countries is low work intensity: in order words, a high share of people live in jobless households or in households with little labour market engagement. In contrast to this "work-poor" group, there are two "resource-poor" country groups.

Figure 2.10: Tree diagram of three lead social exclusion indicators across the EU



Source: Own calculations based on EU-SILC 2009 data – version of 1 March 2011
Notes: hierarchical cluster analysis with 27 cases (each EU member state); the Ward's method is used, which minimizes the sum of squares of any pair of clusters to be formed at a given step; the country clustering of the three key social exclusion indicators is analysed (severe material deprivation, low work intensity, at-risk-of-poverty rate). For a definition of these indicators, see Figure 2.8.

Note that this natural clustering highlights the Cyprus and Malta differ from the other NMS12 countries (which is of little surprise), but also that Estonia, Slovenia, the Czech Republic and Slovakia perform better, with less social exclusion. We can also observe that there is a Mediterranean cluster of countries (with Cyprus, Portugal, Italy, Greece, Spain and interestingly also Estonia), which share common features.

Table 2.1: Three indicators of social exclusion, by country groups, 2008 (% of total population)

	Severe material deprivation	At risk of poverty	Very low work intensity
Group 1 –"resource-poor" countries, with high material deprivation with above-average poverty risk			
HU	21	12	12
PL	12	17	8
LT	13	21	7
LV	17	26	7
Group 2 – "resource poor" countries, with extremely high material deprivation with above-average poverty risk			
RO	27	22	8
BG	37	22	7
Group 3 – „well performers" – countries with above average values in most indicators			
CY	4	16	3

PT	7	18	7
IT	4	18	9
EL	5	20	8
ES	3	19	7
EE	4	20	6
MT	3	15	9
SE	2	13	7
FI	1	14	9
LU	0	15	7
SI	3	11	6
AT	3	12	8
FR	3	13	8
NL	1	11	10
DK	2	13	11
SK	9	11	6
CZ	5	9	6
Group 4 – "work-poor" countries, affected most by low work intensity			
IE	6	15	24
UK	5	17	15
DE	5	16	12
BE	3	15	13
EU27	7	16	9

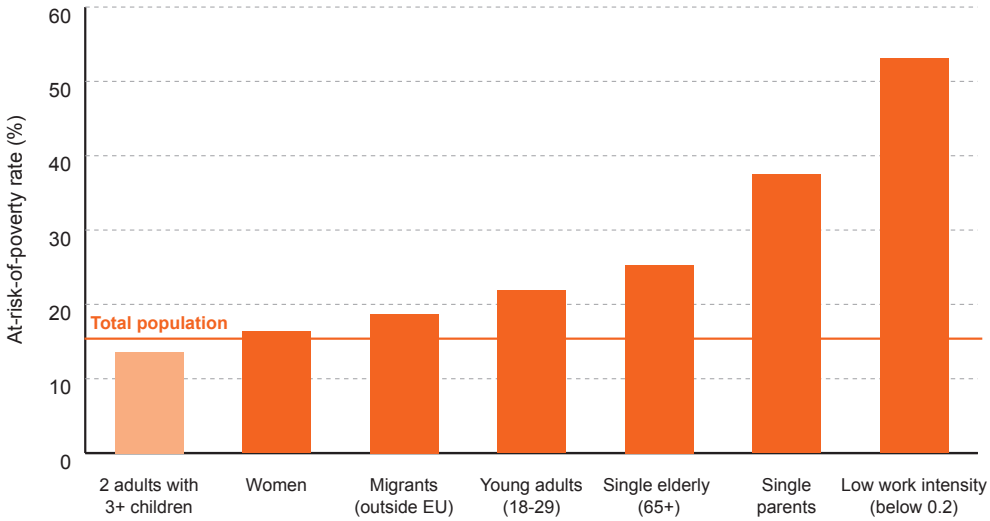
Source: Own calculations based on EU-SILC 2009 data – version of 1 March 2011
Note: for a definition of these indicators, see Figure 2.8.

Social patterns in Germany

The estimated national poverty rate is 16%: this is the share of the population who has incomes below 60% of the national median. Women, migrants from outside the EU, young adults and the elderly living alone have somewhat higher risk. The household type most at risk of poverty is that of single parents, with a rate of 37%. On the other hand, we did not find a statistically significant difference between the poverty rate of "large families" (with three or more children) and the rest of the population. This is a specific German phenomenon, different from most other EU nations.

People who live in households with very low work intensity are rather likely to be poor, with a ratio of 1 out of 2. Their poverty risk is over three times as high as in the total population on average.

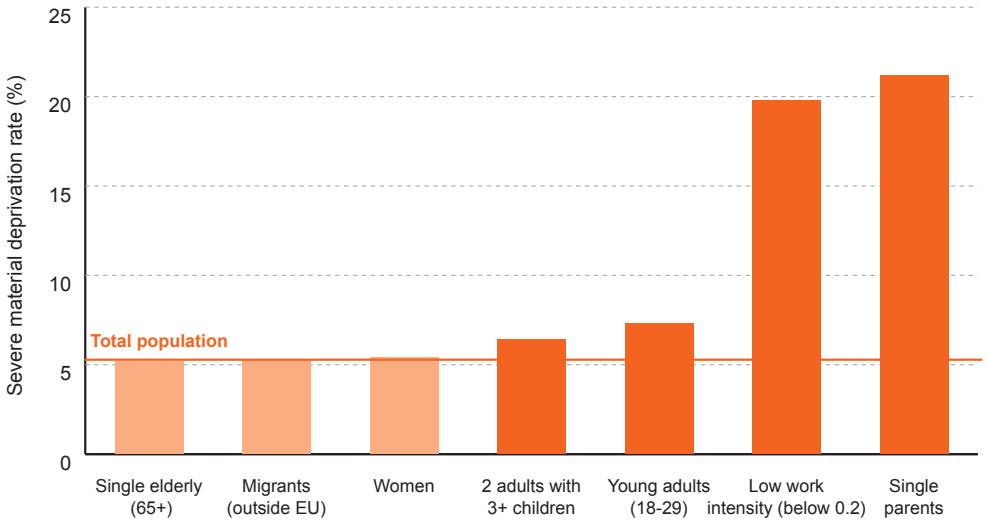
Figure 2.11: At-risk-of-poverty rate of specific social groups in Germany, 2008 income year



Source: Own calculations based on EU-SILC 2009 data – version of 1 March 2011
Note: At-risk-of-poverty = Persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers). Bars with lighter shading indicate that the difference between the means (of the specific group and the rest of the population) is not significant at 10% level.

Lone parents and households with low work intensity are most affected by material deprivation in Germany. One out of five persons in these groups is materially deprived. Young adults and families with three or more children have a slightly higher deprivation rate than the average. We did not find evidence for a higher deprivation among women, single elderly or non-EU migrants in Germany.

Figure 2.12: Severe material deprivation rate of specific social groups in Germany, 2008 income year



Source: Own calculations based on EU-SILC 2009 data – version of 1 March 2011
Note: Severe material deprivation = Severely materially deprived persons have living conditions severely constrained by a lack of resources, they experience at least 4 out of 9 following deprivations items: cannot afford i) to pay rent or utility bills, ii) keep home adequately warm, iii) face unexpected expenses, iv) eat meat, fish or a protein equivalent every second day, v) a week holiday away from home, vi) a car, vii) a washing machine, viii) a colour TV, or ix) a telephone. Bars with lighter shading indicate that the difference between the means (of the specific group and the rest of the population) is not significant at 10% level.

Thus, the two social groups which have the highest risk of poverty and material deprivation are single parents and people living in households with low work intensity. These groups thus suffer from low incomes at the moment, but also from a lack of socially standard consumption goods or relatively

basic consumption items. Material deprivation can be regarded to be an indicator of long term poverty as well, expressing consumption patterns and assets. While people may be able to compensate for short poverty spells using their savings or taking credits, this is rather unlikely if they have an extended period of living on poverty levels of income.

Conclusions

Some 16% of the population were at risk of poverty across the European Union according to EU-SILC survey carried out in 2009, in the sense of having income below 60% of the median of the country in which they live, a total number of 80 million. The proportion concerned varied between 9% and 26% across EU Member States. It was lowest in the Czech Republic, Slovakia, the Netherlands, and Slovenia, and above average in the Baltic States, Bulgaria, Romania and the southern countries, Greece, Italy, Portugal and Spain. The at-risk-of-poverty rate in Germany remains slightly below the EU average (15.5% vs. 16.3%). Taking into account the confidence interval of the estimate, the at-risk-of-poverty rate in Germany is estimated to be between 15.1% and 15.9% with a 95% probability.

Since the risk of poverty is a relative measure which is country-specific, the poverty thresholds differ greatly across countries in terms of the purchasing power they represent. The average poverty threshold in the 12 countries which have entered the EU since 2004 was only around half the average in the other 15 Member States in purchasing power terms and much less in terms of Euro. In Germany, the 2008 poverty threshold for a two-adult and two-children household was calculated to be 23,400 euros, and for a single person, 11,200 euros.

Between 2004 and 2008, the proportion of population at risk of poverty declined in Ireland, Poland, the Czech Republic and Slovakia, and is likely to have declined in Hungary and Portugal. In contrast, the proportion at risk of poverty increased in Denmark, Germany, Finland, Latvia, Luxembourg and Sweden. In the majority of countries there was no statistically significant change in the at-risk-of-poverty rate over the 5 years.

Women tend to face a higher risk of poverty in nearly all EU countries, with the exception of Denmark, Hungary, Ireland and Poland. The at-risk-of-poverty rate for women is 1.7 percentage points higher than that for men in the EU on average. The gender difference is the highest in Bulgaria, Estonia and Cyprus, reaching 3 percentage points or more. This gender difference is evident across all age groups, but is especially large among young adults (aged 18-24) and the elderly (aged 65 or more). There is a very small, although statistically significant gender difference in Germany as well.

Children and the people aged 65 or over are typically exposed to a higher risk of poverty than the working-age population across the EU. Countries vary, however, in the relative disadvantage of these age groups as compared to each other. In 10 out of 27 countries, the risk poverty among *children* is higher than the poverty of any other age group. The risk among children is highest in Romania, reaching 33%. In 10 out of 27 countries, the elderly have the highest risk of poverty. In Cyprus and Latvia about one in two of those aged 65 or over are at risk of poverty.

Germany appears to be unique in the EU (only Norway is similar), in the sense that neither children nor the elderly suffer from relatively high poverty risks. If we refine this analysis and focus on elderly who live alone, we find evidence for their relatively higher poverty risk. While child poverty does not appear to be an issue in Germany, young adults face above average poverty risk.

Single parents and people living households with low work intensity face a poverty risk of 38% and 53%, respectively. These social groups have the highest prevalence of severe material deprivation as well, with 20% or over, which is over four times as high as the national average. This suggests that these groups are affected by long term poverty, which alters their consumption patterns and limits the range of basic goods owned by them.

The analysis of the headline targets of the Europe 2020 Strategy suggests that overall 107 million people in the EU are at risk of exclusion according to at least one the three key indicators (being at risk of poverty, severely deprived or living in households with very low work intensity). The largest group among these is those with income below 60% of the national median – some 80 million people as against 39 million who are materially deprived and 33 million who live in households with low work intensity. Some 6.5 million people, or 6% of the total defined to be at risk of exclusion, are deprived according to all three indicators. Only a minority, therefore, can be defined as suffering from severe cumulative disadvantage.

In Germany, 13 million people are at risk of poverty, compared to 7 million who live in households with low work intensity and 4 million who are materially deprived. Note, however, that 7 out of 13 million Germans at risk of poverty are not materially deprived or characterized by low work intensity, suggesting possibly short term poverty (in the former case) or in work poverty (in the latter case). About 1.5 million people are at risk of exclusion according to all three indicators.

We explored the natural grouping of the three indicators of social exclusion at a country level across the EU. We identified four country clusters. Germany, together with the UK, Ireland and Belgium are characterized by an above-average share of low work intensity rates (12-24%), below average share of people suffering from severe material deprivation (3-6%), and at-risk-of-poverty rates around the EU average. This group can be called *"'work-poor' countries, affected most by low work intensity"*. The cluster of *"'resource-poor' countries, with high material deprivation with above-average poverty risk"* includes Hungary, Latvia, Lithuania and Poland. Bulgaria and Romania constitute the third cluster which may be called *"'resource poor' countries, with extremely high material deprivation with above-average poverty risk"*. The remaining seventeen countries cluster together in the group of *„good performers"* with above average values in most indicators.

3. Early childhood education and care: barriers in access to good starting points in life

Pieter Vanhuysse[36]

Introduction: Social package deals for young families; four worlds of child welfare?

The social foundations of advanced market democracies have changed significantly since the welfare state's three post-war glory decades from the 1950s to 1970s. The literature on comparative social policies traditionally indicates that advanced capitalist democracies tend to cluster into four different models, or "worlds," of welfare in terms of how they package social policies for their citizens (see e.g. Esping-Andersen 1990, 1999). *Liberal* regimes such as the USA, Ireland and the UK rely on flexible and deregulated labor markets with low levels of formal employee protection. On the whole this model successfully creates employment and allows middle class families to access household services at relatively cheap cost through low market prices. On the downside, this strategy translates into high wage and income inequalities. Moreover, poverty for new high-risk categories such as single-parent families is high, because of meagre welfare support. Conservative *continental European* welfare regimes such as Germany, France, Italy, Spain and Austria promote the interests of an insider labor force of highly skilled and highly paid male workers, while reducing the participation for outsiders, which in turn lowers the overall tax base. Young and unskilled workers pick up the unprotected, deregulated jobs, or depend on unemployment insurance. Participation of elderly workers is reduced by means of early retiree schemes. Female careers are discouraged. *Southern European* regimes such as Italy, Spain, Greece and Portugal are, in addition, also "familialistic", in that they assign a maximum of family obligations to women. For instance, the high post-tax-and-transfer cost of childcare makes it prohibitively expensive for mothers to buy child care services in the market. This sharply increases young women's trade-offs between motherhood and careers, and results in a low-fertility equilibrium, which is especially problematic given low labor market participation rates and ageing populations. Lastly, *Nordic* or social-democratic welfare regimes such as Sweden, Norway and Denmark appear best equipped to face the new social risks of postindustrial knowledge economies. *De-familialization* is the key here. Paradoxically, the state maximizes women's economic independence from the family by providing a wide range of generous family services, and in so doing increases the welfare of families. For instance, extensive day care facilities are provided, the net cost of childcare is kept low, and (female) employment is stimulated by public sector absorption and active labor market programs.

Today, however, the traditional model of industrial production, a predominantly male labor force, stable families with high fertility levels, and a female population full-time devoted to housework and motherhood simply no longer obtains today. Changes in values, marriage stability and economic necessities have led to higher divorce rates. The service sector and the knowledge-intensive economy have become predominant, women, including mothers of young children increasingly obtain paid employment, populations are ageing, and fertility rates have decreased (see, e.g., Esping-Andersen 1999, 2009). The advent of highly competitive globalized knowledge economies has only increased the need for child-centered social policies, aimed at boosting human capital. The knowledge economy has increased both the initial entry ticket and the subsequent payoffs of human capital (Powell and Snellman 2004).

[36] I am grateful to Katrin Gasior for excellent advice and assistance with design and layouting.

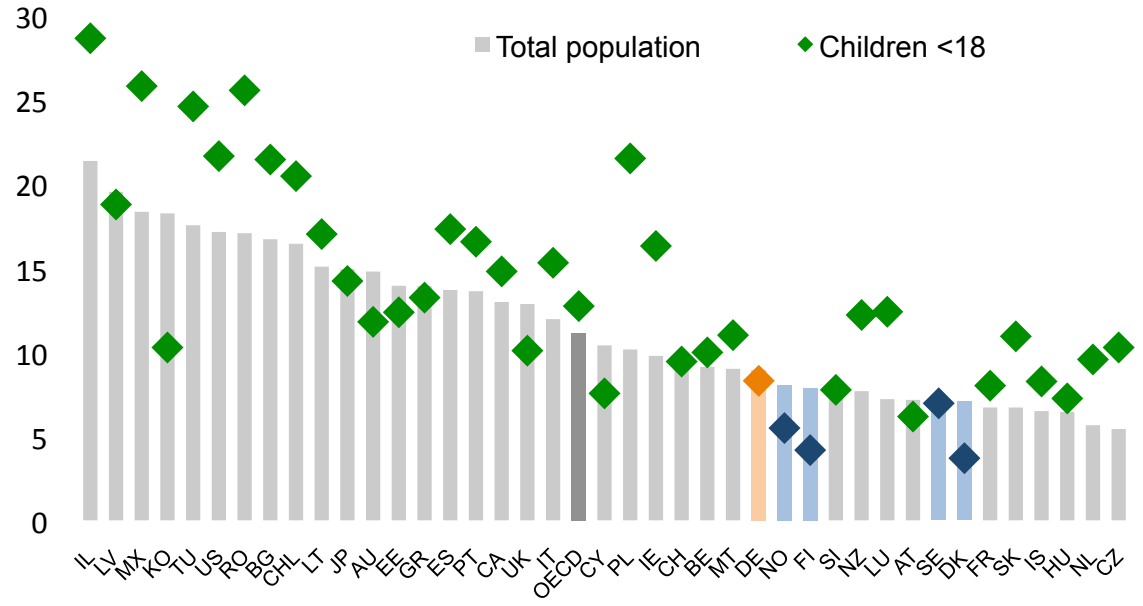
These changing social foundations have been reflected in different ways in changing policy models (Bonoli and Reber 2010; Jensen 2009; Esping-Andersen 2008; 2009). In light of the above, this empirical section surveys and discusses how EU and OECD governments have responded to these new challenges in recent years specifically in terms of early childhood education and care (ECEC) policies. As section 12 below indicates, the economics literature shows that ECEC policies occupy a key role in aiming to prevent social problems in the very early life stages, rather than to remedy these problems after they have occurred through "old-style" welfare programs (such as unemployment benefits, labor market retraining, poverty assistance, and the like) (Heckman 2004; Heckman and Masterov 2007). In addition to being efficient also from a strictly economic (cost/benefit) point of view, these policies contribute to social justice goals of increasing the equality of opportunity or the long-term life chances of all children. Child poverty in particular is crucial, as it leads to lower educational outcomes and cognitive skills, and later on to higher rates of adult unemployment and poverty (see e.g. Danziger and Waldvogel 2000; Esping-Andersen 2008, 2009; Haveman and Wolfe 1995).

Early childhood policy outcomes: child poverty and maternal employment in international perspective

Public policies determine to a large degree whether or not mothers today find it difficult to combine their careers with their family obligations. Depending on the particular welfare regime model they live in, they will face different incentives to square this 'caring-work' circle, which will, in turn, offer their children different chances of a decent starting point on life. One core indicator of life chances for children is child poverty rates. As Figure 3.1 shows, the Nordic welfare states, who can boast particularly generous family policies, have among the lowest child poverty rates among all advanced economies (green triangles). Among EU members states, the highest levels of child poverty are found in the new EU member states, both those in Central Europe - Romania (25.5%), Poland (21.5%), and Bulgaria (21.4%) – and those in Baltic Europe - Latvia (18.8%) and Lithuania (17%).[37] But Southern EU states such as Spain (17.3%) and Portugal (16.6%) score badly as well. The lowest levels are in the Nordic countries: Denmark (3.7%), Finland (4.2%), Norway (5.5%) and Sweden (7%) occupy four of the bottom five ranks, together with Austria (6.2%). Germany (8.3%) performs relatively well in international perspective: it occupies the eleventh rank out of the 34-country sample in Figure 3.1 It is remarkable that while child poverty rates are lower than or equal to those of general population poverty rates in about half of these countries, this is the case in all of these bottom-five countries, and also in Germany.

[37] In addition, non-EU OECD countries such as Israel, Mexico, Turkey and the USA are characterized by still higher child poverty rates.

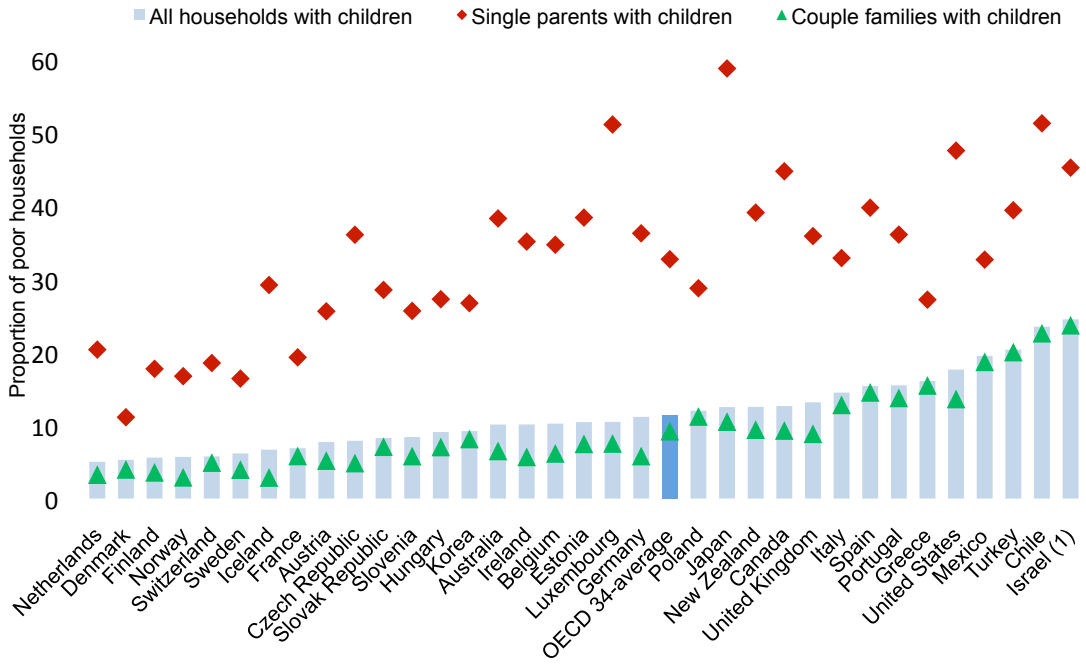
Figure 3.1: Poverty headcount rates for children and the general population, 2008 or latest (50% of median income)



Source: OECD (2011)
Note: Data refer to 2007 for Canada, Denmark and Hungary; 2006 for Chile, Estonia, Japan and Slovenia; 2005 for France, Ireland, Switzerland and the United Kingdom; 2004 for Australia, Austria, Belgium, Czech Republic, Finland, Greece, Iceland, Luxembourg, Poland, Portugal, the Slovak Republic, Spain and Turkey.

Single parenthood, in particular, represents an uncommonly high risk of poverty. As Figure 3.2 shows, single parent households with children (red squares) have significantly higher poverty rates than couple families with children (green triangles) *in every one* of the 34 OECD countries shown. The poverty gaps between these two household types are truly dramatic in a number of cases. For instance, they reach 48 percentage points in Japan, 44 points in Luxemburg, and 31 points in the Czech Republic. This is all the more worrying since the share of single parent families was around or above the OECD average (9.4 percent) in the first two countries (8.4% on average in the past decade), and well above the average in the third (12.9%) (OECD 2011). Moreover, this share has been rising over the past decade in the US and many EU member states, especially among low-SES households (Esping-Andersen 2009). For instance, children in Britain today are more than three times more likely to live in a one-parent household than they were in 1972, and one third of all British children at any one time are now living with just one parent. In 1971, less than 10 percent of all births in England and Wales were outside marriage; in 2008, 45 percent of all births were (Blond 2011). In Germany, where the share of single parent families is lower (5.9%), the gap between the poverty rates of single parent households (36.2%) and those of couple families with children (5.8%) poverty is also comparatively large, at over 30 points. Yet single parenthood not only represents a significantly higher poverty risk in Germany, but it is also associated with a higher prevalence and a longer duration of welfare dependency (Lietzmann 2009). These poverty gaps are smallest in Denmark (7 points), Norway (14 points) and Sweden (15 points), undoubtedly in great part as a result of the significant public policy effort towards helping parents, including lone mothers, in these countries to combine their careers with their motherhood duties (OECD 2011; Esping-Andersen 2009).

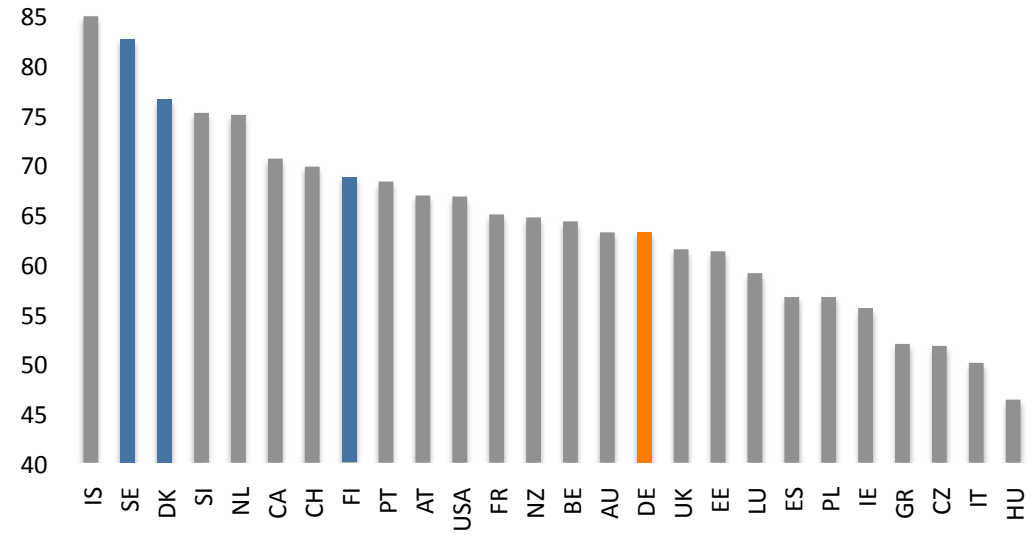
Figure 3.2: Poverty headcount rates by household type, 2008 (50% of median income)



Source: OECD (2011)
Note: Data on household poverty refers to 2006 for Chile, Estonia, Korea and Slovenia; 2005 for Canada, France, Israel, Switzerland and the UK; 2004 for Australia, Mexico, New Zealand and Turkey; 2003 for Japan.

A clear picture that emerges from the literature on child poverty is that the generosity of social benefits, on its own, is rarely enough to keep single-mother families out of poverty (Esping-Andersen 2009; 2002a; 2008). In fact, the single most important factor explaining child poverty is whether or not the mother is employed. This means that failing to harmonize work with motherhood is likely to backfire, as it will only lead to more welfare dependency and child poverty. For instance, social assistance dependency duration among lone mothers in Spain, Portugal and Italy is much longer than in Sweden, where family policies are more generous. This may be because the opportunity cost for mothers of moving back into jobs is lower in Sweden due to free day care and/or better earnings (Esping-Andersen 2009, 2002b, p. 39). As Figure 3.3 shows, the highest levels of employment among mothers of young children are clearly found in Nordic Europe, with Denmark (76.5%), Iceland (84.8%) and Sweden (82.5%) leading the pack. In fact, in these countries there is essentially no difference in employment levels between mothers and non-mothers, due mainly to the fact that most Scandinavian mothers return to work immediately after the end of their (comparatively long) maternal leave periods. The laggard countries in terms of maternal employment are Southern countries such as Greece (51.9%) and, even more so, Italy (50%) and post-communist countries such as the Czech Republic (51.7%) and, lowest of all, Hungary (46.3%). Germany (63.1%) is situated midway between these highest and lowest levels.

Figure 3.3: Employment rates for mothers with children aged below 15 (%), 2008



Source: OECD (2011)

While maternal employment need not negatively affect child development,[38] the economic cost of childcare may of course still prevent mothers, not least single mothers, from working while sending their children to day care. The availability of low-cost, high-quality day care is in turn likely to increase mothers' employment. Economic studies indicate that the price of childcare is indeed a big barrier, especially for full-time employment and for single mothers. An increased probability of full-time employment is associated with an increase in the use of centre-based childcare for both married and single mothers. Connelly and Kimmel (2003a) find that for both married and single women, full-time employment is more elastic with respect to changes in the price of childcare than part-time employment. Moreover, employment elasticities are larger for single than for married mothers. Conversely, high childcare costs can act as a welfare trap. Connelly and Kimmel (2003b) estimate a childcare price elasticity of welfare recipiency at between 1.0 and 1.9 and a childcare price elasticity of employment at between -0.3 and -1.1. Clearly, therefore, policy effort to make childcare affordable and to otherwise invest in ECEC are key to given young children the opportunity for a decent start in life, and to give women and fathers the financial ability to combine parental duties with active employment.

Early childhood policy inputs: ECEC attendance rates and expenditure patterns in international perspective

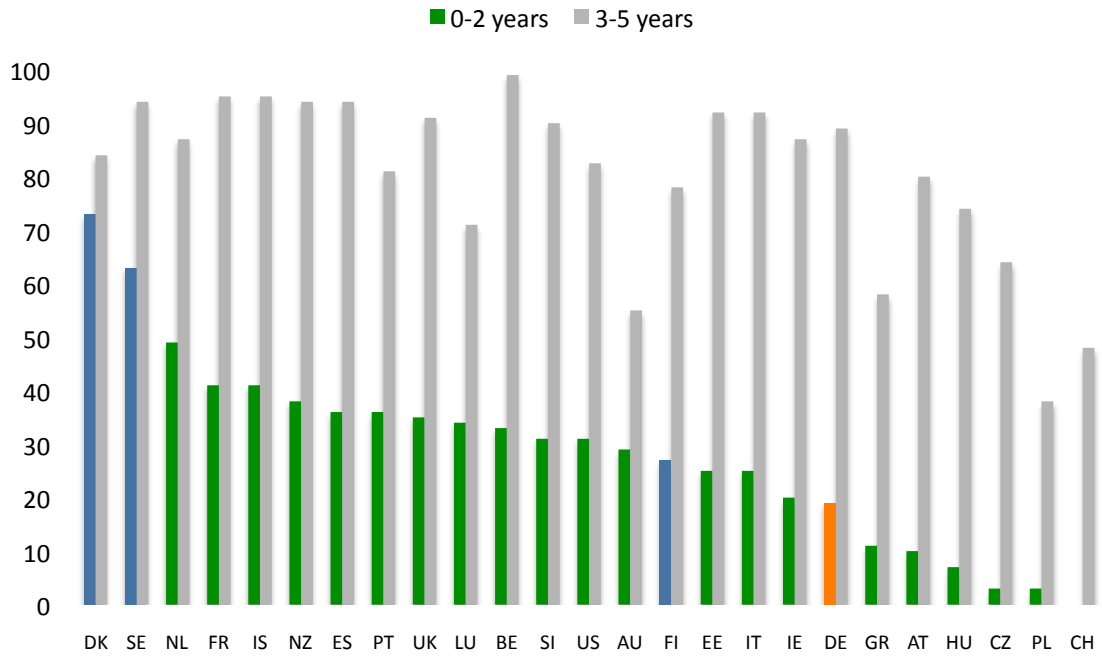
Figure 3.4 shows attendance rates in formal ECEC services for two age groups: age 0 to 2 (green columns), and age 3 to 5 (grey columns). Attendance rates clearly vary enormously between countries. For pre-primary school age children, aged 3-5, they vary from under 60 percent in Anglo-Saxon countries (Australia, Canada, USA) and Croatia, Greece, Poland, and Switzerland, to near-universal (over 90 percent) in Belgium, Estonia, France, Iceland, Italy, New Zealand, Slovenia, Spain, Sweden and the UK.[39] But for the smallest children (those between 0 and 2 years old), attendance

[38] Contrary to some popular misconceptions, the mere fact that mothers go to work does not generally lead to detrimental outcomes for the child, although stressful or insecure forms of mother's employment may negatively affect children (Haveman and Wolfe, 1995; Blau and Grossberg 1992).

[39] Note, however, that these data do not reveal the opening hours of services or how far they are suited to the needs of working parents.

rates range from close to zero in post-communist countries such as the Czech Republic, Hungary, and Poland, and still only around 10 percent in Greece and Austria, to over 40 percent in France and Iceland, close to 50 percent in the Netherlands, over 60 percent in Sweden and over 70 percent in Denmark. Germany follows these international patterns, as it combines relatively low attendance levels for children aged 0-2 (19%) with very high attendance levels for children aged 3-5 (89%). Note also that looking at the age group zero to *two*, as in Figure 3.4, does not indicate high coverage rates for the Anglo-Saxon countries and thus adds a note of caution to the earlier study on the political economy of OECD childcare by Bonoli and Reber (2010), which concludes that there are generally two OECD pathways towards high coverage rates for the age group zero to *three* - high public spending as in the Nordic countries and large earning inequality as in the Anglo-Saxon countries.

Figure 3.4: Attendance rates at formal ECEC services in 2009



Source: computed from:
http://www.leavenetwork.org/fileadmin/Leavenetwork/overviews_2011/overview_07_leave_and_ecec_entitlements.pdf
(accessed 17 August 2011)

The cross-national variation in Figure 3.4 can be linked to the policy efforts made by states in providing places and stimulating the take up of such places through subsidies and promotion campaigns. As we have seen, subsidizing childcare costs can have a major impact on the probability that young mothers, and especially poor single mothers, will find paid jobs. Yet, across the advanced democratic world, the government's role in offering publicly supported childcare varies enormously. As discussed extensively in section 12, the 1990s saw the start of an increasing awareness among many OECD countries of the importance of human capital investment, including early education investment (Heckman 2000; Esping-Andersen 1999). But there was considerable cross-national variation in this respect at the time. In Nordic Europe, countries like Denmark, Sweden and Finland already formally guaranteed a place in subsidized care to any child aged one and older with working parents, as a matter of public policy (Kamerman 2000; see also Kamerman and Moss 2010). Between 20% (Norway) and 48% (Sweden) of children aged 0-2 were in publicly supported care and between 53% (Finland) to 82% (Denmark) of 3-to-6-year-olds. Moreover, the share of childcare costs which was covered by government ranged from 68% (Norway) to 85% (Sweden) for both age groups. In continental Europe, only France was similarly generous already in the 1990s, with respectively 23 and

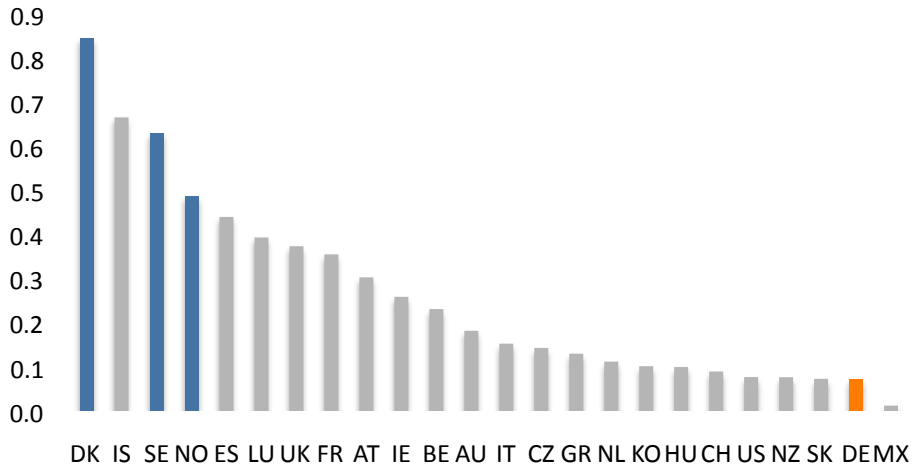
99 percent of children covered, and 72-77% and 100% of childcare costs covered by government. Whereas the USA spent about $600 per preschool-age child per year on ECEC, France spent about five times more and Sweden about seven and a half times more (Waldfogel 2001, p. 105- 106). Whereas in Europe, fees for programs serving children below 3 were around 10-25 % of total operating costs in the 1990s, the equivalent rate was 76% in the US.[40] The case for public assistance in subsidizing ECEC is strong, given that private spending on ECEC is highly regressive. While families earnings less than 1,200$ a month tend to spend 25% of their income on ECEC, families earning above 4,500$ spend only 8.7 % of their earnings (Verry 2000, p. 115).

However, despite growing awareness of the importance of ECEC policies as part of an emerging human capital investment paradigm, progress in this respect has been far from uniform. Even in 2005 countries differ widely in their spending commitment for ECEC services, from a EU-lowest levels in Greece, which spends just 0.1 percent of its GDP, to a high in Iceland and Denmark, which spend twelve times more - 1.2 percent of their GDP. Other Nordic countries such as Sweden (1%), Finland (0.9%) and Norway (0.8%) complete the top-seven ranking together with two continental European countries, Belgium and France (1%) and Belgium (0.8%). Germany by contrast spends less than half as much as this top group (0.4%). Interestingly, the post-communist EU member states display a wide variance in ECEC spending commitments, ranging from high levels in Bulgaria and Romania (8%), both of which joined the EU in 2008, as well as Hungary (0.7%), to medium-low levels in Lithuania (0.6%) as well as the Czech Republic and Slovenia (0.5%), and very low levels in Slovakia and Estonia (0.4%) as well as Poland (0.3%), which has an equally low ECEC spending commitment as countries such as Ireland and Austria. High spending on these ECEC services is likely to be positively correlated with high levels of female employment (the needs factor) and of women in parliament (the power factor), and negatively correlated with spending on older age groups (the intergenerational factor) (Tepe and Vanhuysse 2010; Bonoli and Reber 2010).

Figure 3.5 and Figure 3.6 in turn disaggregate these spending figures into childcare spending on the one hand, which typically goes to the age group 0-2, and preschool spending on the other hand, which typically goes to the age group 3-6. This indicates that, on average, OECD countries tend to spend more on the latter type of services (0.3% of GDP, or PPP converted 3667 US$ per child) than on the former (0.2% of GDP, or 2549 PPP converted US$ per child). Moreover, there is more cross-national variation in very early childcare spending commitments, which range from 0.1 percent of GDP in countries such as Slovakia, Germany and the Netherlands to as much as 0.6 percent of GDP in Sweden, 0.7 percent in Iceland and 0.8 percent in Denmark. In the latter three countries, every young child in childcare services received on average respectively 5928, 5733, and 6376 US dollars (PPP converted) from the state, compared to 414 dollars in Slovakia, 860 dollars in Germany, and 1092 dollars in the Netherlands (OECD 2011).

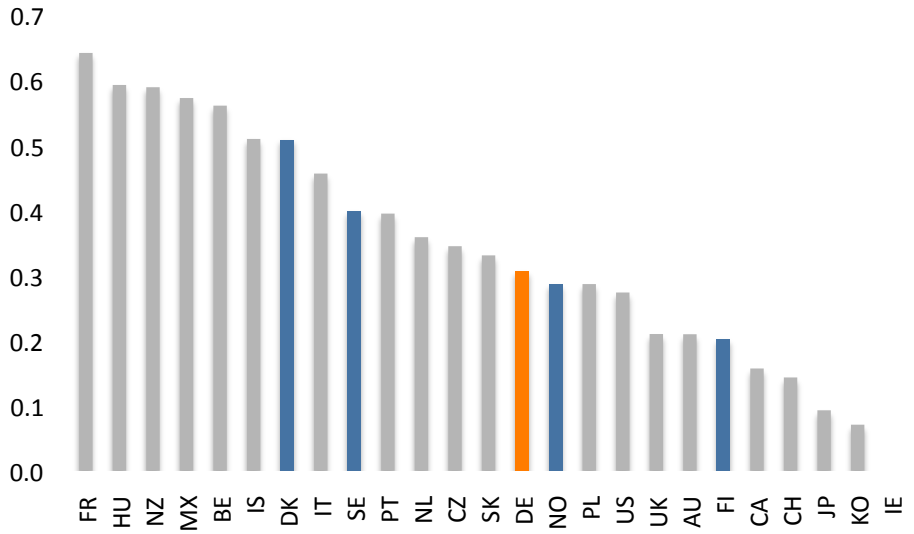
[40] See Kamerman (2000, p. 15). In 1999, center-based care for one infant cost on average about 14% of the median income of a three-person family in the US (Phillips and Adams, 2001). While federal assistance for poor families through the Child Care Development Fund was available, it was used by only 12 % of the 15 million American children estimated to be eligible (Knitzer 2001).

Figure 3.5: Public expenditure on childcare services, percent of GDP, 2005



Source: OECD (2011)

Figure 3.6: Public expenditure on preschool services, percent of GDP, 2005

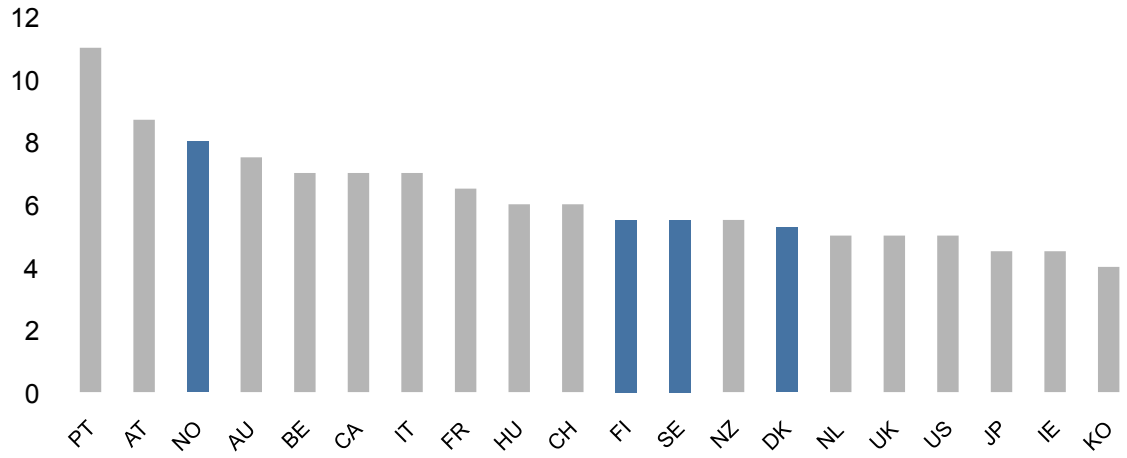


Source: OECD (2011).

Clearly, differences in public expenditure commitments reflect differences in legal rights for ECEC. Today, altogether twenty OECD countries have an entitlement to an ECEC service, but in no less than fourteen cases this is only from 3 years of age or later, including also in Estonia and Hungary, where there is a *de jure* entitlement at an earlier age, but a *de facto* shortage of places, such that the legal entitlement is not operational until around 3 years. Moreover ECEC entitlement in these countries is often limited to a part-time place. Only six countries have entitlement before 3 years: at 21⁄2 years in Belgium, and at 12 months or younger or at the end of parental leave in the Nordic countries (Denmark, Finland, Norway, and Sweden) plus Slovenia. Full-time places are available in all the latter cases. It is only in these countries that policies are designed to ensure no gap between the end of leave and the start of an ECEC entitlement. For instance, the Swedish state in 2011 provides a legal entitlement to ECEC from 1 year of age on a full-time basis whereas the maximum period of paid post-natal leave is 16 months, which leaves no gap between the end of leave and the start of the

ECEC entitlement.[41] Elsewhere, the gap is from 18 months (in Estonia) and 20 months in Germany to no less than 67 months (in Poland). When to this is added the many countries that have no ECEC entitlement altogether, this goes some way towards explaining the low levels of maternal employment in these countries, as privately paid child care costs can be seen as 'the equivalent of a *regressive tax* on mothers' labour supply' (Esping-Andersen 2009, original emphasis). In addition, it serves to highlight the extensive lack of coordination between these ECEC services on the one hand and parental leave policies on the other hand.[42] Policies enabling the reconciliation of work and family life are clearly helpful as well in allowing mothers to combine careers and parental duties. Here too, mothers with children fare comparatively worse in Germany than in Nordic countries: 11 percent of German mothers reported having a poor work-life balance compared to 27 percent of other women in full-time employment – an 16 percentage point work-life 'disadvantage gap' for mothers, which compares unfavorably to much smaller gaps in Denmark (2 points), Finland (5 points) and Sweden (4 points) (Eurofound 2007: 17).[43]

Figure 3.7: Child-to-staff ratios in formal day-care services, average for 0-3 years olds, latest year available



Source: OECD (2011)

A better quality of childcare should be a core element of effective human investment policies. Quality is notoriously hard to measure, and definitions of quality tend to vary somewhat, but most definitions include the following elements: low child-teacher ratios, adequate in-service teacher support and consultative help, sustained home-school communication, and well-trained caregivers provided attentive and communicative care to children. Controlling for home and family background, children in care centers that meet a greater number of professional guidelines for child-staff ratio, group size, teacher training and teacher education tend to have higher cognitive and language abilities and higher school readiness.[44] The irreducible requirement of high-quality care for very young children is excellent caregivers. As Thompson (2001 p. 30) puts it: 'Relationships matter. They provide the nurturance that strengthens children's security and well-being, offer the cognitive

[41] See http://www.leavenetwork.org/fileadmin/Leavenetwork/Country_notes/sweden_02052011.pdf

[42] See: http://www.leavenetwork.org/fileadmin/Leavenetwork/overviews_2011/overview_07_leave_and_ecec_entitlements.pdf.

[43] On work-life balance and the coordination of ECEC and parental leave policies, see furthermore also Haux (2011), Kotowska et al (2010), Kamerman and Moss (2009).

[44] See Barnett (2002); Burchinal (1999). For instance, an extensive study of preschoolers in 400 US child care centers found that a composite quality measure (including global quality, teacher responsiveness, child-centredness, and teacher ratings of their relationship with the child) was positively related to higher vocabulary and reading scores and to teacher's ratings of the child's cognitive skills, even after adjusting for maternal education, child's sex and ethnicity. Again, this effect was strongest in the case of children of mothers with less education (Peisner-Feinberg and Burchinal, 1997).

challenges to exercise young minds, impart essential catalysts to healthy brain growth, and help young children discover who they are and what they can do.'

Studies of the effect of early child care quality on cognitive, linguistic and other developmental outcomes stress that intensive and attentive interactions with qualified caregivers are the true motor of development (Burchinal 1999). Most studies agree that good care is likely to be best provided in small groups, with low adult-child ratios, when caregivers are well-educated, well-compensated and stable in their roles. These conditions are far from uniformly evident at present. As Figure 3.7 shows, child-to-staff ratios for formal day care services for the youngest children (those aged 0-3) vary widely, ranging from small classes of four or five children per teacher in Ireland the Netherlands, the UK and Denmark, to around eight children per teacher in Norway and Austria, and as many as eleven in Portugal.[45]

Conclusions

As we have seen, positive recent policy changes notwithstanding,[46] Germany's performance can be described as average at best in international comparison as regards both inputs and outcomes on ECEC policies - worse, certainly, than the performance of the Nordic countries. More generally*, the Nordic countries clearly represent the best practice model on ECEC policies* as they comprehensively offer the best chances of equal starting points in life to all young children, irrespective of the socio-economic circumstances of their birth and early childhood circumstances. As regards outcomes, Germany (8.3%) does perform relatively well in international perspective when it comes to child poverty, as it occupies the eleventh rank out of a 34-country OECD sample. Yet these are much higher child poverty levels than in Denmark (3.7%), Finland (4.2%), Norway (5.5%) and Sweden (7%), who occupy four of the bottom five ranks, with Austria (6.2%) also boasting low rates. While the share of single parent families is relatively low in Germany (5.9%), the gap between the poverty rates of single parent households (36.2%) and those of couple families with children (5.8%) is comparatively large, at over 30 points. Again, Germany performs noticeably worse in terms of this poverty gap than the best performing Nordic countries: Denmark (7 points), Norway (14 points) and Sweden (15 points). In the same vein, highest levels of employment among mothers of young children are again found in Nordic countries such as Denmark (76.5%), Iceland (84.8%) and Sweden (82.5%). Germany (63.1%) is situated midway between these Nordic levels and the EU-wide lowest levels in Southern Europe and post-communist Europe.

In terms of policy input indicators such as total public spending on ECEC services, the EU-wide top seven consist of *all five Nordic countries*, as well as France and Belgium. Germany spends less than half as much as this group (0.4% of its GDP). More crucial and potentially more worrying still: Germany spends particularly little on the childcare services in the very youngest (0 to 2) age group: 0.1% of its GDP, as compared to EU-wide highest levels of 0.6 percent in Sweden, 0.7 percent in Iceland and 0.8 percent in Denmark.[47] This marginal focus on the crucial youngest-young age group is

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[45] For instance, turnover among childcare staff is around 30% per year in the US. Currently, of all childcare services in the US, those catering for toddlers and infants are the most scarce, expensive and low-quality (Larner et al. 2001, pp.15, 16).

[46] On the plus side, compared not just to the recent past but also to neighboring conservative welfare states such as Austria, German policies towards young families, including childcare policies, have made great strides since 2000. New policies introduced by the Red-Green government and carried further by the subsequent coalition of Social Democrats and Christian Democrats include a parental leave benefit which is short-term, enables financial independence for most parents, and is not tested against the partner income (Leitner 2010). Some policy elements do still support the traditional breadwinner (rather than dual-earner) model. For instance, the benefit is universal and the leave period still extends until the third birthday of the child. In addition, a small flat-rate benefit for the child's second and third year is to be introduced (Leitner 2010).

[47] Note, however, that a major new policy aims to remedy this by speeding up the expansion of childcare places for children under three. Thus, by 2013 the coverage rate for children aged 0–3 should have risen to 35 percent, and from 2013 onwards every child will have the right to a childcare place from its first birthday (Kinderförderungsgesetz 2008

also evident in attendance rates for ECEC services, where Germany closely follows larger international patterns, as it combines relatively low attendance levels for children aged 0-2 (19%) with very high attendance levels for children aged 3-5 (89%). Needles to say, increasing the availability of low-cost and high-quality childcare facilities (and take-up rates) would have important add-on effects through the ways in which, by reconciling work and family obligations of mothers ('babies and bosses') they could increase mothers' labor market participation rates and indirectly therefore could reduce both welfare dependency levels and child poverty rates.[48] But in addition to these indirect effects, the reason why these low 0-2 attendance figures are particularly worrying is that mounting economic and sociological evidence indicates that this youngest-young age group is precisely the one most likely to benefit *directly* from state investment. This is the subject of section 12 (starting p. 167).

BGBl; see Leitner 2010). See also footnote 11. In another recent policy change, from January 2010 onwards child benefits and child-related tax exemptions have both been raised, although there is evidence that this will happen in a regressive fashion, benefiting richer families more than poorer families.

[48] On work-family reconciliation policies see e.g. Haux (2011), Kamerman and Moss (2010), Kotowska et al. (2010).

4. Health inequalities, barriers in access to public health care

Ulrike Waginger

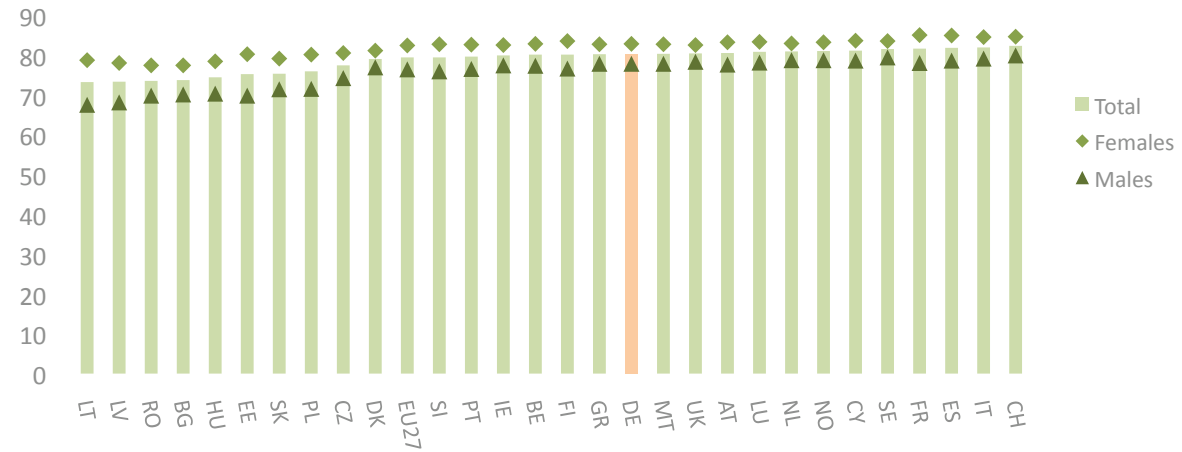
Health, poverty and social exclusion are closely related concepts interacting with each other in important ways. Social exclusion can lead to decline in health, but poor health can also contribute to exclusion (see chapter 13 for more details). Several dimensions of social exclusion have been identified thus far which also affect people's health, including income and wealth, housing situation and working conditions (see chapters 2 and 5). Educational attainments also strongly affect life-style, which may result in health inequalities.

The aim of this analysis is to elucidate the relationship between people's socio-economic status and their health from a European comparative perspective. This chapter focuses on people "on the margin", who face a high risk of social exclusion, while chapter 9 focuses on people "at the top" by analysing whether there are health advantages for those with high socio-economic status.

Life expectancy and healthy life expectancy across Europe

Since the demographic transition in Europe of the last century, European countries have experienced a continuous rise in average life expectancy due to declines in child mortality as well as to gains in the maximum average life-span (i.e. increase in the maximum average age at death). Together with declining fertility rates, these developments have led to an overall rapid population ageing in most European countries (i.e. the proportion of older persons is increasing in relation to the rest of the population). Interestingly, the age group growing fastest is the one of the oldest old, aged 80 and above, due to mortality declines at oldest ages.

Figure 4.1: Life Expectancy at birth in Europe, 2009



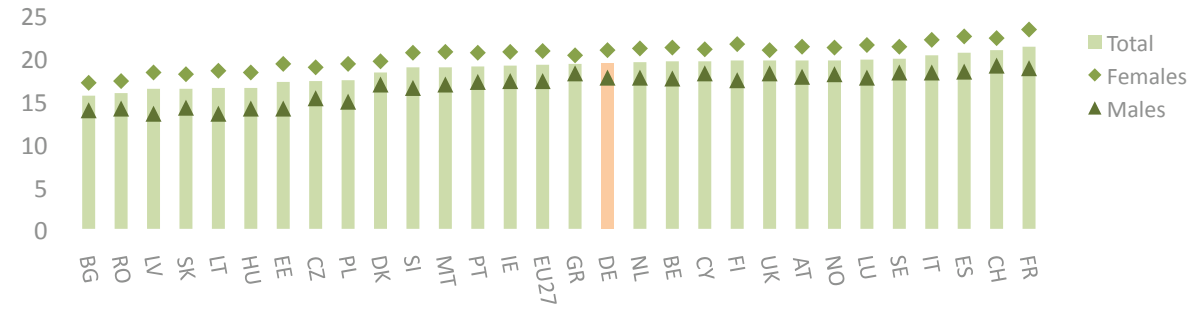
Source: EU-SILC 2009 (demo_mlexpex), version from 4 May 2011; accessed 22 July 2011 (data for Italy and EU27 from 2008).

Due to strong birth cohorts after World War II in most European countries (the so-called "baby boomers"), the group of older persons will increase even more rapidly in the coming years.

Nowadays, people at age 65 have still quite some time to live – on EU average another 19 years, almost eight of which are likely to be in good health (see Figure 4.2 and Figure 4.4). However, this

increasing portion of older persons also presents challenges and requires action on the part of European governments, as older people, especially those with low income or poor health, are amongst the most vulnerable in terms of the risk of social exclusion.

Figure 4.2: Life Expectancy at age 65 in Europe, 2009



Source: EU-SILC 2009 (demo_mlexpex), version from 4 May 2011; accessed 22 July 2011 (data for Italy and EU27 from 2008).

The latest European data (2009) show that average life expectancy varies by approximately nine years across Europe (see Table A.2 in the annex; Eurostat 2011). Germany is placed slightly above EU-27 average both in terms of average life expectancy at birth and average life expectancy at age 65. Gender differences are greater in countries where the average life expectancy is lower.

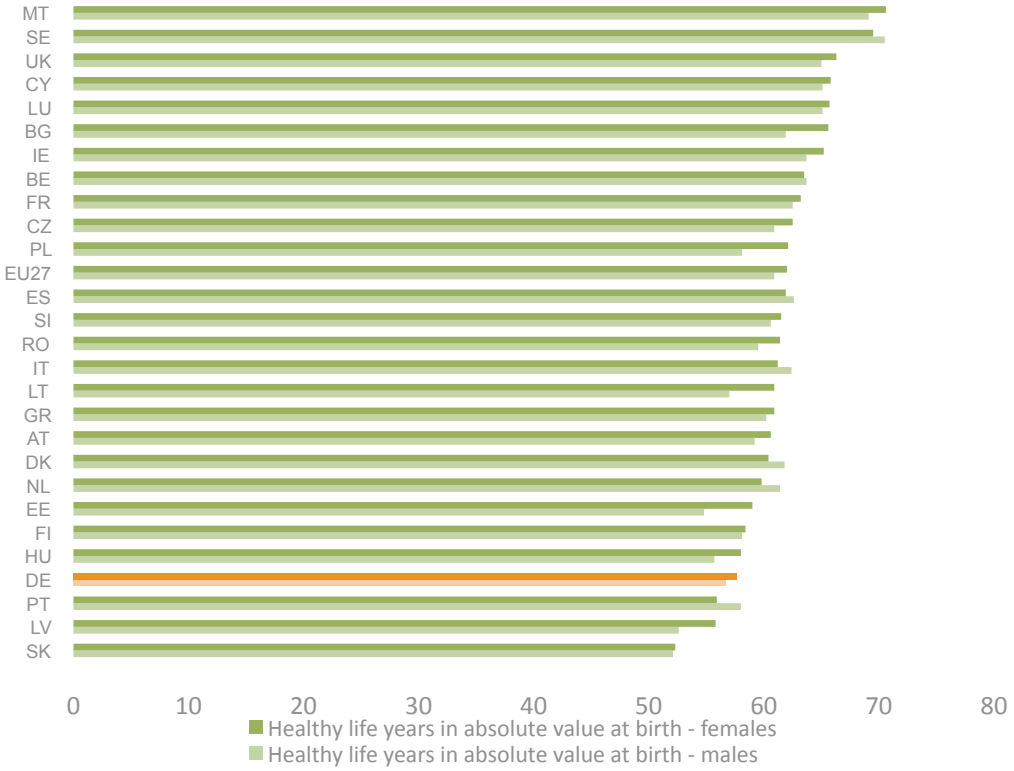
Data on healthy life expectancy, which shows the number of years a person is expected to live in a healthy condition, i.e. in absence of functional limitations or disability (also called disability-free life expectancy - DFLE), shows a larger cross-country variation, with a gap of 18 years between the country with the highest and the one with the lowest rate (see Table A.3 in the Annex and Figure 4.3 and Figure 4.4). However, even if clear inequalities in health status between countries exist, it must be noted that cultural differences in the perception of health status are also found, which must be borne in mind when analysing the indicator (Eurostat 2010:78).

The average healthy life expectancy appears to be far below EU average in Germany, which appears to be a rather unexpected finding. Why it is so? One possible explanation for this is related to the nature of the indicator, which is partly subjective[49].

Germany, for instance, is among those countries, where people have previously been shown to under-rate their health state, whereas Danish and Swedish respondents had a tendency to over-rate their health (Jürges 2007). Analysing SHARE data (Survey of Health, Ageing and Retirement in Europe), Jürges found that taking these differences in reporting style into account reduced cross-country variations, but did not eliminate them completely. The average healthy life expectancy appears to be far below EU average in Germany, possibly reflecting the German culture of how one's own health is perceived rather than effective poorer health than among the population in other European countries. Compared to the more objective data on the average life expectancy, which is based on mortality (where Germany performs relatively well), the data on healthy life years show substantial discrepancies. This confirms the impression that this result is due to people's attitude more than due to their effectively lower health.

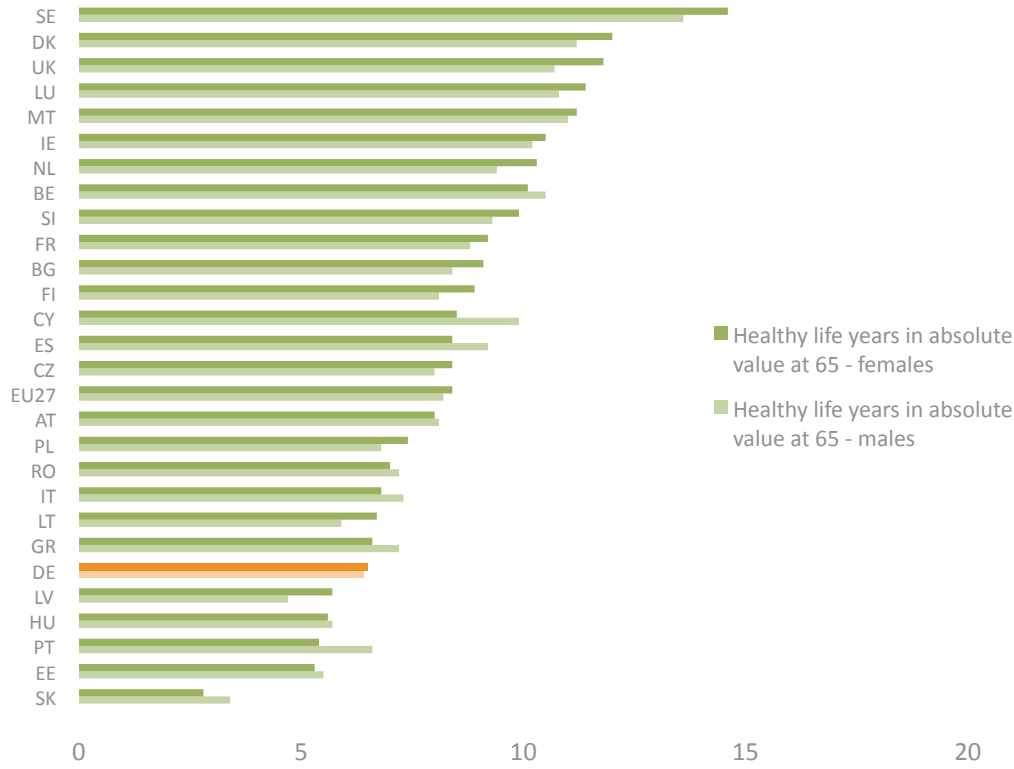
[49] Healthy life years are calculated using the Sullivan method which combines information on mortality and morbidity data (i.e. limitations in activities because of health problems).

Figure 4.3: Healthy life expectancy at birth, 2009



Source: EU-SILC 2009 (hlth_hlye), version from 14 March 2011; accessed 23 July 2011 (data for Italy, UK and EU27 from 2008).

Figure 4.4: Healthy life expectancy at age 65 in Europe, 2009



Source: EU-SILC 2009 (hlth_hlye), version from 14 March 2011; accessed 23 July 2011 (data for Italy, UK and EU27 from 2008).

Does income matter for health?

We explored the relationship between income and health, using the EU-SILC question on self-perceived general health. The validity of this single standard question as an accurate indicator of health in general was confirmed by previous studies (e.g. Siegrist 2006).

Table 4.1: Self-perceived general health by income group, EU-27, 2009 (% respondents)

	Very good	Good	Fair	Bad	Very bad
By gender					
Females	20,3	44,2	24,7	8,6	2,2
Males	24,4	46,1	21,1	6,7	1,7
By age group					
18-44	35,4	50,9	10,9	2,3	0,5
45-54	17,3	51,0	24,0	6,4	1,3
55-64	11,5	42,5	33,1	10,7	2,2
65-74	7,0	34,2	40,6	14,6	3,6
75+	4,4	22,9	41,5	23,5	7,7
By income group (quintiles of equivalised income)[50]					
First quintile (<20%)	17,9	39,2	27,9	11,8	3,1
Second quintile (>20% - <40%)	18,3	42,0	27,1	10,0	2,6
Third quintile (>40% - <60%)	21,7	45,5	23,3	7,5	1,9
Fourth quintile (>60% - <80%)	24,7	48,1	20,2	5,7	1,3
Fifth quintile (>80% - <100%)	28,7	50,5	16,5	3,5	0,8
Total	22,3	45,1	23,0	7,7	1,9

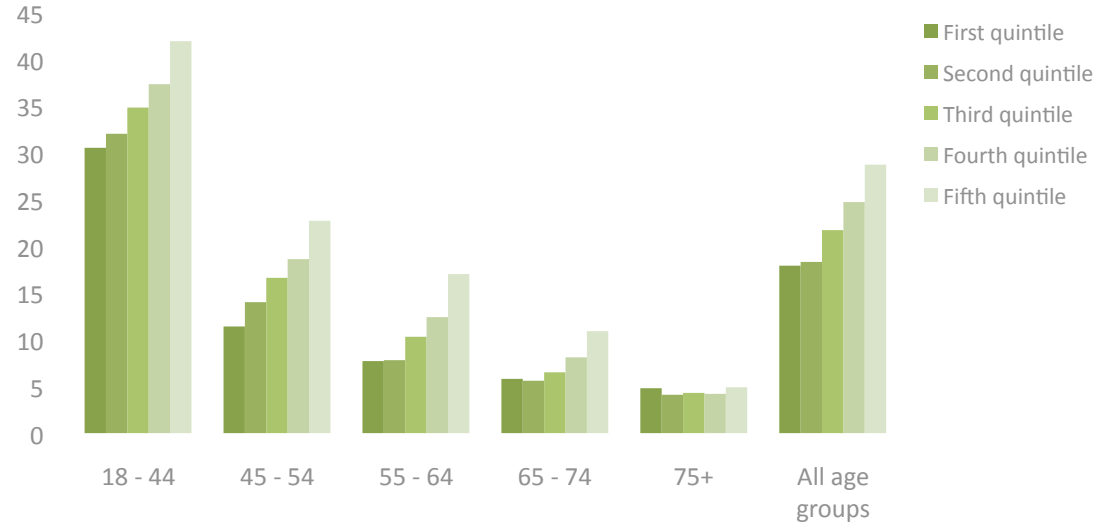
Source: EU-SILC 2009 (hlth_silc_10) - version from 22 February 2011; accessed 28 July 2011 (vgl. Eurostat 2010).
Note: Survey question: "How is your health in general?" with answering options: very good, good, fair, bad, very bad.

When exploring self-perceived health of respondents by age groups, a clear and well-known **age gradient** can be found. Health declines with age, which can be seen both in the decrease of those answering "very good" or "good" and the increase of those reporting to have "bad" or "very bad" health. Thus, older people state worse self-perceived health (and younger people report better general health) than the average. This natural decline of health with age is a fundamental underlying pattern.

The data on the EU as a whole shows that people of lower income groups are more likely to report adverse health than those with high income. 14.9% of the people in the lowest income bracket report bad or very bad health, while only 4.3% of those in the highest income bracket do so.

[50] Income quintiles were computed on the basis of the total equivalised disposable income of year (n-1), i.e. total disposable household income divided by the household equvalised size using the so-called modified OECD equivalence scale. This scale gives a weight of 1.0 to the first adult, 0.5 to any other household member aged 14 and over and 0.3 to each child below age 14 (Eurostat 2011, Metadata).

Figure 4.5: Self-perceived general health by age and income, EU-27, 2009 (% respondents in very good health; quintiles of equivalised income)

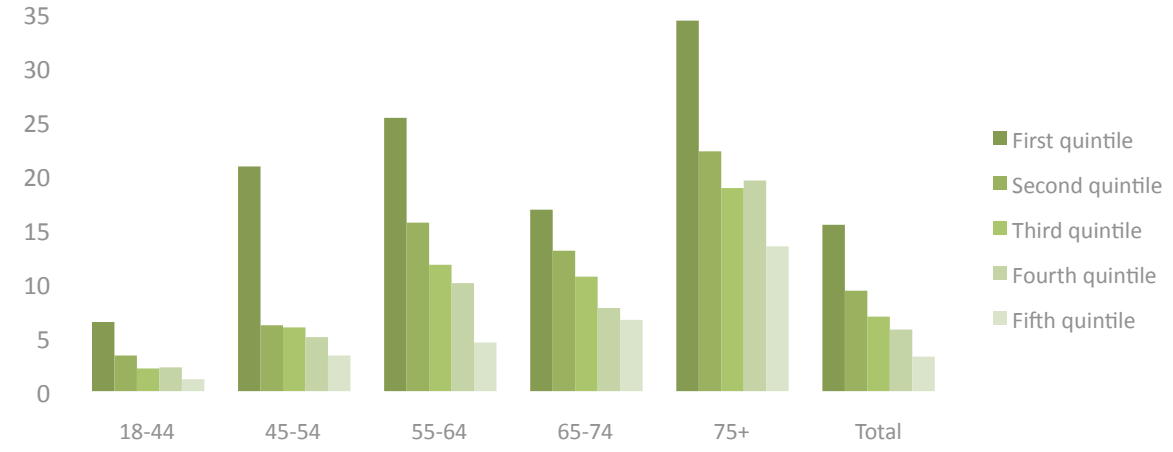


Source: EU-SILC 2009 (hlth_silc_10) - version from 22 February 2011; accessed 28 July 2011.

The analysis of health inequalities by income and age groups suggests, that the pronounced income pattern which prevails younger age groups disappears in older age. For instance, 41.9% of respondents aged 18-44 in the highest income group answered their health to be “very good”, but only 30.5% of those in the lowest income group did so, while almost no differences in health outcome were found for those aged 75 and over (all income groups show similar values between 4% and 5%). One possible explanation might be that those surviving until old age are those who are relatively healthy (for numerical results see Table A.2 in the annex).

With respect to Germany, Figure 4.6 demonstrates the relationship between income and self-perceived health status by age group.

Figure 4.6: Self-perceived general health by age and income, Germany, 2009 (% respondents in bad or very bad health)

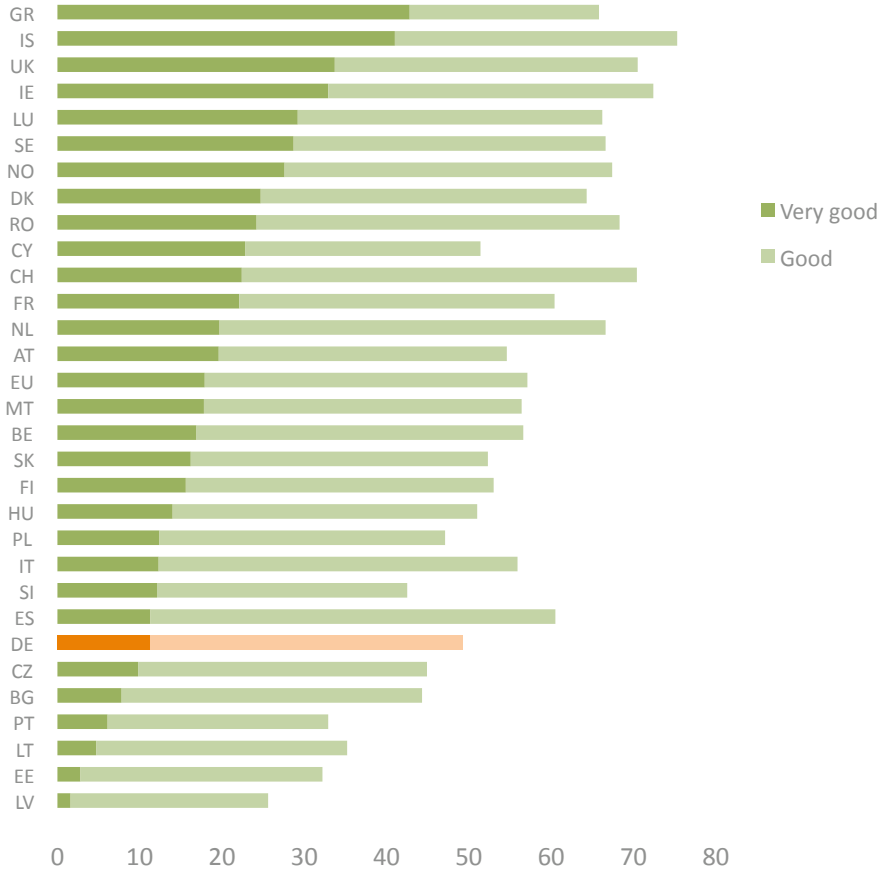


Source: EU-SILC 2009 (hlth_silc_10) - version from 22 February 2011; accessed 28 July 2011.

A clear disadvantage for those belonging to lower income groups can be seen for all age groups with the lowest income quintile being far more likely to experience bad or very bad health than other income groups (see Table A.5 in the annex for numerical data).

Comparing the general health of those belonging to the lowest income quintile by country, there are substantial variations across EU Member States. Percentages of people stating to experience very good health range from 1.6% in Latvia to 42.8% in Greece. Germany is found among the quarter of countries with lowest rates of self-perceived outstanding health, giving once more the impression that cultural differences in responding rather than actual variations in health outcome cause these results. In fact, when including those who choose the answer option "good" to describe their health, the picture is slightly improving, but the very critical perception of health in some countries remains. Thus, even if this indicator tends to reflect people's actual health well in general, it must be borne in mind (as stated above) that responses from some countries may be strongly influenced by cultural differences and attitudes (Jürges 2007).

Figure 4.7: Self-perceived general health by country and income, EU-27, 2009 (% respondents in very good health, lowest income quintile)



Source: EU-SILC 2009 (hlth_silc_10) - version from 22 February 2011; accessed 28 July 2011.

In general, however, there is a clear pattern across countries, with the lowest prevalence of "very good health" among the poorest income quintiles. This suggests that income matters for health.

Subjective gaps in health service provisions

The relatively low share of people who report unmet needs for medical or dental examinations and treatments suggests that overall provision of health services in EU Member States is rather successful. Medical and dental needs were met in over 93% of the cases. The main reasons why needs were not met included:

- access barriers to health services like

- costs, waiting times and distance,
- and personal reasons such as
  - waiting for the problem to get better on its own or
  - not taking the time to consult a doctor, etc.

Table 4.2: Main reasons for unmet medical needs by income quintiles of equivalised income, EU-27, 2009

	First quintile	Second quintile	Third quintile	Fourth quintile	Fifth quintile	Total
Too expensive	4,2	2,3	1,6	1,0	0,5	1,9
Too far to travel	0,4	0,2	0,1	0,1	0,1	0,2
No time	0,9	0,9	1,1	1,2	1,3	1,1
Didn't know any good doctor or specialist	0,1	0,1	0,1	0,1	0,1	0,1
Waiting list	1,1	1,1	0,9	0,9	0,8	1,0
Fear of doctor, hospital, examination or treatment	0,5	0,4	0,3	0,3	0,3	0,4
Wanted to wait and see if problem got better on its own	1,7	1,5	1,3	1,1	1,0	1,4
Other reasons	1,1	1,1	1,0	0,9	0,9	1,0
No unmet needs to declare	90,0	92,3	93,5	94,4	95,1	93,1

Source: EU-SILC 2009 (hlth_silc_08) - version from 30 May 2011; accessed 24 July 2011.
Note: Survey question: Was there any time during the past 12 months when you really needed to consult a specialist but did not? With answering options: 1 Could not afford to (too expensive), 2 Waiting list, Could not take time because of work, care for children or for others, 4 Too far to travel/no means of transportation, 5 Fear of doctor/hospitals/examination/ treatment, 6 Wanted to wait and see if problem got better on its own, 7 Didn't know any good doctor or specialist, 8 Other reasons.

Table 4.3: Main reasons for unmet dental needs by income quintiles of equivalised income, EU-27, 2009

	First quintile	Second quintile	Third quintile	Fourth quintile	Fifth quintile	Total
Too expensive	7,6	5,2	3,9	2,7	1,3	4,1
Too far to travel	0,2	0,1	0,1	0,1	0,0	0,1
No time	0,5	0,6	0,6	0,8	0,9	0,7
Didn't know any good doctor or specialist	0,1	0,1	0,0	0,1	0,1	0,1
Waiting list	0,7	0,5	0,6	0,4	0,5	0,5
Fear of doctor, hospital, examination or treatment	1,3	1,1	0,9	0,9	0,7	1,0
Wanted to wait and see if problem got better on its own	0,7	0,5	0,5	0,5	0,4	0,5
Other reasons	0,9	0,8	0,8	0,7	0,7	0,8
No unmet needs to declare	88,1	91,2	92,7	93,9	95,5	92,3

Source: EU-SILC 2009 (hlth_silc_09) - version from 22 February 2011; accessed 28 July 2011.

People, who considered their needs unmet were more likely to live on low income. On average, 10% of the EU population belonging to the lowest income quintile perceived their needs as unmet, while only half as many (4.9%) of the highest income group did so. Country variations were considerable with unmet needs of the lowest income group reaching as high as 25% in some countries.

Main reasons why medical and dental needs were not met vary by country. In the EU as a whole, not being able to afford **costs** was quoted most frequently as a reason for not consulting doctors or

dentists. 1.9% of the total EU-27 population has chosen cost as the main reason for unmet medical needs and 4.1% considered dental services too expensive. As expected, unmet needs due to costs were significantly higher for the lowest income group (4.2% for medical and 7.6% for dental services) than for the highest income group (0.5% and 1.3% respectively), indicating that income matters for meeting one's health care needs.

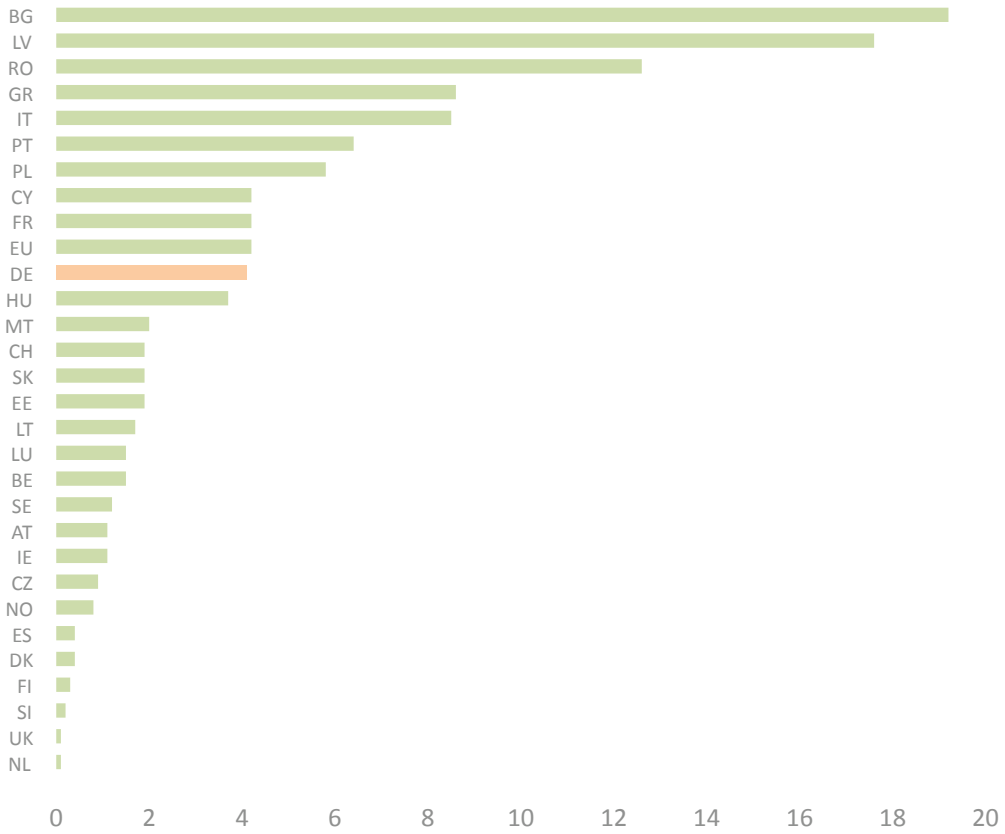
Waiting times were considered to be a more or less equal constraint across all income groups - a closer look on this issue by countries will be given in below.

Compared to costs and waiting times, **geographical distance** to health services was considered to be a minor issue. However, it becomes a more pronounced problem when examining results by age groups as shown below; (see chapter 13 for more details on access barriers to health care across countries and national policy measures to tackle them).

Cost as main reason for unmet medical and dental needs

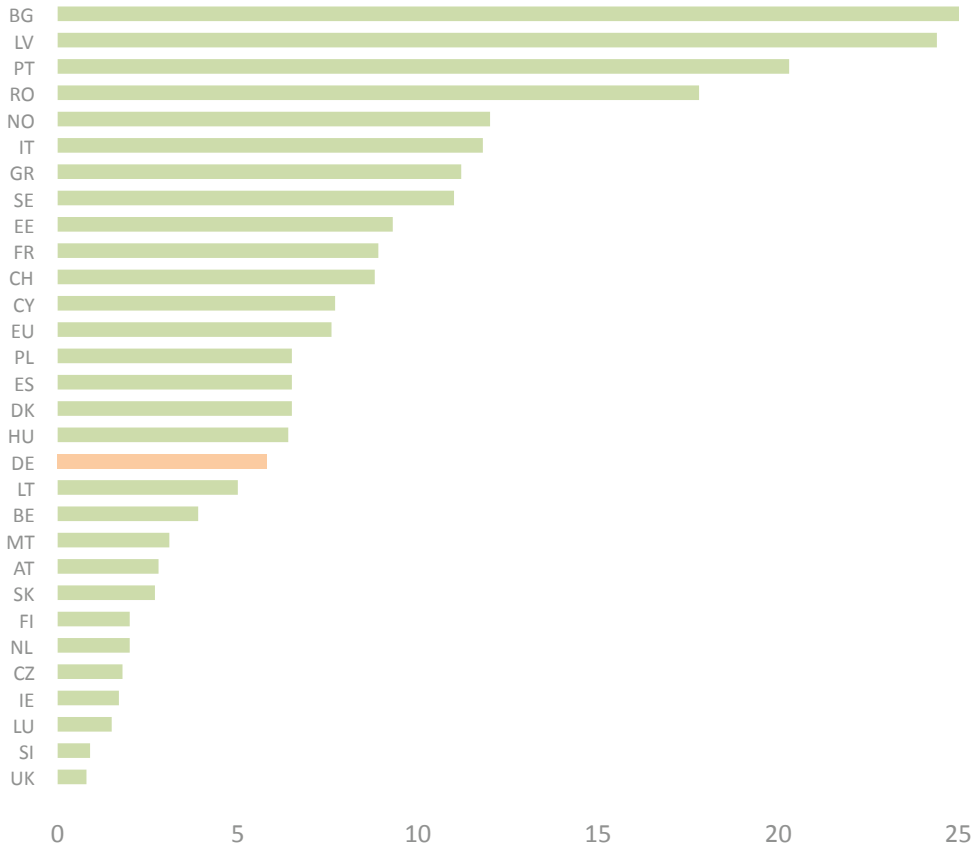
In most European countries out-of-pocket expenses were considered the main reason for unmet medical and dental needs. Eastern European countries in particular, as well as some Southern European countries face substantial access barriers to health services due to co-payments, which are more severe for those at risk of poverty and social exclusion.

Figure 4.8: Cost as main reason why medical needs were unmet: lowest income group by country, 2009 (% respondents; bottom income quintile)



Source: EU-SILC 2009 (hlth_silc_08 and hlth_silc_09) - version from 30 May 2011; accessed 24 July 2011.

Figure 4.9: Cost as main reason why dental needs were unmet: lowest income group by country, 2009 (% respondents; bottom income quintile)



Source: EU-SILC 2009 (hlth_silc_08 and hlth_silc_09) - version from 30 May 2011; accessed 24 July 2011.

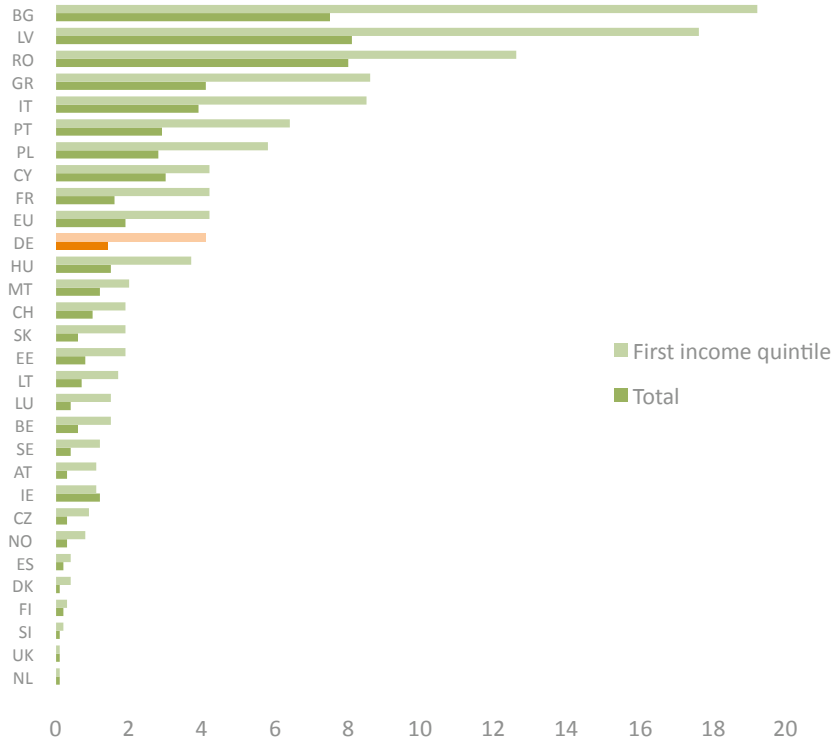
Country variation by income group shows a dramatic picture: up to one quarter of the population in the lowest income group find their dental needs unmet because of not being able to pay for examinations and treatments, and almost up to one fifth could not afford medical services. Eastern European countries (such as Bulgaria, Latvia, Romania and Poland) as well as Southern European countries (like Greece, Italy, Portugal) have very high levels of **unmet medical needs** due to cost for the lowest income group. On the contrary, most Western European countries (United Kingdom and the Netherlands), Central European countries (Austria and Czech Republic among others) as well as Scandinavian countries (Finland, Denmark and Norway) are characterised by rather low rates.

In comparison to the most Western European countries, Germany has relatively high rate of unmet needs due to out-of-pocket expenses for medical health services among the poorest income quintile group (5.8%).

Waiting times as main reason for unmet medical and dental needs

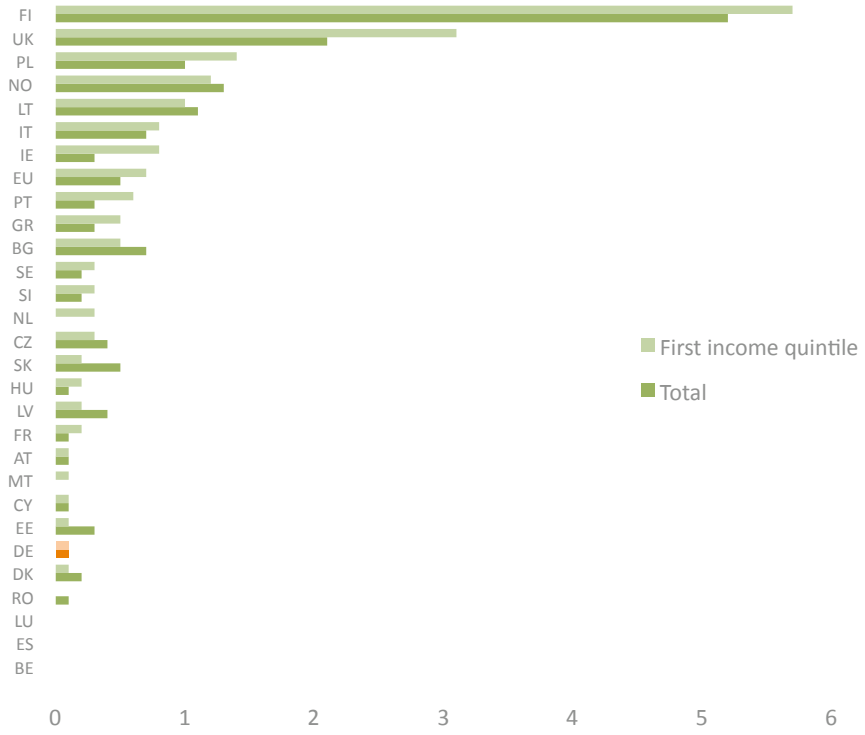
While waiting times do not appear to be an issue in most EU Member States, they have traditionally been the main access barriers in some other countries, like Finland and the UK (Huber et al. 2008). Figure 4.10 shows that in some countries there is a rather large discrepancy between income groups: lowest income groups experiencing waiting times about twice as often as an issue compared to the population as a whole. For Germany, waiting times do not seem to be a reason for unmet dental needs (0.1%), however, it is a bit more of an issue in case of medical services in general (see Figures below, and Table A.6 and Table A.7 in the annex). According to EU-SILC data from 2009, 0.6% of the respondents in Germany perceived their medical needs not met due to waiting lists.

Figure 4.10: Waiting times as main reason why medical needs were unmet: lowest income group vs. total population by country (% respondents; first quintile of equivalised income



Source: EU-SILC 2009 (hlth_silc_08 and hlth_silc_09) - version from 30 May 2011; accessed 24 July 2011.

Figure 4.11: Waiting times as main reason why dental needs were unmet: lowest income group vs. total population by country (% respondents; first quintile of equivalised income)



Source: EU-SILC 2009 (hlth_silc_08 and hlth_silc_09) - version from 30 May 2011; accessed 24 July 2011.

Some tax-financed health care systems, like the Finish and the British NHS traditionally considered waiting times an acceptable constraint in order to keep public programmes cost-effective and mostly co-payment free, which has lead to rather high rates of unmet needs due to waiting lists (Huber et al. 2008). In Finland, for instance, many patients faced very long waiting times to see a doctor and extensive waiting lists for elective surgeries. Since 2005 the government is aiming to improve waiting times with the introduction of specific waiting time targets (OECD 2005). Policy measures taken to tackle this issue of waiting times are further discussed in chapter 13.

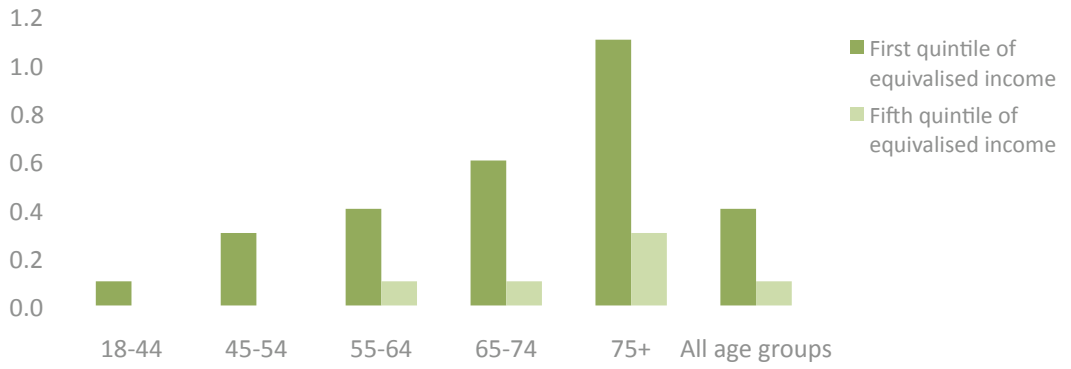
Distance to services as reason for unmet needs

Geographical barriers, such as great distance to get to services, lack of public transportation and no coverage of transportation cost, may represent an access barrier to health care particularly to those at risk of poverty. One aspect of these geographical barriers was covered in the EU-SILC questionnaire by the answer option "too far to travel" for the question of the main reason for unmet needs (see Table 4.2 and Table 4.3).

Even if the distance to health services was considered less of an issue by respondents compared to cost and waiting lists (only a very low number of 0.2% experienced unmet medical needs and 0.1% unmet dental needs due to services being too far to travel), these barriers gain importance for vulnerable groups, in particular for lone parents, families with children, older people and people with functional impairments, as well as for people living in rural and less populated areas in general (see chapter 13.2.4 for more information on geographical barriers to health services).

When exploring data by age group it can be seen that distance to health services is becoming more of an issue with age. These results indicate that older people, who often experience limited functional capacities, are those most seriously affected by access barriers to health care due to geographical distance (see Figure 4.12). This tendency can be also seen in Germany, although only relatively few people report their needs unmet due to services being too far (see Table A.10 in the annex).

Figure 4.12: Distance to services as main reason why medical needs were unmet: lowest and highest income group by age group, EU-27, 2009 (% respondents)



Source: EU-SILC 2009 (hlth_silc_08) - version from 30 May 2011; accessed 29 July 2011.

Overall, very low numbers of people considered the distance to services to be the main barrier of access to services: less than 1% of respondents in all the countries. Therefore, country variations are minor, even if slightly more people experienced difficulties in Eastern European and in large countries (such as Norway). When examining country differences by income, these variations increase, with highest rates for Bulgaria (2.4%), Poland (1.5%) and Norway (1.1%) among the lowest income quintile. Only 0.3% of the German respondents belonging to this group considered their medical needs unmet due to distance (see Table A.8 in the annex). In most countries gender

differences were small with a minimally higher rate for women (for country and gender comparisons see Table A.9 in the annex). Whereas differences between countries were rather small on average, a substantial regional variation in the provision of health services is apparent within countries, and shortages are more severe in some regions than in others (see chapter 13 for details on regional differences).

Conclusion

People from lower socio-economic groups are clearly disadvantaged in terms of health. This disadvantage particularly applies to those “on the margin” who are at risk of social exclusion. People of lower income groups show significant lower levels of very good health than those of higher income brackets.

Individuals at risk of poverty are also more likely to be affected by barriers of access to health care. Co-payments, lack of free transportation or distances to services, as well as waiting times (with no option to bypass them by making use of private services) impose constraints on people in lower income groups, who are more likely to experience financial difficulties, so these issues may increase inequalities in health between socio-economic classes (further comparisons of health status by education and income can be found in chapter 9).

5. Housing problems and access to basic local services

Orsolya Lelkes, Katrin Gasior

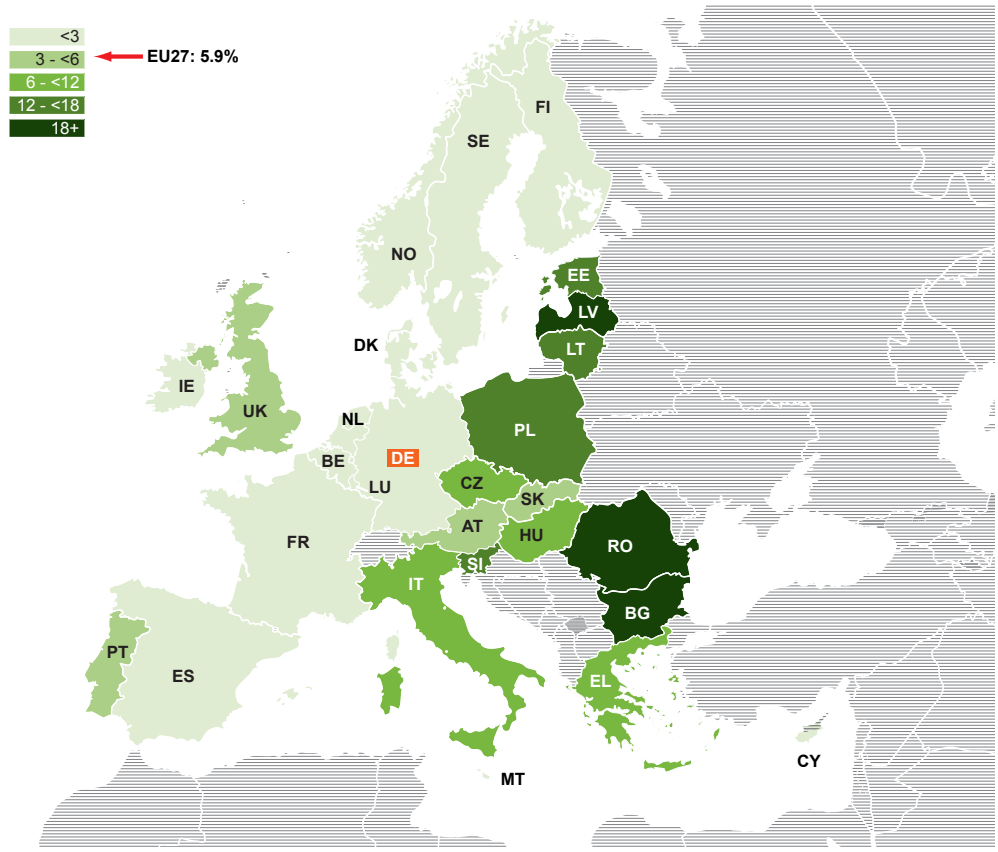
Housing quality is both an output measure itself, expressing an important element of quality of life, but it is also a determinant of social participation chances, as it has an impact on health, on social relations, and on access to jobs. In addition to the quality of housing in a narrow sense, neighbourhood characteristics, the accessibility and quality of local social services, in particular public transport play a major role.

This chapter will focus on housing problems, such as poor housing quality, overcrowded households, and housing costs, and access to basic local services, including public transport and postal services. The calculations are based on EU-SILC 2009, with representative samples of the population in 27 EU countries.

Housing deprivation

In 2009, an estimated 30 million people, 6% of the EU27 population suffered from severe housing deprivation. This is defined as living in a dwelling which is both overcrowded and has at least one fundamental quality shortage (either (1) a leaking roof or damp walls, floors, foundations or rot in window frames or floor; or (2) neither a bath, nor a shower, nor an indoor flushing; or (3) too dark). The map suggests a major geographical divide, with highest rates of deprivation in Eastern and Southern Europe (Figure 5.1). The rates vary between 0-1% and 29%. In Cyprus, the Netherlands, Finland, Norway and Ireland, the rate is 1% or below. In contrast, in Latvia and Romania, over one in five person is affected by severe housing deprivation (23% and 29%, respectively). Germany, with its rate of 2%, is one of the countries least affected by severe housing deprivation.

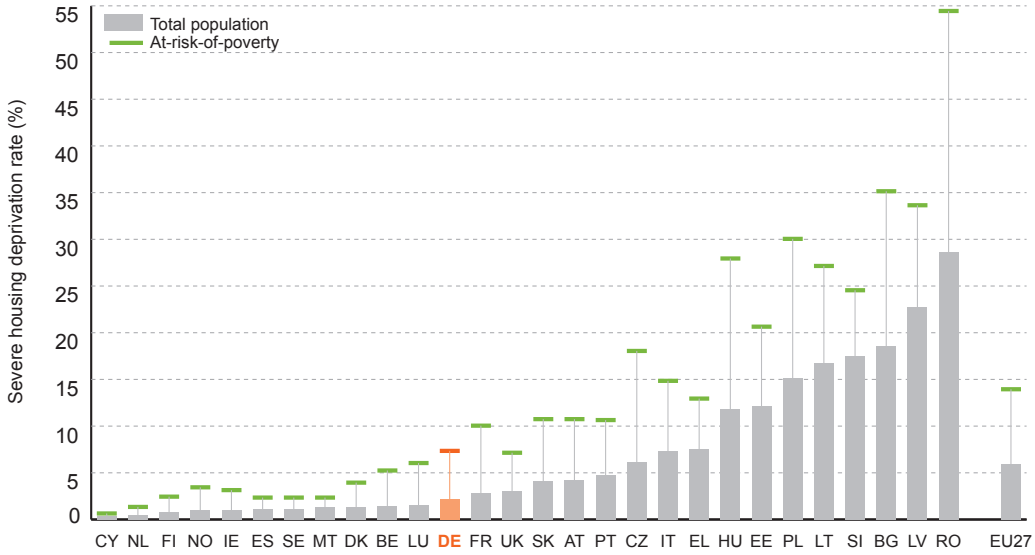
Figure 5.1: Severe housing deprivation rate across the EU, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Severe housing deprivation refers to the percentage of the population in a dwelling which is considered as overcrowded and exposed to at least one of the following three housing deprivation measures: (1) a leaking roof or damp walls, floors, foundations or rot in window frames or floor; (2) neither a bath, nor a shower, nor an indoor flushing; or (3) too dark.

Low income groups are more likely to be exposed to housing deprivation (Figure 5.2). The prevalence of severe housing deprivation is close to 14% among those at risk of poverty in the EU on average, which implies a rate of over twofold compared to the total population. The highest prevalence of housing deprivation among low income individuals, with rates of 30% or over occurs in Bulgaria, Latvia, Poland and Romania, with a rate as high as 55% in the latter. In Germany, 7% of those at risk of poverty suffer from severe housing deprivation. This is significantly below the EU27 average, but still above the national average figure, highlighting the cumulative disadvantage of some of the poor population.

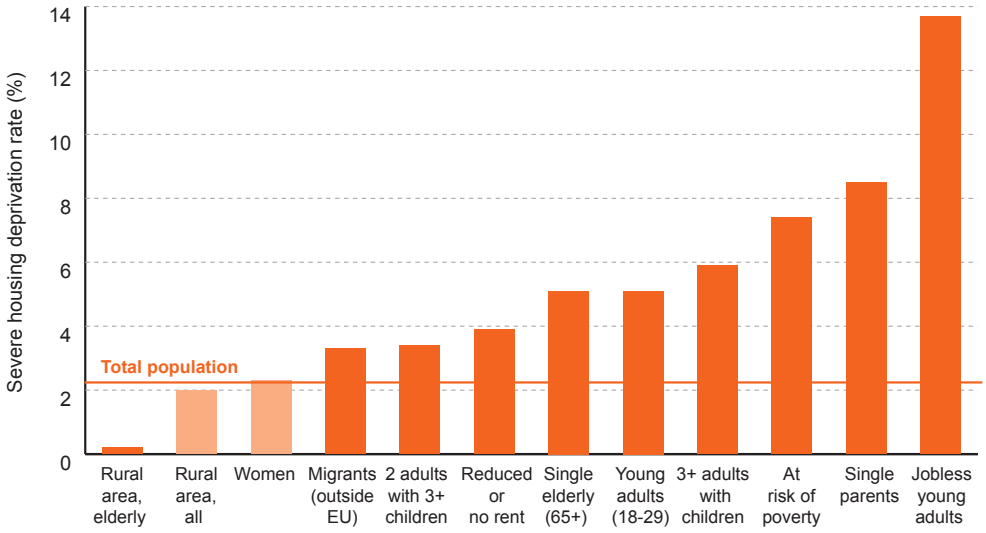
Figure 5.2: Severe housing deprivation rate, comparing total population and those at-risk-of-poverty, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Population at-risk-of-poverty: persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income (after social transfers). Severe housing deprivation rate: see Note Figure 5.1. EU27: population-weighted average of national indicators.

There are substantial social differences in terms of housing deprivation in Germany (Figure 5.3). We explored the situation of a few selected social groups, based on demographic characteristics and the degree of urbanisation. Jobless young adults face the highest prevalence of severe housing deprivation (the accumulation of at least one major housing quality shortfall and overcrowdedness), with a rate of 14%. Single parents, single elderly, young adults, large families (those with 3+ adults and those with 3+ children), those at risk of poverty, and migrants from outside the EU have an above average exposure to housing deprivation. Note that people who live in social housing (in a dwelling which is provided for free or rented at a lower price than the market price) are more likely to experience housing deprivation, with a rate of 4%. Housing deprivation problems are somewhat less likely to affect those in rural areas: the difference is small, but statistically significant. Those elderly, who live in rural areas do not seem to be affected by housing deprivation at all (the estimated rate is 0.2%). There is no evidence of a gender difference, which comes at no surprise, given that the indicator is household based, and the overall majority of women lives in households with men.

Figure 5.3: Severe housing deprivation rate across different social groups in Germany, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Bars with lighter shading indicate that the difference between the means is not significant at 10% level. Rural area, elderly: refers to persons aged 65 or more, living in "thinly populated areas". Migrant: based country of birth, Reduced or no rent: an accommodation which is provided for free or rented at a lower price than the market price), Jobless young adult: unemployed aged 18-29, based on self-proclaimed economic status. Severe housing deprivation rate: see Note Figure 5.1.

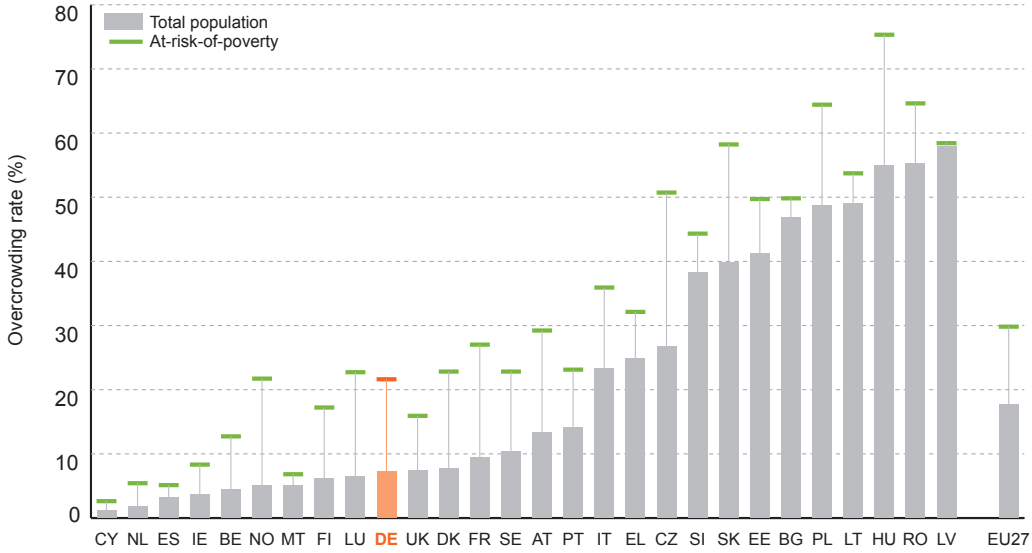
In the following section, we scrutinize one component of the "severe housing deprivation" indicator: overcrowding.

Overcrowding rate

The indicator of overcrowding measures whether there is sufficient space in the dwelling, using one single formula across all EU countries, based on the number of rooms and the household size and composition (for details, see the notes under Figure 5.4).

In 2009, 18% of the EU27 population lived in overcrowded conditions (Figure 5.4). The problem is much more prevalent in Eastern European countries: in Bulgaria, Estonia, Lithuania, Poland, and Slovakia the overcrowding rate reached 40% or more, and in Hungary, Romania, and Latvia it was over 50%. The lowest percentages were recorded in Cyprus (1%) and the Netherlands (2%). In Germany, the estimated rate is 7%, which is about the same as in Luxembourg or in the UK.

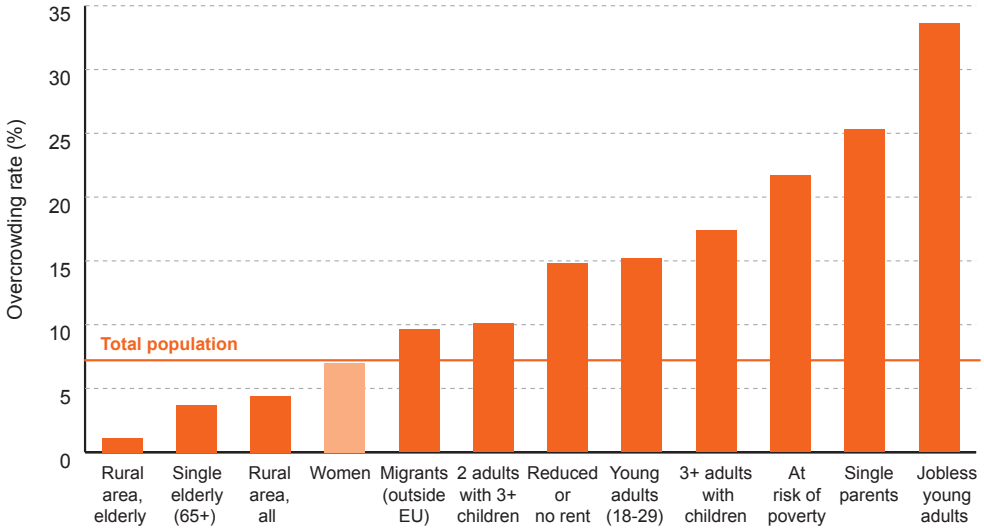
Figure 5.4: Overcrowding rate, comparing total population and those at-risk-of-poverty, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Notes: A person is considered as living in an overcrowded dwelling if the household does not have at its disposal a minimum number of rooms equal to: one room for the household; one room per couple in the household; one room for each single person aged 18 or older; one room per pair of single people of the same gender between 12 and 17years of age; one room for each single person between 12 and 17 years of age and not included in the previous category; one room per pair of children under 12 years of age.
EU27: population-weighted average of national indicators.

The population at risk of poverty is more likely to live in overcrowded dwelling. The social gap between low income groups and the rest of the population tends to be proportionately larger in countries with lower overall overcrowding rate. In Germany, 22% of the population at risk of poverty is exposed to overcrowded conditions. Similar rates prevail in Norway, Luxembourg, Denmark, and Sweden. On the one hand, this level is much below that of many Eastern European countries, especially that of Poland (65%), Romania (65%), and Hungary (75%), but on the other hand, it is relatively high in national standards, with a difference of about threefold compared to the total population. The lowest percentages were recorded in Cyprus (3%), Spain (5%), the Netherlands (6%), and Malta (7%).

Figure 5.5: Overcrowding rate across different social groups in Germany, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Bars with lighter shading indicate that the difference between the means is not significant at 10% level. Overcrowding rate: see note under Figure 5.4.

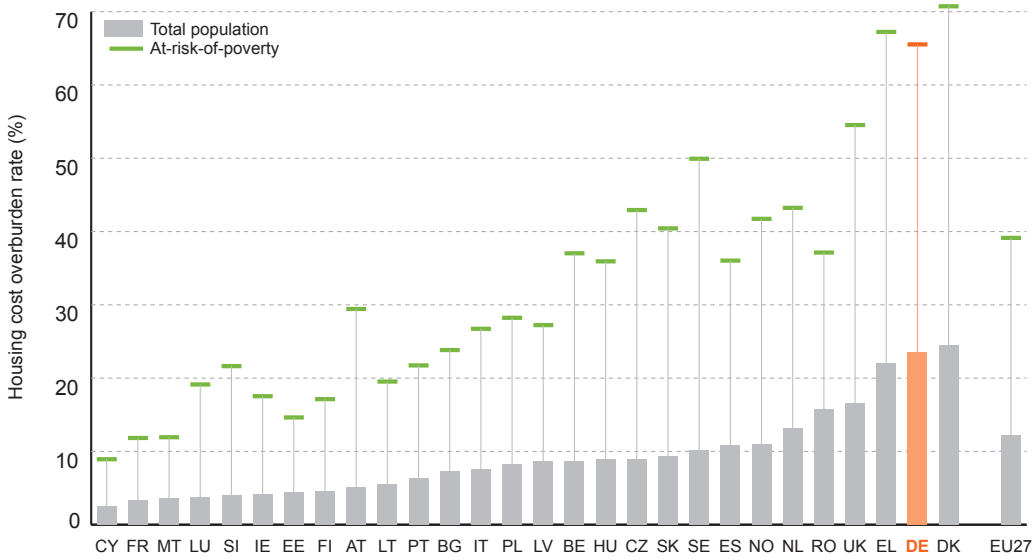
Focusing on the social disparities of the overcrowding rate in Germany, we find that jobless young adults and single parents are the most affected, with rates over 25%. Overcrowding seems to be related to the affordability: these household types tend to live in dwellings rented at market price (60-67% compared to the national average of 39%, see Table A.11 in the Annex) and probably many of them cannot afford more spacious homes. Other social groups with above average prevalence of overcrowding include those at risk of poverty (as discussed earlier), large families (those with 3+ adults and those with 3+ children), and migrants from outside the EU. Tenants with a free accommodation or subsidized rent are more likely to experience overcrowding. The elderly, even those who are single, and people who live in rural areas are less likely to be exposed to this problem (1-4%). We did not find evidence for a gender difference, as expected, as this indicator is measured on a household level. These patterns are rather similar to those shown on Figure 5.3 referring to severe housing deprivation. In both cases jobless young adults are by far the most disadvantaged group, signalling partly a life cycle effect: young adults are less likely to own their housing and if without a job, they are less likely to afford a home of an adequate quality (also due to the lack of savings).

Housing cost overburden

In 2008 12% of the EU27 population lived in a household that spent 40% or more of their net income (equivalised disposable income net of housing allowances) on housing. This rate varied from 3% in Cyprus and France to over 20% in Greece, Germany and Denmark. This suggests that in several prosperous countries a relatively large share of the population is affected by this problem.

Higher income countries tend to be exposed to higher housing costs as well. The housing cost overburden rate calculates expenditure on housing in relation to the total income of the household (adjusted for household size), and therefore it accounts for differences in average living costs and in income levels across countries. So, the cross-country variation of the indicator highlights an aspect of inequality, and also refers to the spending structure of households. This latter is strongly related to the structure of the housing market (share of subsidized social housing, and that of privately rented homes and also the regulation of the rental prices) and the service charges for public amenities, such as water, sewage removal, energy prices, etc. as well.

Figure 5.6: Housing cost overburden rate, comparing total population and those at-risk-of-poverty, 2008 income year



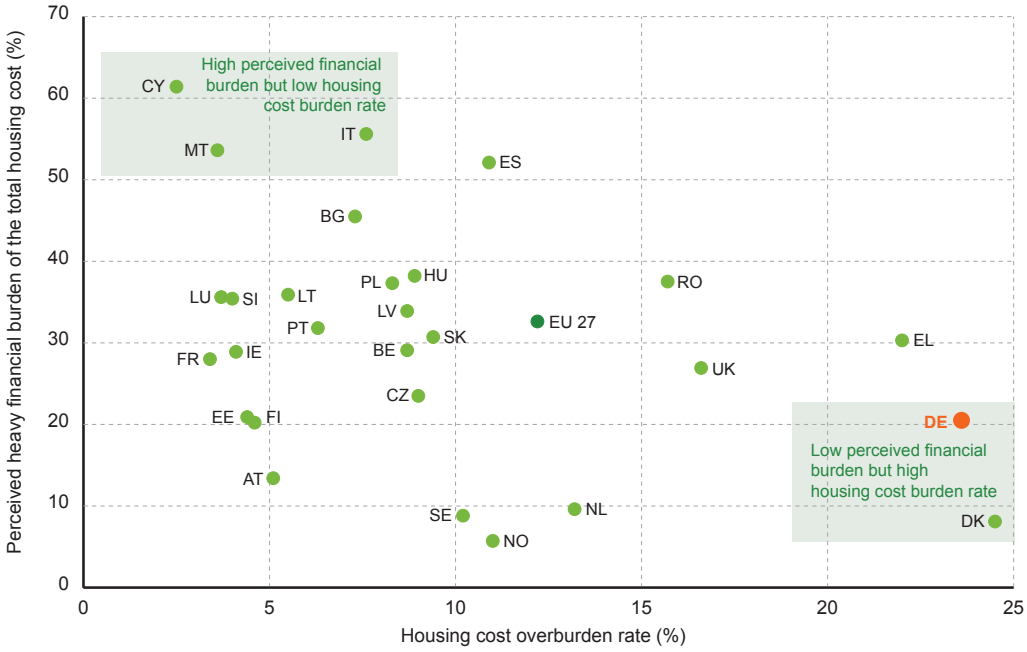
Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Percentage of population living in a household where the total housing costs (net of housing allowances) represent more than 40 per cent of the total disposable household income (net of housing allowances).

The population at risk of poverty is more affected in all the countries, as shown in Figure 5.6. In 13 out of 27 EU member states at least one in three persons on low incomes had housing costs in excess of 40% of their disposable income. In Sweden, the UK, Greece, Germany and Denmark one in two persons on poverty levels of income are affected. Note, however, that the high prevalence of housing cost overburden in Germany is due to a measurement error, and may not reflect the actual social situation.

The German EU-SILC questionnaire currently excludes the largest part of housing allowances ("Kosten der Unterkunft (KdU)"), and includes only "Wohngeld", accounting for only about 6% of total housing allowances[51]. Therefore, currently the European Commission does not publish German figures of the housing cost overburden rate of people with an income below the poverty threshold. This issue will be resolved in the EU-SILC 2012 questionnaire.

[51] According to the 2008 Social Budget, spending on housing allowances accounts for 14,1 milliard Euros: consisting of 0,8 milliard Euros Wohngeld and 13,1 milliard Euros KdU.

Figure 5.7: Comparing housing cost overburden rate and perceived heavy financial burden of the total housing costs across the EU, 2009



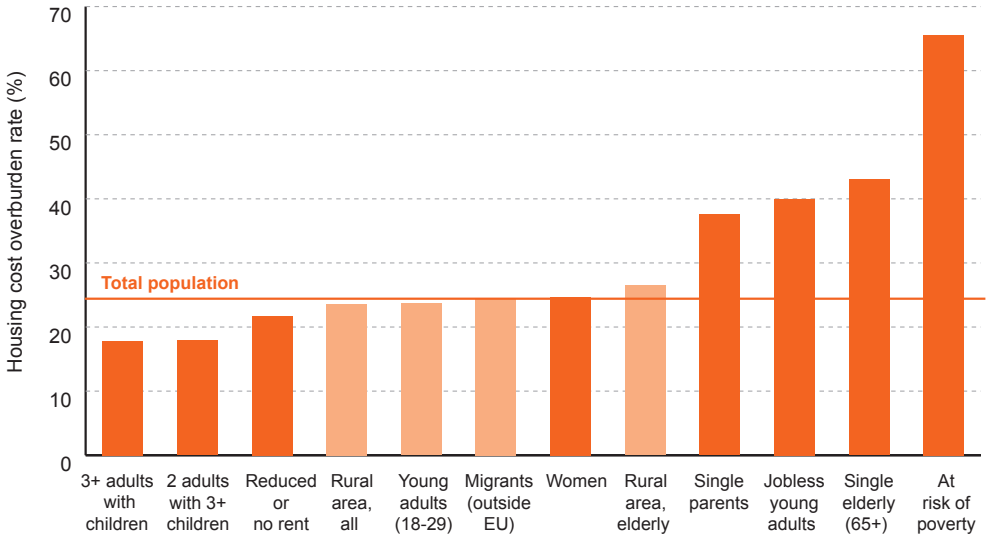
Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: for housing cost overburden rate see Note Figure 5.6; perceived heavy financial burden: comprises of the answer category "heavy burden" to the following survey question "Please think of your total housing costs including mortgage repayment or rent, insurance and service charges. To what extent are these costs a financial burden to you?" Answer categories: a heavy burden, a slight burden, not burden at all.
The German EU-SILC questionnaire currently excludes the largest part of housing allowances (about 94% of total), thus the housing cost overburden rate is overestimated.

How is the households' perceived financial burden related to their actual overburden? In other words, how are the subjective and objective aspects of housing overburden related? The straightforward hypothesis is that higher actual overburden tends to be correlated with higher perceived overburden. It is often not the case, however, on a country level, as shown by Figure 5.7.

Typically, the prevalence of self-perceived housing cost overburden is much higher than that measured by the objective indicator. The self-perceived indicator ranges between 20% and 40% for most countries and reaches as high as over 50% in Spain, Malta, Italy and Cyprus. The greatest mismatch between the subjective and objective indicators occurs in two specific country groups. In Germany and Denmark, the housing cost overburden rate is rather high by European standards (24-25%), while the perceived financial burden indicator remains relatively low. In other words, although a relatively high proportion of the population spends over 40% of their net incomes on housing costs, less of them find it a "heavy burden". Note, however, that the German figures may not be adequate, as most of the housing allowances are not included in the calculation of the housing cost overburden rate, which is thus likely to be overestimated.

These two countries have a relatively high segment of the housing market with rented homes at market prices (34% in Denmark, 39% in Germany, in contrast to the EU27 average of 17%), so for many of these tenants high rents may be a social norm. In contrast, in Cyprus, Malta and Italy, the housing cost overburden rate is low (3-8%), but over 50% report heavy financial burden. In these countries, the housing market is dominated by home owners (74%, 79%, and 73% respectively, see Table A.11 in the Annex)

Figure 5.8: Housing cost overburden rate across different social groups in Germany, 2008 income year



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: see Note under Figure 5.6.
The German EU-SILC questionnaire currently excludes the largest part of housing allowances (about 94% of total), thus the housing cost overburden rate is overestimated.

The analysis of social patterns in Germany is constrained by a prevalent measurement error: the EU-SILC 2009 survey includes only a small fraction of total housing allowances (Wohngeld). Based on the available figures, 24% of the German population were found to live in a household that spent 40% or more of their equivalised disposable income on housing, which is much above the EU average as shown before (Figure 5.8). This rate is significantly higher for the population at risk of poverty with a rate of 66%. Low income groups are thus strongly affected, despite the fact that 14% of them lives in free dwelling or in a home rented below market price, which is about twice as high as the national average (Table A.12 in the Annex). Other groups, which are affected with a relatively high prevalence of housing costs overburden, include single elderly, jobless young adults and single parents. These households are less likely to own their homes, and instead they tend to rent it at market price (50-67% of the specific groups compared to the national average of 39%, as shown by Table A.12 (in the Annex), or rent it at a reduced rate or get it for free (11-17% compared to the national average of 8%). Large households (either with three or more adults or with three or more children) are relatively less affected, just as people living in dwelling with subsidized or no rent. The overall majority of large households own their homes (83% of families with three or more children and 70% of households with three or more adults and children), which may explain their relatively lower housing burden. Housing costs represent a high fixed cost within the household budget, and thus they are less of a burden for those household types where they can be pooled over several people (earners). Women are slightly more affected in Germany, probably due to the lower incomes of single women households or households consisting of only women.

Access to basic local services

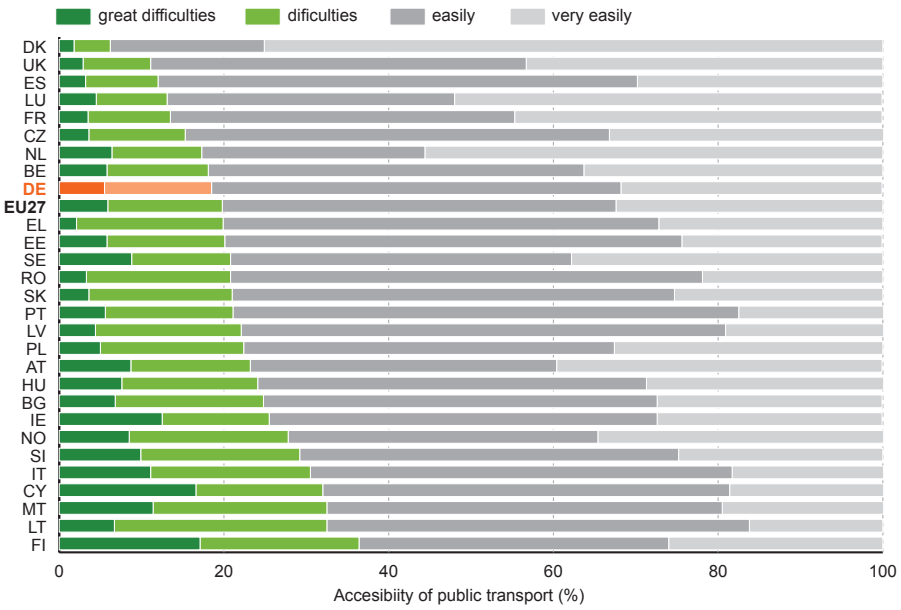
We explore the access to public transport and postal or banking services, as assessed by the individuals themselves. The accessibility of the services is assessed in terms of physical and technical access, and opening hours, appropriate timetable, but not in terms of quality, price and similar aspects. Physical access is assessed in terms of distance but also of infrastructure and equipment for respondents with physical disability.

We describe the cross-country variation in failures in access to these public services, and the relationship between poverty and access. We also highlight differences across social groups within Germany.

Accessibility of public transport

About one in five persons in the EU27 report difficulties with access to public transport (Figure 5.9). Denmark has the lowest barriers with access to public transport: only 6% of the population reports difficulties or great difficulties. Denmark, being a small and prosperous country, so it may come at little surprise. The picture is a bit more varied if we observe the following countries, with rates between 11% and 14%, which include Luxembourg (which is yet another a small and prosperous country), but also the UK, France and Spain. At the other extreme are Italy, Cyprus, Malta, Latvia and Finland, where over 30% of the population finds that public transport is accessible only with difficulties (or great difficulties). In Cyprus and in Finland 17% of the population claim that they have "great difficulties", which is the highest rate within the EU. We focus on this group, those with "great difficulties" in exploring the relationship with poverty status.

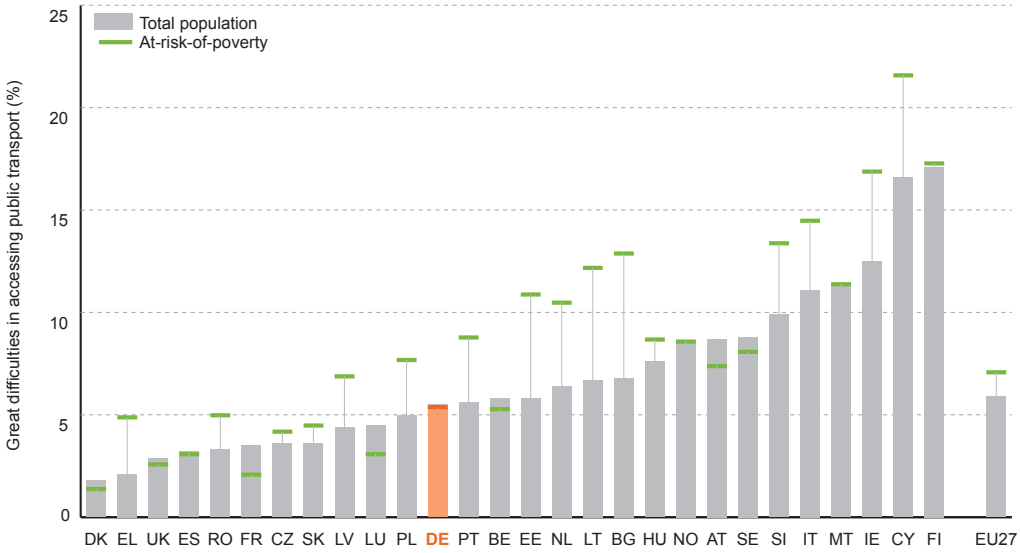
Figure 5.9: Accessibility of public transport across the EU, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Accessibility refers to physical and technical access, and opening hours.

Access to public transport is particularly relevant for low income groups, as they are less likely to afford a car and its maintenance. Public transport is thus vital for commuting, for having access to jobs, so ultimately it can help to break out of poverty. Access to public transport can be therefore regarded to be essentially linked to the problem of social exclusion, especially to the territorial aspect of it. In 12 out of 27 countries, including Germany, the population at risk of poverty does not have a relatively higher prevalence of "great difficulties" with public transport than the total population, which is rather reassuring for the social inclusion agenda (Figure 5.10). In some Mediterranean and Eastern European countries (including Greece, Italy, Cyprus, Portugal, and Bulgaria, Romania, Poland, the Baltic States and Slovenia), and also in Ireland and the Netherlands, low income groups are much more likely to experience "great difficulties" with accessing public transport.

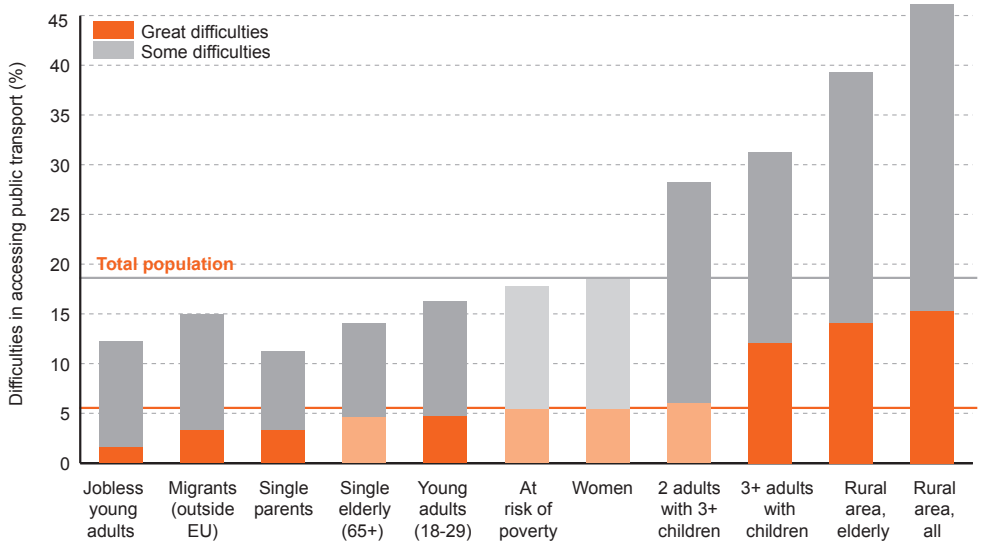
Figure 5.10: Accessibility of public transport comparing total population and those at-risk-of-poverty, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Accessibility refers to physical and technical access, and opening hours. Only persons with great difficulties included.

In Germany, people living in rural areas and also large families are likely to experience difficulties or great difficulties in accessing public transport (Figure 5.11). The relative disadvantage of larger households may be partly due to physical and technical access (e.g. using push chairs), but it may be due to the territorial distribution, i.e. that they are more likely live in the countryside. Many other social groups, however, which tend to be disadvantaged on other grounds, face access problems less than the total population: jobless young adults, migrants, single parents and single elderly (if both categories of "great" and "some" difficulties are included).

Figure 5.11: Difficulties in accessing public transport across different social groups in Germany, 2009

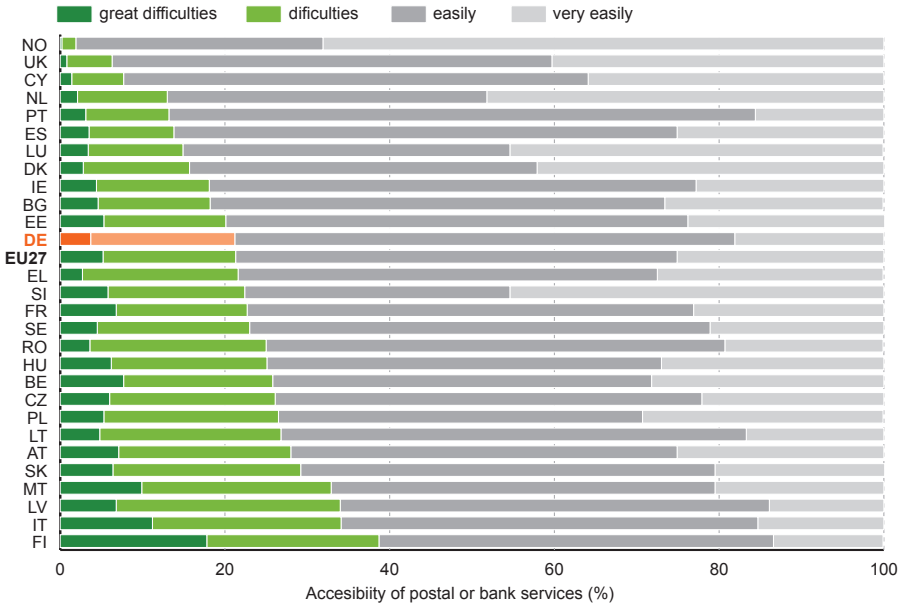


Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: see Note Figure 5.10.

Accessibility of postal or banking services

The survey questions explore the physical and technical access, and are not intended to be based on a subjective feeling. The services provided at home, including on-line banking, are taken into account, if they are actually used by the households. This indicator thus highlights not only the physical infrastructure, but also the "digital divide", the access to internet and its use for services.

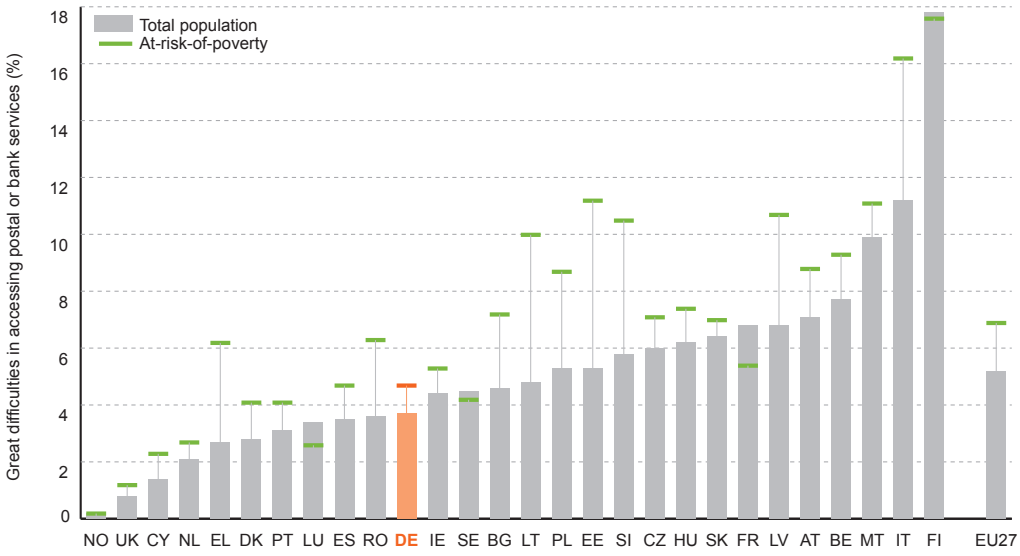
Figure 5.12: Accessibility of postal or banking services across the EU, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Accessibility refers to physical and technical access, and opening hours.

Norway, the UK and Cyprus are the least affected by difficulties in access to postal and banking services (2-8%), as shown by Figure 5.12. In contrast, in Malta, Latvia, Italy and Finland, over one in three persons is affected (33-39%). In Finland, 18% of the population says that they have "great difficulties" with access to postal and banking services (in addition, 21% reports "difficulties"), which is the highest rate across the EU. Germany, with its rate of 21%, is at the level of the EU27 average.

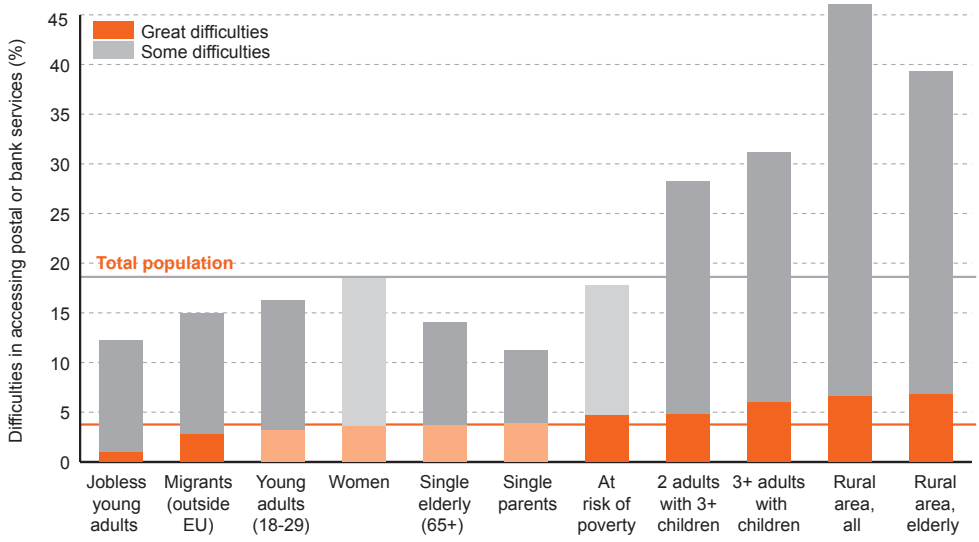
Figure 5.13: Accessibility of postal or banking services comparing total population and those at-risk-of-poverty, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Accessibility refers to physical and technical access, and opening hours. Only persons with great difficulties included.

There is some correlation with low income. People with poverty level of incomes are more likely to have great difficulties with access to postal and banking services across most countries of the EU, including Germany as well (Figure 5.13). The greatest social disparity between the poor and non-poor population prevails in Bulgaria, Estonia, Lithuania, Greece and Poland. In contrast to the general European pattern, there is no such disadvantage for low income groups in a few countries, including Norway, Luxembourg, Sweden, France and Finland.

Figure 5.14: Difficulties in accessing postal or banking services across different social groups in Germany, 2009



Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: see Note Figure 5.13.

The rural population, including the elderly living in rural areas, have the largest relative disadvantage compared to the general population, especially when we use a more general threshold of access, including both “great” and “some” difficulties. Large households, including couples with three or

more children, but also three or more adults with children, also face an above average difficulty. Interestingly, migrant status (being born outside the EU) seems to be correlated with lower than average access problems.

The chart also highlights a methodological issue, namely that the choice of the threshold for access problems critically influences the outcomes. There are certain social groups for which we can observe a statistically significant relationship, but only for one specific cut-off point, and not the other, and there are other social groups for which the other cut-off point reveals a significant relationship. The low income population has a greater prevalence of "great difficulties" with access, but there is no such pattern for the broader, joint category of "some difficulties" and "great difficulties". On the other hand, the single elderly, single parents, and jobless young adults are found to have less access problems than the general population if we consider the broader category, while no such pattern was found for the stricter definition, focusing on "great difficulties".

Conclusions

In 2009, an estimated 30 million people, 6% of the EU27 population suffered from severe housing deprivation. This is defined as living in a dwelling which is both overcrowded and has at least one fundamental quality shortage (either (1) a leaking roof or damp walls, floors, foundations or rot in window frames or floor; or (2) neither a bath, nor a shower, nor an indoor flushing; or (3) too dark). There is a major geographical divide across Europe, with highest rates of deprivation in Eastern and Southern Europe. Germany, with its rate of 2%, is one of the countries least affected by severe housing deprivation.

In 2009, 18% of the EU27 population lived in overcrowded conditions, which is an objective indicator based on the number of rooms, household size and composition. The problem is much more prevalent in Eastern European countries, with rates of 40, or even 50% (Hungary, Romania, and Latvia). The lowest percentages were recorded in Cyprus (1%) and the Netherlands (2%). In Germany, the estimated rate is 7%, which is about the same as in Luxembourg or in the UK.

The population at risk of poverty is more likely to live in overcrowded conditions or in a dwelling with quality shortfalls. In Germany, 22% of the population at risk of poverty is exposed to overcrowded conditions. Similar rates prevail in Norway, Luxembourg, Denmark, and Sweden. These rates may appear low compared to Eastern Europe, but they are relatively high in national standards, with a difference of about threefold compared to the total population. The prevalence of severe housing deprivation is close to 14% among those at risk of poverty in the EU on average, which implies a rate of over twofold compared to the total population. In Germany, 7% of those at risk of poverty suffer from severe housing deprivation.

In Germany, jobless young adults are the most disadvantaged group in terms of overcrowding (34%) and housing quality shortfalls (14%), signalling partly a life cycle effect. Single parents are also largely affected by overcrowding (25%), and by severe housing deprivation (9%). Both of these household types tend to live in dwellings rented at market price, so it is clearly related to affordability. Other social groups with above average prevalence of overcrowding and quality shortfalls include those at risk of poverty, large families (those with 3+ adults and those with 3+ children), and migrants from outside the EU. Tenants with a free accommodation or subsidized rent are more likely to experience overcrowding in Germany.

In 2008 12% of the EU27 population lived in a household that spent 40% or more of their net income (equivalised disposable income net of housing allowances) on housing. This rate varied from 3% in Cyprus and France to over 20% in Greece and Denmark. The estimate for Germany is constrained by a prevalent measurement error: the EU-SILC 2009 survey includes only a small fraction of total housing allowances (Wohngeld), thus the housing cost overburden rate is likely to be overestimated.

The population at risk of poverty is more affected in all the countries. In 13 out of 27 EU member states at least one in three persons on low incomes had housing costs in excess of 40% of their disposable income. In Sweden, the UK, Greece, and Denmark one in two persons on poverty levels of income are affected.

We compared the households' perceived financial burden related to their actual overburden. Typically, the prevalence of self-perceived housing cost overburden is much higher than that measured by the objective indicator. In Germany and Denmark, the housing cost overburden rate is rather high by European standards (24-25%), while the perceived financial burden indicator remains relatively low. These two countries have a relatively high segment of the housing market with rented homes at market prices (34% in Denmark, 39% in Germany, in contrast to the EU27 average of 17%), so for many of these tenants high rents may be a social norm.

We explored the access to public transport and postal or banking services, as assessed by the individuals themselves. The accessibility of the services is assessed in terms of physical and technical access (e.g. distance, equipment for respondents with physical disability), and opening hours, appropriate timetable, but not in terms of quality, price and similar aspects.

About one in five persons in the EU27 report difficulties with access to public transport. Denmark has the lowest barriers with access to public transport: only 6% of the population reports difficulties or great difficulties. At the other extreme are Italy, Cyprus, Malta, Latvia and Finland, where over 30% of the population finds that public transport is accessible only with difficulties (or great difficulties). We did not find a straightforward relationship between the nation's wealth, geographical size and the prevalence of difficulties in access to public transport.

Access to public transport is particularly relevant for low income groups, as they are less likely to afford a car and its maintenance, and it is vital for commuting, for having access to jobs. In 12 out of 27 countries, including Germany, the population at risk of poverty does *not* have a relatively higher prevalence of "great difficulties" with public transport than the total population, which is rather reassuring for the social inclusion agenda. In Germany, people living in rural areas and also large families are likely to experience difficulties or great difficulties in accessing public transport. Interestingly, many other social groups, which tend to be disadvantaged on other grounds, are less likely to have access problems: jobless young adults, migrants, and single parents.

Norway, the UK and Cyprus are the least affected by difficulties in access to postal and banking services (2-8%). In contrast, in Malta, Latvia, Italy and Finland, over one in three persons is affected (33-39%). Germany, with its rate of 21%, is at the level of the EU27 average.

There is some correlation with low income situation. People with poverty level of incomes are more likely to have difficulties with access to postal and banking services across most countries of the EU, including Germany as well.

6. Social isolation

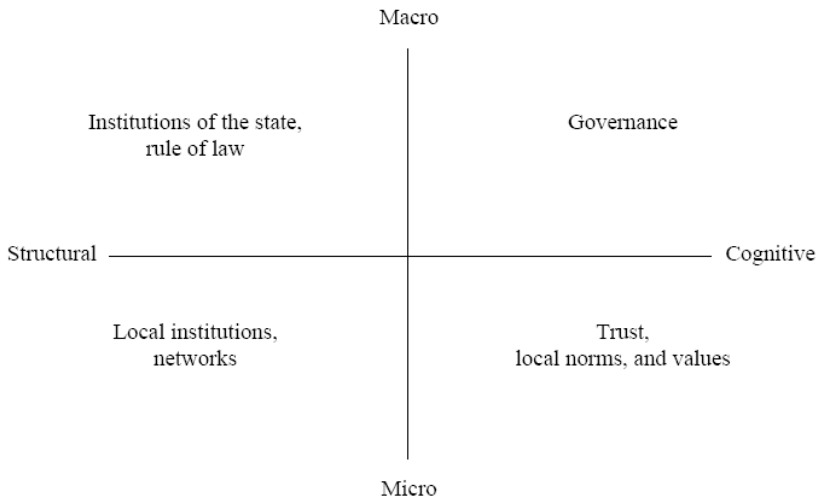
Orsolya Lelkes

Social isolation is the lack of resources, the shortfall of social capital or social participation. In order to understand in what ways it is a disadvantage, we need to understand what social capital is.

Social capital can be seen as a resource “that can be used by the actors to realize their interests”, and thus it “facilitates productive activity” (Coleman 1990, pp. 304-305). Social capital can be regarded as a goal in itself, as social relationships, and interpersonal trust proved to bring happiness to people’s lives (Helliwell 2006). Marriage has the strongest effects (both in a positive and a negative way), but friends tend to be the source of companionship, and are leisure partners (Argyle 1999). People with stronger support networks were found to live longer (ibid, p. 362). Granovetter (1973, 1983) distinguishes between “strong ties” which provide emotional support, and “weak ties” (acquaintances) which have a larger reach, and thus can be more useful with providing information or access to resources (e.g. jobs) or organizing collective action. Note, however, that social networks can also have negative effects on individuals (mafia, gangs), and can even create "epidemics" of obesity, smoking and substance abuse (Christakis and Fowler 2009).

What is social capital? There is a great variety of interpretations in the literature. A micro level concept of social capital is associated with Putnam (1993), who views social capital as social networks, “horizontal associations” between people. By including interaction between social groups, rather than just individuals, Coleman (1980) introduced a vertical component to social capital. The broadest interpretation may be attached to Olson or to Douglas North, whose view of social capital includes the macro-level social and political environment, the formalised institutional relationships, including the political regime, civil and political liberties, and the rule of law as well (see Figure 6.1 for an overview).

Figure 6.1: Dimensions of social capital



Source: Grootaert and Bastelaer (2001)

According to a 2000 OECD document "There is still no consensus, however, on which aspects of interaction and organisation merit the label of social capital, nor on how to measure it and how to determine empirically its contribution to economic growth and development." (OECD 2000, p. 43)[52]. Although many would perhaps still agree about the lack of consensus related to the concept of social capital, much has happened in recent years. The OECD itself has become actively involved in novel ways of measuring the progress of societies[53], marked by a series of events[54] and publications.

The National Accounts of Well-being, developed by the UK think tank, New Economics Foundation, which also include various measures of "supportive relationships" and "trust and belonging", also merited much attention (2009).

A recent report by the "Stiglitz Commission" (Stiglitz, Sen and Fitoussi 2009) includes "social connections and relationships" as one of the dimensions of well-being, next to material living standards (income, consumption and wealth), health, education, personal activities including work, political voice and governance and the environment (present and future conditions). The recommendations of the Report include the following:

- Shift emphasis from measuring economic production to measuring people's well-being.
- Quality of life depends on people's objective conditions and capabilities. […] In particular, substantial effort should be devoted to developing and implementing robust, reliable measures of social connections, political voice, and insecurity that can be shown to predict life satisfaction.
- Quality-of-life indicators in all the dimensions covered should assess inequalities in a comprehensive way. (ibid, pp 12-15)

The World Bank increasingly supports participatory and "bottom-up" approaches to development. The Bank measures the role of social capital in the implementation of the so-called Community Driven Development (CDD) projects, including sectors such as microfinance, youth inclusion, natural resource management, and urban development, and the impact of such CDD programmes on social capital.

This chapter provides empirical evidence on social isolation across Europe, using a variety of measures. These highlight rather extreme situations of social marginalisation. Are there distinct country clusters based on geographical location or cultural proximity? How is social isolation related to other measures of social exclusion, is there a cumulative disadvantage? Or are these phenomena mostly driven by demographic explanations, such as gender or age?

Data and measurement

The analysis is based on the European Social Survey Data (ESS)[55]. We restricted the sample to 24 countries, including EU member states and Norway. The resulting sample includes 46 000 individuals. The sample size varies between 1215 (Cyprus) and 2725 (Germany), and covers the adult population aged 15 or over. The field work was conducted in 2008 or 2009, in Germany it was between 27. 08. 2008 and 31. 01. 2009. The final sample size for Germany includes 2 751 individuals after a response rate of 48%.

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[52] For a reading list on measuring social capital, see e.g. the website of the Social Capital Gateway: http://www.socialcapitalgateway.org/NV-eng-measurement.htm

[53] For more information, see the Global Project on "Measuring the Progress of Societies" homepage: www.oecd.org/progress.

[54] The 3rd OECD World Forum is held in Busan, Korea, on the 27-30 October 2009.

[55] The ESS4-2008 Edition 4.0 was released on 2 February 2011. Norwegian Social Science Data Services, Norway - Data Archive and distributor of ESS data.

Box 6.1: Key survey questions of interest in the European Social Survey (ESS)

"Do you have anyone with whom you can discuss intimate and personal matters?"

"Intimate" implies things like sex or family matters, "personal" could include work or occupational issues as well.
Answers: 1 yes, 2 no.

→ *We use the term "no friend" for those who gave the answer "no".*

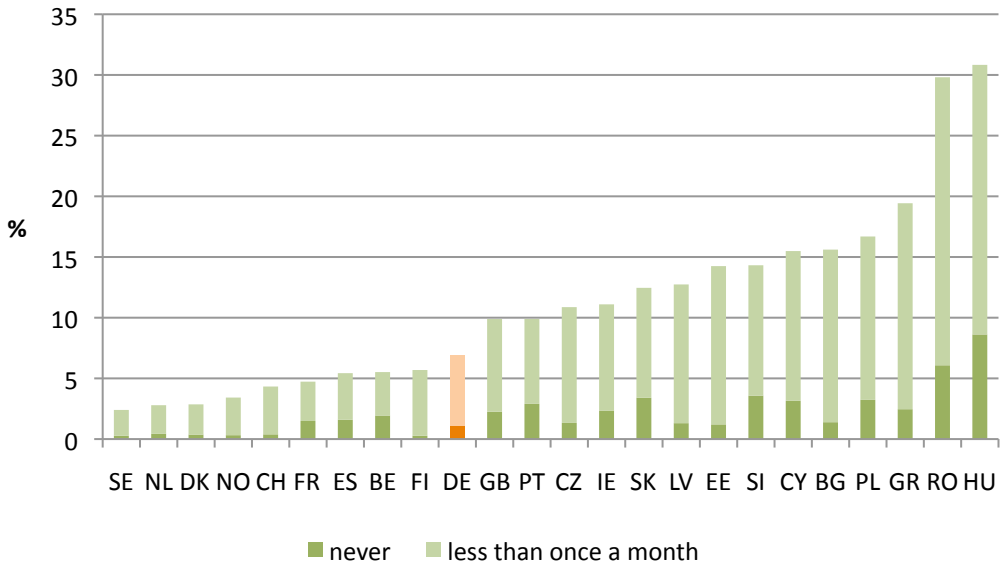
"How often do you meet socially with friends, relatives or colleagues?"

"Meet socially" implies meet by choice rather than for reasons of either work or pure duty.
Answers: 1 never, 2 less than once a month, 3 once a month, 4 several times a month, 5 once a week, 6 several times a week, 7 every day.

→ We focus on those who answered "never" or "less than once a month".

Social isolation: an overview

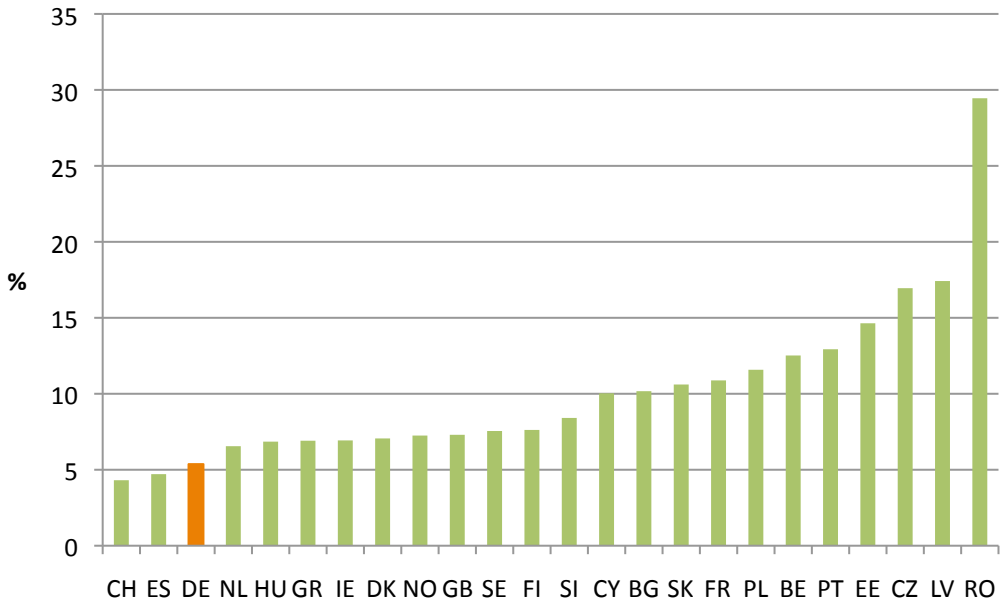
Figure 6.2: Social isolation: meeting friends, relatives or colleagues less often than once a month or never, 2008



Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0

On average about 10% of the people can be regarded socially isolated in terms of personal contacts: 2% never meets friends, relatives or colleagues, while 8% does it less often than once a month. Germany performs better with a total percent of 7%, out of which only 1% is without social contacts (the remaining 6% has social meetings less than once a month). In general, the Nordic countries, Denmark, the Netherlands, Switzerland, France and Belgium have a relatively small socially isolated population according to this measure. At the other extreme are Hungary and Romania, with an estimated figure of 30%. We checked whether these patterns of social isolation are confirmed by an alternative indicator, that of having no one to discuss personal matters with.

Figure 6.3: Social isolation: having no one to discuss personal matters with, 2008



Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0

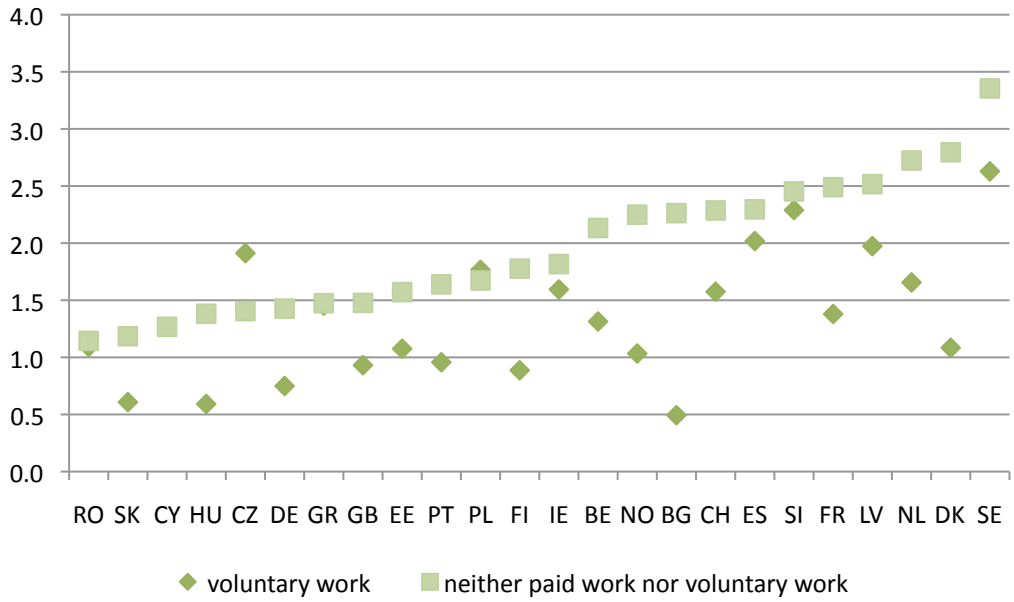
Social isolation is found to be low in Germany, according to a number of other indicators as well. Using the alternative indicator, Germany stands in the forefront of European countries together with Switzerland and Spain with the lowest level of social isolation, and the difference between these three countries is not statistically significant. In Germany, an estimated 5% of the population have no one to discuss personal matters with. Similarly, according to the EU-SILC 2006 special module on social participation, 5% of the Germans were not able to ask any relative, friend or neighbour for help (Lelkes 2010). The EU average figure is 7%, with an estimated range between 2% and 16% across countries.

Comparing the evidence on scarce social meetings and personal support (Figure 6.2 and Figure 6.3), we find the latter figures lower in a number of countries. It highlights that at times people have social meetings, but these fail to provide a personal support if needed. We do not know to what extent it is a problem of social skills, a limited ability to make and maintain such contacts, or very simply, to be able to ask for help when needed. The identified problem of social isolation, however, is a clear signal that a basic human functioning is missing.

Social isolation by social groups

In the following section, we focus on differences across social groups, and exactly these differences are highlighted on the following charts. For example, Figure 6.4 shows the ratio of those with no friends by employment activity groups compared to the total population, thus controlling for country level differences in the level of social isolation. It thus provides complementary information to that presented in Figure 6.2.

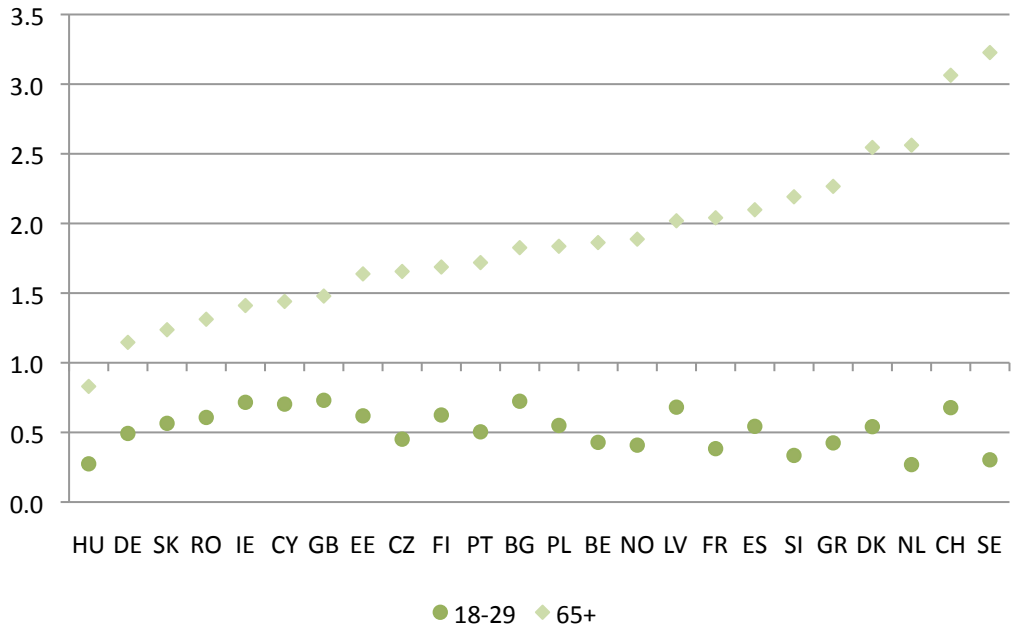
Figure 6.4: Ratio of those with no friends by employment activity compared to those in paid work, 2008



Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Notes: "No friend": having no one to discuss intimate and personal matters with
"In the last month have you done any paid or voluntary work?" If yes: "Is that paid work only, voluntary work only or both?" Answers: 1 yes - paid work only, 2 yes - voluntary work only, 3 yes - paid and voluntary work, 4 no – neither. (In the figure above, categories 1, 2 and 4 are included.)

Paid work and voluntary work tend to be good safeguards of social networks. People who reported to have done neither paid work nor voluntary work in the past month are much more likely to have no one whom they can talk to about personal matters (Figure 6.4). The results suggest that voluntary work is often at least as good protection against social isolation as paid work itself. Note that the indicator of activities used here is rather short term and refers to the last month only, so it may not adequately capture true social networks related to employment or voluntary activities. Overall, however, it seems that activity of any sort is helpful for social integration. This underlines the current European policy focus on active ageing, which highlights the importance of volunteering and other free time activities in addition to the employment of older people.

Figure 6.5: Ratio of those with no friends with by age groups compared to the "middle aged" population (aged 30-64), 2008

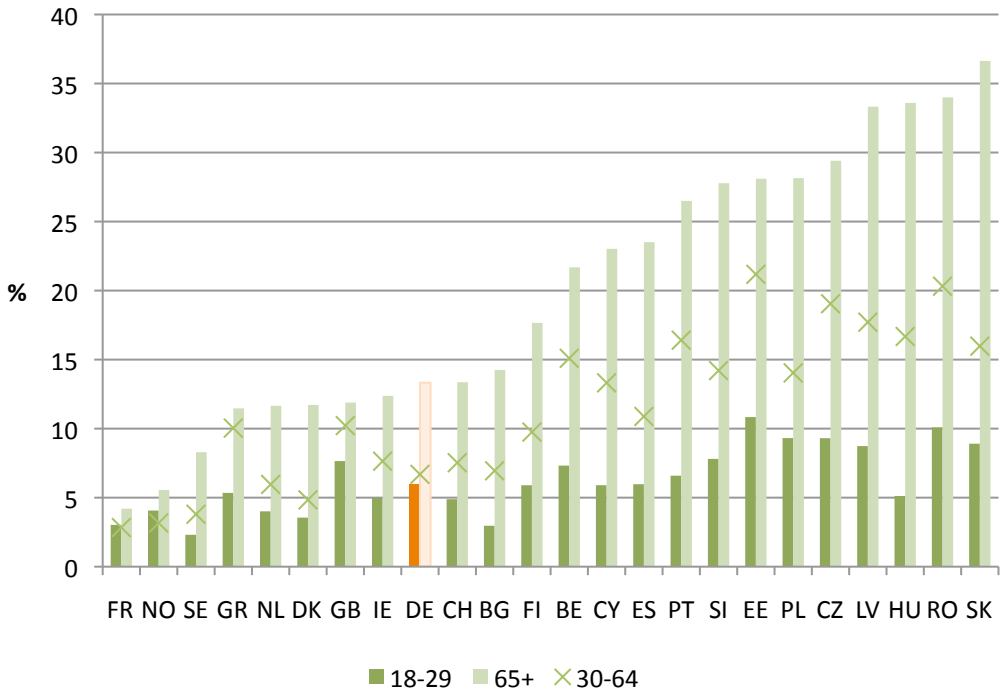


Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Note: "No friend": having no one to discuss intimate and personal matters with
Reading note: a value of the ratio of 1 means a value for a given group equal to the value for the population aged 30-64. A value superior to 1 means a percentage of those having no such person higher than the population aged 30-64.

The old age population is affected by the dissolution of friendships or the death of friends, and the growing difficulties with replacing these relationships. As a result, in the majority of the countries, over 1 in 10 persons aged 65 or more has nobody to discuss personal matters with. This number increases to over 1 in 4 in case of the Czech Republic, Latvia and Romania, indicating that a large share of the elderly is isolated. Young adults, on the other hand, tend to be more socially connected, in the overall majority of the countries much less of them say to have no such confidant than among "older" adults. In Germany, these ratios are favourable compared to other countries, with only 6% of the elderly and 3% of young adults reporting that they have no one to discuss personal matters with.

As shown by Figure 6.5, the relative disadvantage of those aged 65 or more is twice as high in many countries compared to the working age population, with the biggest age disparity in Switzerland and Sweden. In contrast, young adults have an "isolation risk" of only about of that of "middle aged" people in Hungary and Germany.

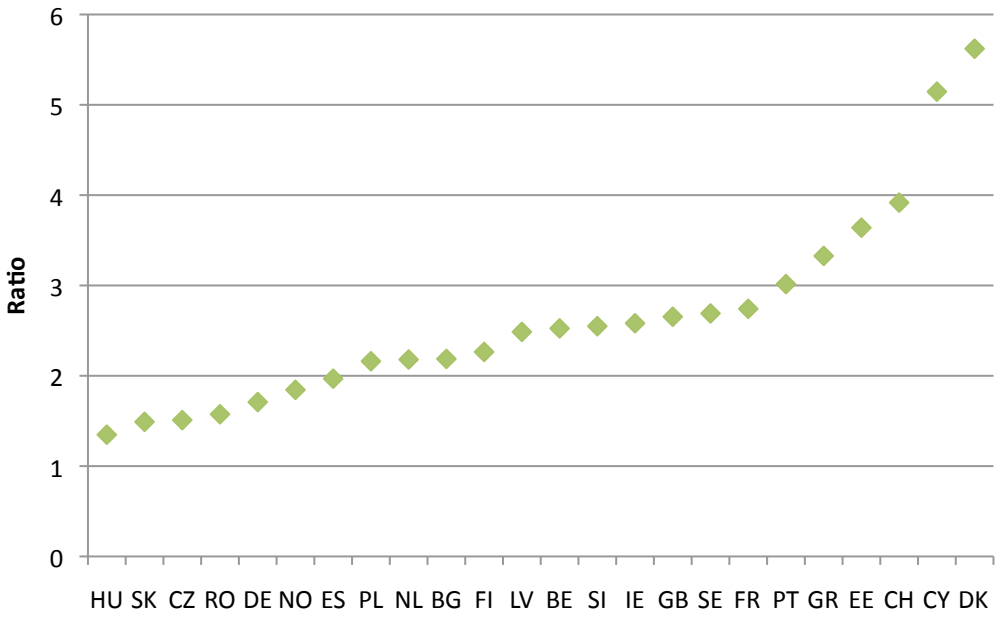
Figure 6.6: Self-assessed social isolation: respondents saying to have much less social activities than most others of the same age



Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Note: Survey question: "Compared to other people of your age, how often would you say you take part in social activities (Events/encounters with other people, by choice and for enjoyment rather than for reasons of work or duty)?" Answers: 1 Much less than most, 2 Less than most, 3 About the same, 4 More than most, 5 Much more than most.

A special survey question explored the subjective aspect of age related social isolation, by asking people on their social activities in comparison to people of their own age. We focus on the group of those who say that they take part in "much less" social activities than most people of their age group. Interestingly, self-assessed relative isolation also increases by age. The percentage of those saying that they take part in events much less than others of their age reaches 20% among those aged 65 or more in half of the European countries studied here (Figure 6.6). How is it possible? Is it increasing polarisation within this age group, with another old age subgroup becoming more active socially? No, it is not the case. Rather, it is attributable to the subjective, self-assessed nature of the indicator. Older people are much more likely to believe that they do "much less" or "less" than most other s of their age (41% altogether), while only 18% thinks that they do "more" or "much more". Thus, many older people may believe to be worse off than others of their age group, because they have very limited contact with their peers. In contrast, only few young adults tend to assess themselves to be "much less" socially active than others of their age. This is likely to be related to the value attached to social contacts in this age group, due to studying, entering the labour market or searching for a partner.

Figure 6.7: Ratio of those socially isolated (rare or no meeting) in the bottom income quintile group compared to the top quintile group, 2008

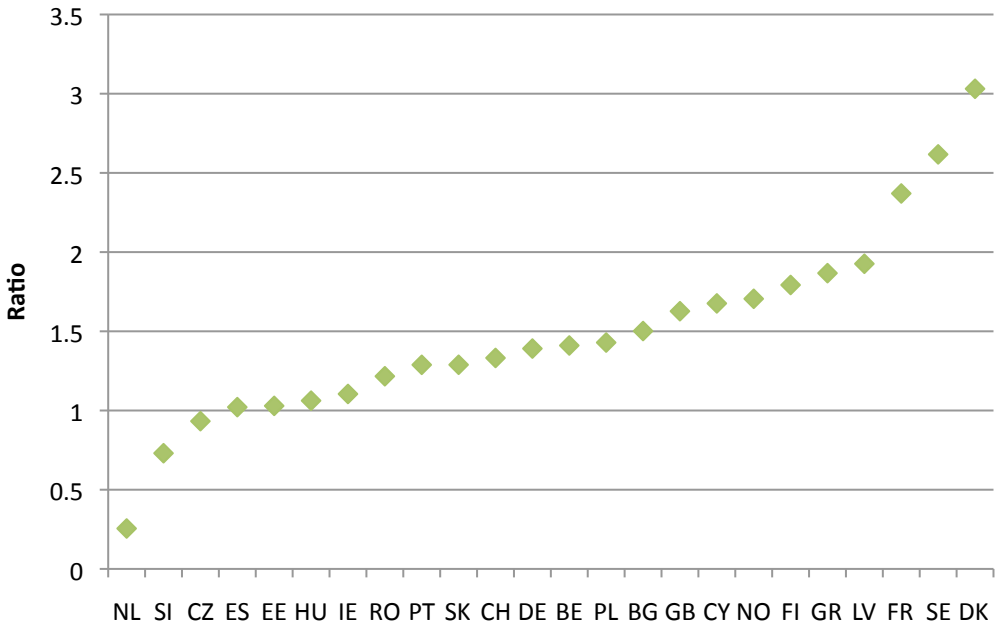


Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Note: Income quintile groups are created on the basis of total disposable household income adjusted for household size (OECD equivalence scale).

Low income groups tend to be more exposed to social isolation in all the countries. Individuals who live in households which belong to the bottom fifth of the income distribution are much more likely to have very infrequent social contacts or none at all (Figure 6.7). In Germany, the ratio is 1,7, with 8.2% of the people in the bottom income quintile group and 4.8% of people in the top income quintile group reporting to see friends or relatives less than once a month or never.

Poverty may cause social isolation, e.g. if people cannot afford going out with friends or inviting them to their homes. On the other hand, social isolation may also ultimately result poverty, as friends and acquaintances (primarily the so-called 'bridging social capital') can provide useful support in finding (good) jobs. The direction of causality is thus not clear. We know, however, that these states are not desirable, and the accumulation of social isolation and poverty signals the risk of social exclusion.

Figure 6.8: Ratio of those who are socially isolated (rare or no meeting) among people who feel discriminated against compared to those who do not, 2008



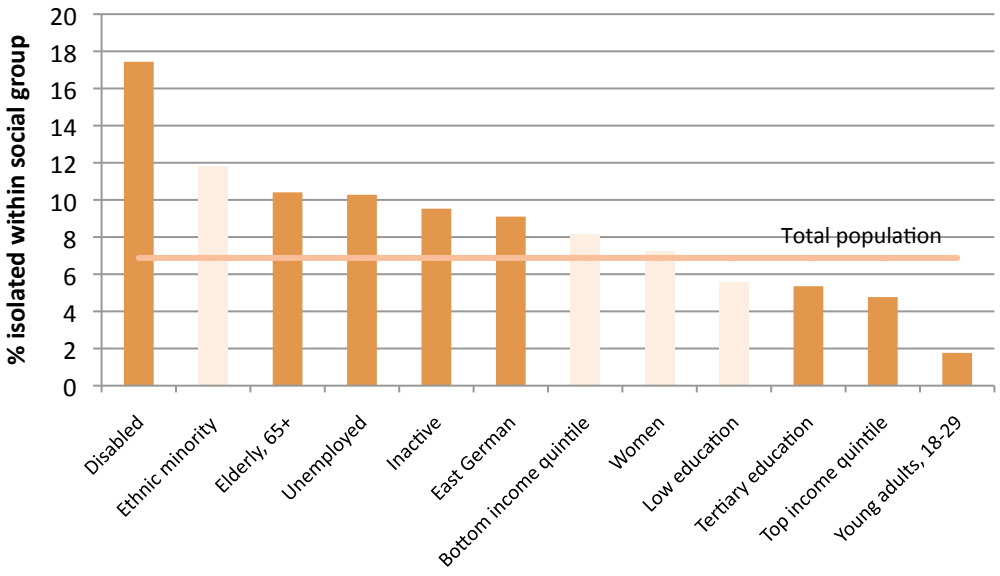
Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Note: "Would you describe yourself as being a member of a group that is discriminated against in this country?" Answers: 1 yes, 2 no.

Individuals who feel that they suffer from discrimination in their country are more likely to suffer from social isolation. We might have expected the contrary as minority groups often tend to nourish more intense contacts with group members as a sort of self defence. As we see, however, people who feel that they are discriminated against are more likely to have sporadic or no social contacts. The causality is not clear, however. Discrimination may be a cause for being cut –off. The alternative explanation is that individuals with limited social skills (hence no contact or very limited social contacts) may blame the mainstream society for their failure in order to maintain their self esteem. Both of these states, being discriminated against and lacking social contacts, however are undoubtedly undesirable.

Social isolation in Germany

Social isolation, measured as rare or no social contact, is very high among the disabled, over twice as more frequent than among the general population. 17% of those who are hampered a lot in their daily activities by disability are isolated socially. Old age, inactivity or unemployment, or living in East Germany also increases the prevalence of social isolation.

Figure 6.9: Social isolation (rare or no meeting) across specific social groups in Germany, 2008, % within group

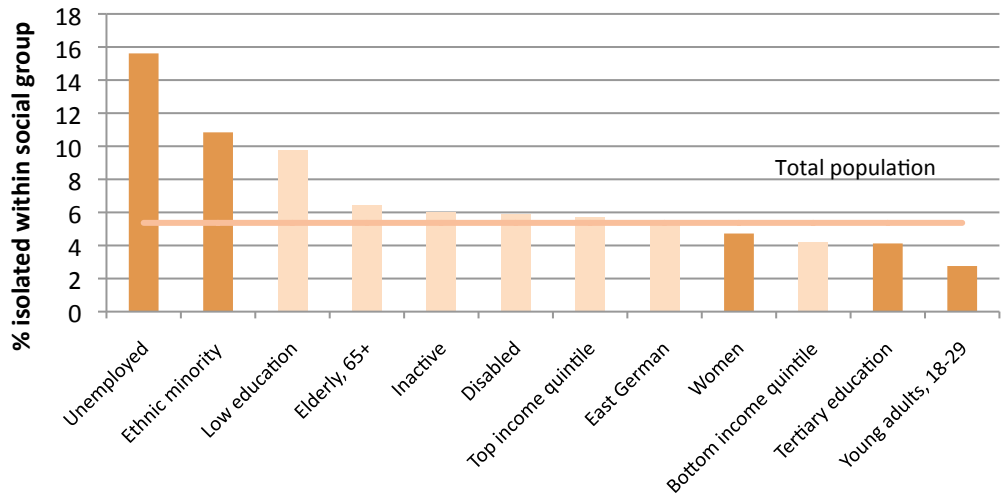


Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Notes: Bars with a lighter shading indicate that the difference between the means is not significant at 10% level.
Inactive: includes those in retirement, doing housework or those who are long term sick or disabled, and excludes those who are in full-time education.
Low education: less than lower secondary education (isced 0-1), for Germany: "Grundschule nicht beendet" or "Schule beendet ohne Abschluss einer weiterführenden Schule"
Disabled: those who say that they are hampered "a lot" in their daily activities by a longstanding illness, or disability, infirmity or mental health problem.
Ethnic minority: respondents saying that they belong to a minority ethnic group in the country.

Isolation is relatively low among young adults, the top income quintile and those with tertiary education. Young adults seem to be particularly well protected against isolation, with less than 2% affected.

For a number of social groups, we did not find a statistically significant difference: ethnic minorities, low education, low educational attainment or women. There is a particularly wide dispersion among the ethnic minority groups (the 95% confidence interval ranges from 5% to 17%).

Figure 6.10: Social isolation (no friend) across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Suvey, ESS4-2008 Edition 4.0
Notes: Bars with a lighter shading indicate that the difference between the means is not significant at 10% level.

The alternative measure of social isolation, with the share of those who have nobody with whom they could talk about personal matters, shows much less pronounced pattern across social groups. It is also evident that more people have little or no personal contacts than no close friends. Probably "personal" is the keyword here, given the increasing importance of alternative communication methods (phone, e-mail, internet platforms). Many people may have no personal contacts, but still feel connected to others. It holds particularly for the disabled, who were found to be the most disadvantaged group in terms of lack of social contacts, but they are not significantly different from the total population in terms of having no friend.

The unemployed are most exposed to social isolation, about 16% of them having no close friends. The estimates for ethnic minorities statistically significant in this case (although still with a rather wide confidence interval, 5-16%), showing that they are more likely to be isolated.

Women, young adults and those with tertiary education are much less likely to be without a friend. The ratio is the smallest among young adults, with around 3%. This confirms earlier evidence with the alternative indicator.

Conclusions

Our analysis, based on the European Social Survey with 46000 individuals, suggests that social isolation in Germany is comparatively low by international comparison. Germany, together with Switzerland and Spain, stand in the forefront of our selection of 24 European countries, with the lowest level of population being isolated. This particular indicator suggests that about 5% of the German population have no one to discuss personal matters. In about half of the countries in our sample, this ratio reaches 10%, and it peaks at 29% in Romania. Alternative indicators also suggest that Germany performs well by European standards. 7% of the population meets friends, relatives or colleagues less often than once a month or never (and only 1% "never"). Similarly, according to the EU-SILC 2006 special module on social participation, 5% of the Germans were not able to ask any relative, friend or neighbour for help (Lelkes 2010).

There are clear social patterns recurring across countries. We found that paid work and voluntary work tend to be good safeguards of social networks, as people engaged in any of these are less likely to be isolated. There is evidence of a very pronounced age pattern, affecting old age people in particular. Germany appears to be an exception here, with only 6% of the elderly reporting that they

have no one to discuss personal matters with. Low income groups tend to be more isolated across all the countries. In Germany, the ratio is 1.7 between the bottom and the top income quintile group. “Minority groups” (those who feel that they suffer from discrimination in their country) are also more likely to suffer from social isolation.

In Germany, unemployment is associated with greater social isolation, while young age and higher education is associated with lower prevalence of social isolation, according to the both alternative indicators used in our analysis. 16% of the unemployed have no close friend, and 10% of them have very rare personal contacts. Social isolation, measured in terms of limited social contact, is very high among the disabled (those who are “hampered a lot” in their daily activities), over twice as more frequent than among the general population. Old age, inactivity or living in East Germany are also associated with a higher prevalence of limited social contacts. All these differences were tested and found to be statistically significant. Interestingly, the social isolation among low income groups was not found to be significantly different from that of the total population.

In case of Germany, the accumulation of social isolation and unemployment warrants for caution. Almost one out of six unemployed claims that they have no one to discuss intimate and personal matters with. This, combined with the mental stress related to unemployment, is likely to make them more prone to psychological hardship, which may well have physical health consequences as well. All this may greatly impair their ability to re-enter the labour market or even to engage in meaningful social activities such as volunteering or home care (child care or long term care).

7. Subjective well-being: "misery"

Orsolya Lelkes

The pursuit of happiness is one of the most ancient and fundamental human concerns. Who would say that they would not want to be happy? What is happiness, however? The quest to answer this question has occupied countless philosophers and thinkers. Social science has contributed with a rather pragmatic answer to this discussion: happiness is what each person means by it, but nevertheless it is measurable by simply asking people. Using large scale surveys, first American scientists, first of all Gallup, then others (Gurin, Veroff et al. 1960; Cantril 1965; Bradburn 1969; Andrews and Witney 1976, pl. 259; Campbell, Converse et al. 1976) explored systematically the issues of life satisfaction and specific aspects of satisfaction.

There are numerous measures of the so-called subjective well-being, with an extensive contribution from psychologists. "Subjective" refers to the fact that criteria for judgement may vary from person to person, opposite to "objective" quality of life measures, where measurement is based on external standards, on observable criteria. These measures can be "affective", measuring feelings and emotions (pleasures and pains) at a given moment, or "cognitive", with retrospective assessments of quality of life as a whole, or "eudemonic", exploring the purpose in life. Large scale surveys typically assess the cognitive component of subjective well-being, asking people on their life satisfaction or happiness.

Overall assessments of well-being tend to use self-reported happiness and self-reported satisfaction with life as a whole. In these measures, people weight and assess their specific set of life circumstances and conditions. Thus, this measure also provides information on the gap between objective living conditions and people's own evaluation of these situations. This latter will also be largely affected by people's aspirations. In "happiness economics", economists use these overall measures as empirical measures of "utility", which then allows a systematic test and assessment of theoretical models, such as "how bad unemployment is", or "what are the trade-offs between inflation and unemployment", or also the exploration of policy issues such as the effects of climate on welfare and well-being, defining compensations for aircraft noise nuisance (Van Praag and Ferrer-i-Carbonell 2004).

For the sake of policy appraisals, often more detailed questions are used, such as satisfaction with particular domains of life (income, health, job, etc.) or with particular public services.

Subjective well-being indicators were shown that these measures have a high degree of validity, reliability and consistency (see e.g. the review of Diener, Suh et al. 1999). The measures are shown to correlate strongly with other methods of well-being measurement, such as reports of significant others, number of positive and negative events recalled, and clinical interviews (Sandvik, Diener et al. 1993; Kahneman and Krueger 2006). Krueger and Schkade (2008) find that the test-retest correlation of life satisfaction is lower than those typically found for income or education, but "they are probably sufficiently high to support much of the research that is currently being undertaken on subjective well-being, particularly in studies where group means are compared".

Cultural bias can affect outcomes, especially in cross-country comparison, so it is better to avoid drawing far-reaching conclusions from simple cross-country comparisons of average level of happiness. Multivariate regression techniques can control for country-specific cultural or language effects. In addition, panel data can control for time-invariant fixed individuality traits. In a more simple manner, comparing social groups compared to a country baseline level can also control for country level differences. This chapter will thus focus on disparities of well-being within countries, which may also be of more interest from a policy point of view.

Data and quantitative studies helped us a great deal to get closer to understand what makes us happy – by and large, and on average. The availability of large scale cross-national datasets with information on subjective well-being enabled social scientists, including economists, to study the systematic patterns of happiness across countries, the relationship between circumstances, institutions and self-reported well-being. Life satisfaction is found to be higher among more educated individuals and higher income people. The unemployed and individuals suffering from health problems have lower life satisfaction. The relationship between age and life satisfaction shows a U-shape, with lowest values in the middle age, when excluding the effect of income and education (Lelkes 2007). This suggests that old age can potentially be a rather satisfying period of life. Marriage and social interactions with people tend to make people happier.

This chapter will explore the situation of those at the bottom of the life satisfaction scale, and in particular, will compare social groups in selected countries. This analysis will be complemented later in chapter 11, focusing on the "happy people", those at the top of the scale. This focus on either the bottom or the top of the well-being scale is relatively rare in the empirical literature, and to our knowledge, there has not yet been a systematic comparison of the determinants of "misery" and those of "bliss".

Data and measurement

There are two variables measuring subjective well-being in the European Social Survey (ESS): life satisfaction and happiness. Life satisfaction is our key variable, which is sometimes considered to pick up less ephemeral feelings than happiness. This is measured by the following question:

"All things considered, how satisfied are you with your life as a whole nowadays"?

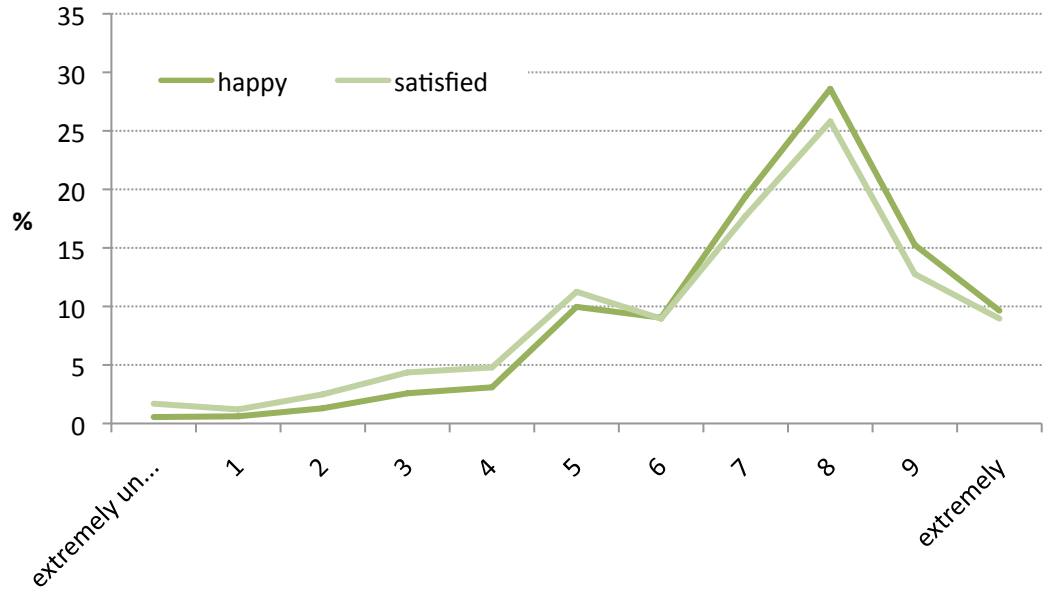
This question is answered on a scale of 0 to 10, where 0 means extremely dissatisfied and 10 means extremely satisfied.

Self-reported happiness is used as a complementary measure, for checking the robustness of the findings.

The Cantril Ladder is the currently most frequently used measure of overall life satisfaction (or that of happiness), where people are asked how they value their life between the extremes of the best possible life (10) and the worse possible life (0). What people mean when they think about these extremes is left up to them. Originally, Cantril (Cantril 1965) explicitly asked the individuals to reveal what the 'best' and the 'worst' meant, and only then requested the assessment of their current situation by actually pointing to the specific point on the ladder.

The overall distribution of life satisfaction and happiness is shown in Figure 7.1 and in Table A.13 in the Annex. There is a high correlation between the two variables (R=0,71).

Figure 7.1: Distribution of self-reported happiness and life satisfaction scores, 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0

There is, as is usual, evidence of positive skew in the distribution of life satisfaction: most people are found towards the "satisfied" end of the spectrum. The modal life satisfaction response is eight, while the mean and the median are both around seven. A non-negligible number of respondents report life satisfaction at the top and bottom ends of the scale.

Average self-reported happiness is somewhat higher than life satisfaction. The two variables have a somewhat different distribution across the population. People are more likely to claim that they are dissatisfied than that they are unhappy, and a higher share of the population regard themselves happy compared to satisfied (see Figure 7.1). The same pattern holds for the total sample and for Germany.

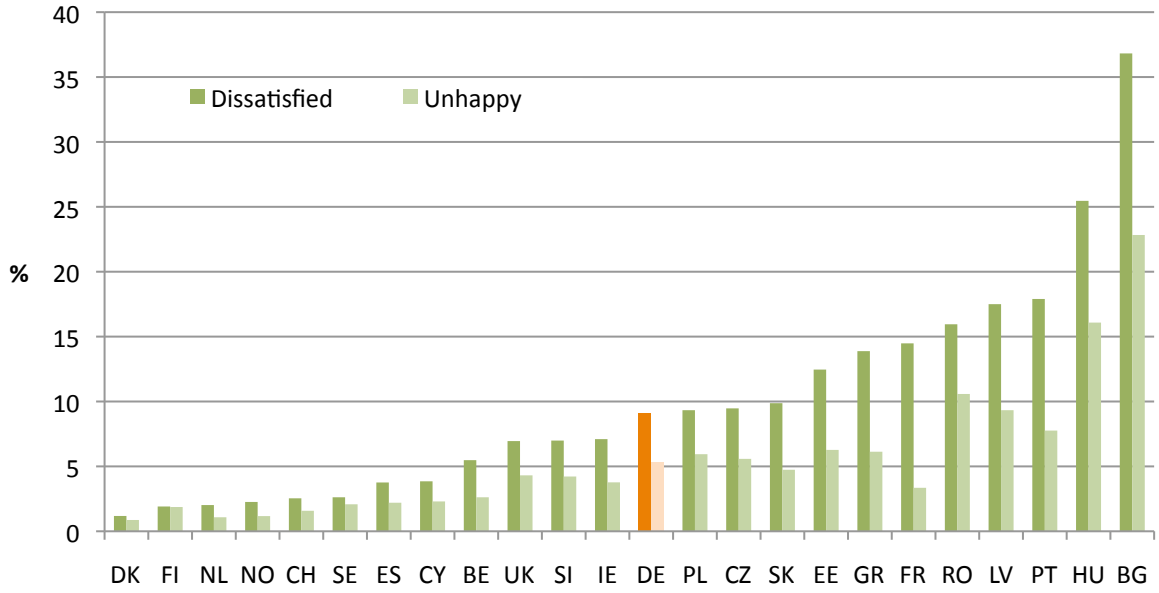
In terms of terminology, subjective well-being is a general term, with several dozen specific indicators, including self-reported life satisfaction and self-reported happiness. In this chapter, subjective well-being is at times used interchangeably with these more specific measures.

Our measure of dissatisfaction used here includes all those who rated their own life satisfaction with scores from 0 to 3 (on a scale of 0 to 10). A similar coding is used for the definition of unhappiness.

Overview across Europe

The estimated figures of low well-being range between 1% and 37% for dissatisfaction and 1% to 23% for unhappiness (Figure 7.2). Countries with the lowest share include Denmark, Finland, the Netherlands, Norway, Sweden and Switzerland. In contrast, the highest shares of unhappy or unsatisfied population are in Romania, Bulgaria, Hungary, and Latvia. As mentioned in the introduction of this chapter, these survey questions may be interpreted differently across cultures, and the phrase "happiness" or "satisfaction" can mean rather different things, so one should not rush setting up country league tables here. For example, in France and Portugal, many people say that they are dissatisfied (15% and 18%, respectively), but the share of unhappy is not high (3% and 8%). In Germany, 9% of the population can be regarded dissatisfied, while 5% is unhappy.

Figure 7.2: The "miserables" (population with low subjective well-being) across European countries, 2008, % of population



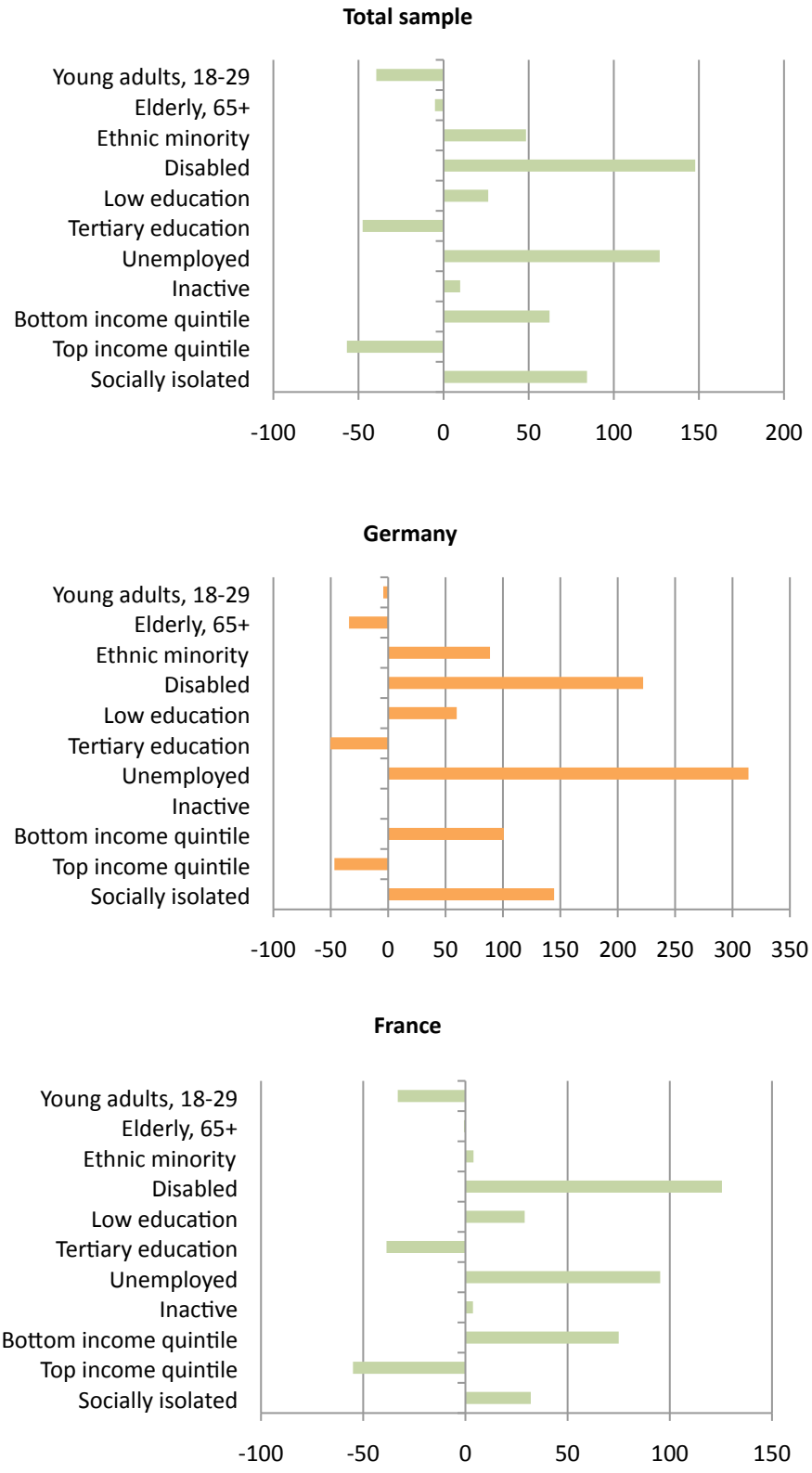
Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Dissatisfied: self-reported life satisfaction scores between 0 and 3 on a scale of 0 to 10
Unhappy: self-reported happiness scores between 0 and 3 on a scale of 0 to 10

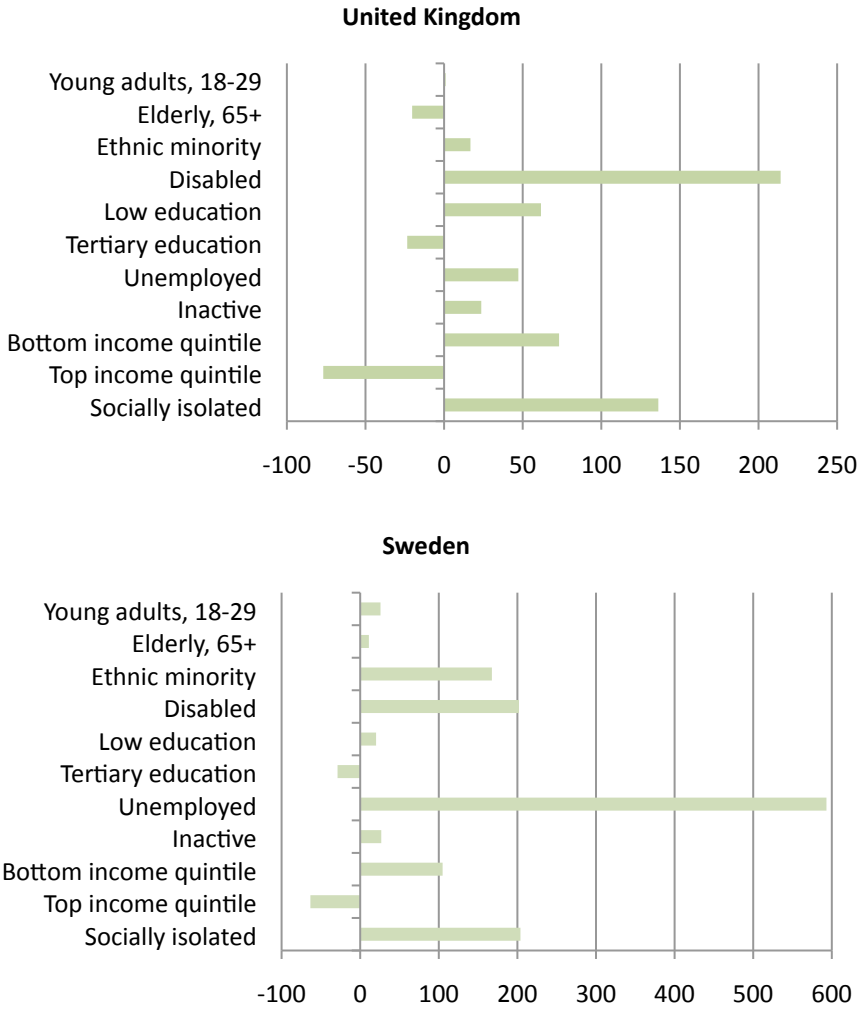
Differences across specific social groups *within* countries are expected to provide more accurate policy implications. Note, however, that the well-being differences across social groups tend to be systematic across countries: as shown by the following charts, the unemployed, the disabled, low income groups and those who are socially isolated are more likely to suffer from low subjective well-being. This general pattern also underscores the accuracy and validity of subjective well-being measures.

"Misery" across specific social groups

In the following section, we present evidence on the variation of "misery" across social groups in selected four countries, including Sweden, the UK, Germany and France. According to our calculation, Sweden and the UK have a better performance than Germany. France was chosen due to its political efforts on promoting subjective well-being and its geographical proximity to Germany. In "top" countries (such as Denmark), the number of observations for the dissatisfied tends to be low, so the detailed estimates do not bring robust results.

Figure 7.3: Dissatisfied population subgroups, compared to national (or in case of the first chart: total sample) average in selected countries, 2008, % difference





Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Dissatisfied: self-reported life satisfaction scores between 0 and 3 on a scale of 0 to 10
% difference= ((group mean-national mean)/national mean)*100
Low education: less than lower secondary education (isced 0-1), for Germany: "Grundschule nicht beendet" or "Schule beendet ohne Abschluss einer weiterführenden Schule"
Ethnic minority: respondents saying that they belong to a minority ethnic group in the country.
Disabled: those who say that they are hampered "a lot" in their daily activities by a longstanding illness, or disability, infirmity or mental health problem.
Socially isolated: respondents who say that they have no one with whom they can discuss intimate and personal matters? "Intimate" implies things like sex or family matters, "personal" could include work or occupational issues as well.
Inactive: includes those in retirement, doing housework or those who are long term sick or disabled, and excludes those who are in full-time education.
Total sample refers to 24 European countries, including those shown on Figure 7.2.

Disability, unemployment and social isolation are the three main factors associated with dissatisfaction. In addition, ethnic minorities, low income groups, or those with low education are more likely to be dissatisfied. In contrast, young adults, those with tertiary education or currently being in education and the top fifth income group have a significantly lower chance to be dissatisfied.

Age and gender does not seem to make a difference at a country level, the differences across age groups or gender groups are not statistically significant in any of our selected four countries. In the total sample of 24 European countries, however, there is a somewhat higher percentage of women who claim to be dissatisfied than men. There is also evidence that young adults are less often dissatisfied than older age groups. In France, this well-being benefit of the young adults is statistically

significant[56]. These age group differences, however, vary a great deal across countries. As said earlier, it may not be age per se which makes people miserable, but rather the circumstances and other factors associated with it.

Ethnic minority status tends to bring lower well-being. 16% of those who say that they belong to an ethnic minority are dissatisfied with their lives as a whole. Self-proclaimed ethnicity status is used here, where individuals themselves can claim to belong to an ethnic minority. 6% of the total sample claims to be an ethnic minority, with figures as high as 18% and 21% in Romania and Bulgaria. In Germany, the share is 5%. This measure may not capture all of the ethnic minorities in the country (people may not confess this if they are afraid of stigma or survey samples may not adequately include them), but given the measurement difficulties of ethnic groups in general (e.g. data protection issues, which often prohibit the collection of such ethnicity information e.g. in censuses), it is likely to provide very useful information about these social groups. Ethnic minorities appear to suffer the most in Sweden and Germany in terms of subjective well-being. The estimates for France and the UK are not statistically significant, or to put it differently, there is no evidence that the observed sample pattern prevails in the original population as well.

Educational attainment plays an important role: low education brings a "well-being penalty", while high education a "well-being bonus". While people with very low educational attainment (below lower secondary level) are more likely to be dissatisfied, those with completed tertiary education are much less likely to be so. This effect, however, is statistically significant only in the total sample of 24 European countries and in few selected countries. In France, Germany and the UK, the "bonus" effect for the highly education is most likely to prevail in the population, while in France and the UK, the "penalty" effect for those with low education is likely to be present. Note, however, that despite these measurement uncertainties (which are likely to arise from low number of observations in these categories) the size of the effect is large.

Unemployment has a large well-being cost. In the 24 European countries analysed here, 130% more unemployed have low well-being levels than the total population. The well-being cost of unemployment is particularly high in Sweden, where 600% more of the unemployed are dissatisfied (than the total population on average), or to put it differently, while 3% of the population is dissatisfied, this share reaches 18% among the unemployed. The well-being penalty of unemployed groups is also relatively high in Germany, with over 300% higher prevalence of dissatisfaction among the unemployed. The negative association between unemployment and well-being is strong and statistically significant in all the selected four countries.

The inactive are a mixed group, consisting overwhelmingly of pensioners, but also of those who are permanently sick or doing housework. There is a mild effect (showing a lower dissatisfaction among the inactive) across Europe and in the UK. The relationship between inactivity and dissatisfaction is not statistically significant in France, Germany and Sweden.

Income and happiness are related, as shown by our indicators of the relative income situation within countries. The bottom fifth income group has a much larger share of dissatisfied. In contrast, the share of those who are dissatisfied falls among the top fifth income group. In our sample of European countries, 18% of the poorest fifth are dissatisfied, while the share is only 5% among the top fifth. The very same figures hold for Germany as well. The difference is large and statistically significant in each of our four countries. Note, however, that the overall majority of the bottom quintile group is *not* dissatisfied, despite their unfavourable financial situation. This highlights the importance of other determinants of well-being.

Social isolation and dissatisfaction are strongly related. Those who said that they have nobody with whom they could discuss personal matters are more likely to be dissatisfied. This relationship is

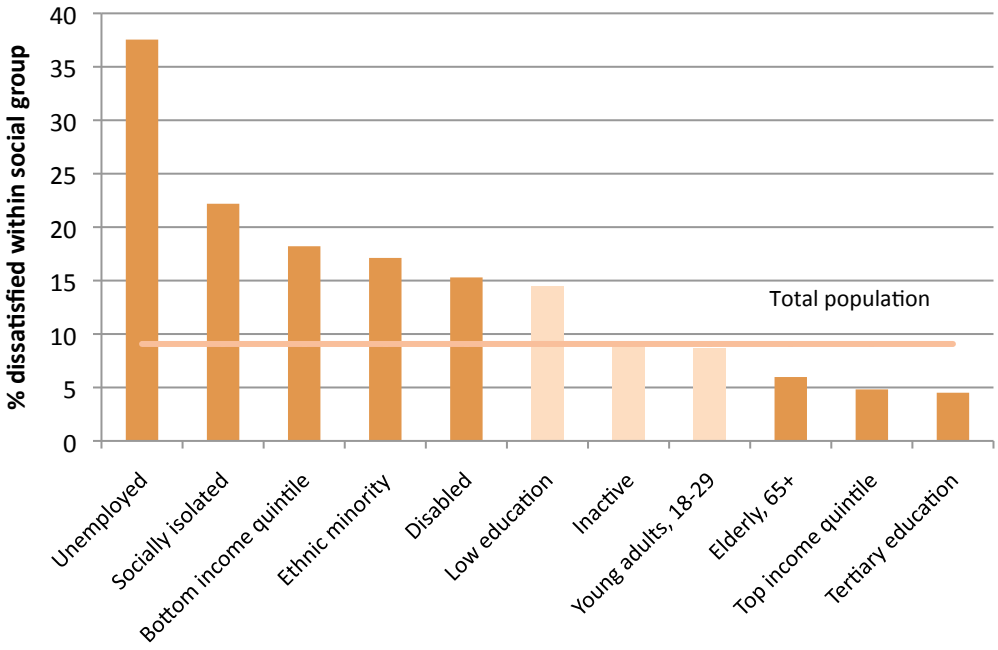
[56] At 5% confidence level.

sound and statistically significant across all four countries. The probability of being dissatisfied rises by over 80% on average among those who are socially isolated, and as a result one out of five socially isolated people are dissatisfied.

"Misery" across social groups in Germany

Focusing on Germany, we find that the unemployed, those who are socially isolated and those on low income are the most likely to be dissatisfied. Nearly four out of ten unemployed is dissatisfied with their lives as a whole (see Figure 7.4). The ratio is over one out of five among those who have no one with whom they could discuss personal matters.

Figure 7.4: Dissatisfaction across specific social groups in Germany, 2008, % within group

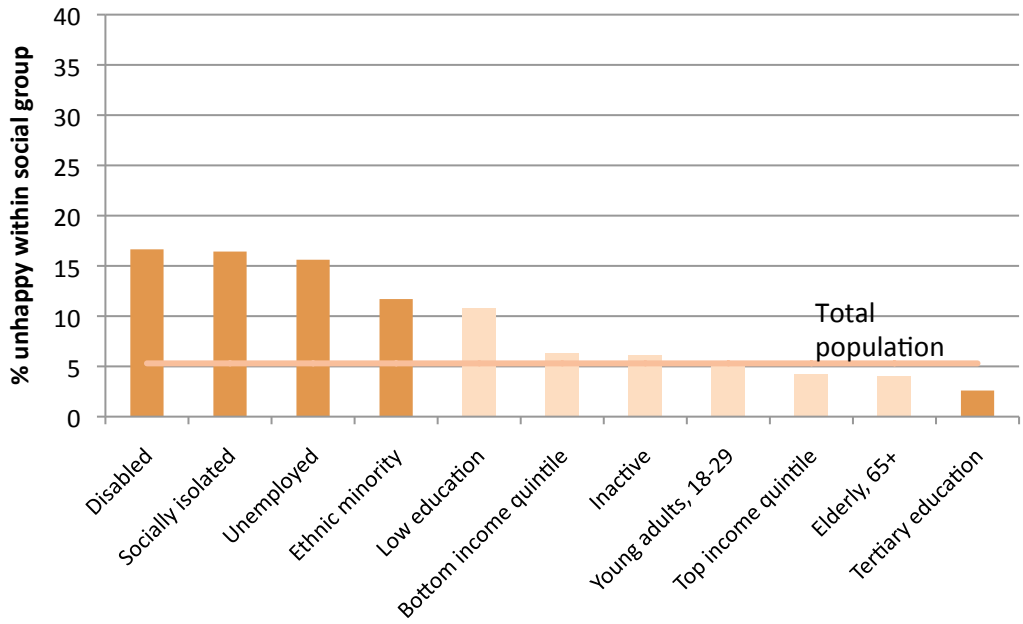


Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Bars with a lighter shading indicate that the difference between the means is not significant at 10% level. Dissatisfied: self-reported life satisfaction scores between 0 and 3 on a scale of 0 to 10. Low education variable for Germany: "Grundschule nicht beendet" or "Schule beendet ohne Abschluss einer weiterführenden Schule" (less than lower secondary education (isced 0-1))

Ethnic minority groups, the disabled and those with primary education or less are likely to suffer from very low subjective well-being.

In contrast, only less than 5% of people with tertiary education or with high incomes (top income quintile) are dissatisfied. The elderly population, aged 65 or over, are also less likely to be dissatisfied.

Figure 7.5: Unhappiness across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Bars with a lighter shading indicate that the difference between the means is not significant at 10% level. Unhappy: self-reported happiness scores between 0 and 3 on a scale of 0 to 10. Low education variable for Germany: "Grundschule nicht beendet" or "Schule beendet ohne Abschluss einer weiterführenden Schule" (less than lower secondary education (isced 0-1))

In order to test the robustness of our findings, we also used an alternative measure of subjective well-being, self-reported happiness. As expected, the share of unhappy people within these groups is much lower. This reflects the pattern shown before on Chart X, namely that people are less inclined to report low happiness scores compared to satisfaction scores. So, for example, while 38% of the German unemployed are dissatisfied, only 16% of them are unhappy.

Using an alternative measure, unhappiness, we find the same pattern for Germany: the disabled, socially isolated, unemployed the ethnic minorities are more likely to have low subjective well-being. The relationship between income groups and unhappiness becomes statistically insignificant here, just as low education or age group. Tertiary education remains the only attribute with a much lower prevalence of unhappiness than for the total population on average.

Conclusions

The described relationship of "misery" and external circumstances highlights that the generally used indicators of social exclusion, including joblessness, low income, bad health and social isolation, have a negative impact on people's subjective well-being.

Politicians cannot influence the age or gender of people, neither can they perform match-making for marriage. What they can obviously influence among the individual level determinants of happiness, is income inequality, education, employment, including the quality of employment.

The unemployment was shown to have a clear causal effect, making people unhappy. This effect on happiness is large, and it goes beyond the pure negative effect of income loss related to becoming unemployed. Policies reducing unemployment are expected to have a clear effect in raising overall well-being.

Using GSOEP data, Schwarze and Haerpfer (2007) find the average German to be inequality averse. The effect of inequality on subjective well-being differs by the income level and the political ideology of the individual (Alesina et al. 2004). Inequality "hurts" as people tend to evaluate their own situation compared to others (Clark, Frijters et al. 2008). Reducing income inequalities is thus likely to increase total societal subjective well-being . This may hold, however, only on the long run. Note, that a (most unlikely) one-off transfer of incomes from the rich to the poor, even if it was politically and socially feasible, is expected to decrease total well-being. The reason is an asymmetry: income loss hurts more than the joy related to income gains. According to Kahneman and his colleagues, people value modest income losses roughly twice as much as equal size gains (Kahneman, Knetsch et al. 1991; Rabin 1998). This "endowment" effect is one of the very typical human psychological biases: people are attached to things they already own, even in experimental settings within a very short time span (Rabin 1998).

Higher educational attainment reduces the chances of mental misery, and much of this effect comes in indirect ways: through lifestyles, including better health literacy, higher earnings. Education, however, is clearly a way of improving long term life chances and the quality of life. The current data does not allow us to state more on the relationship of subjective well-being and the specific types and methods of education. We, however, can clearly conclude that a policy focus on increasing total well-being needs to inherently include education policy measures.

The findings also highlight the importance of integrating ethnic minorities. Despite the measurement difficulties of identifying these groups, self-proclaimed ethnic minority status seems to be clearly correlated with lower subjective-well-being.

Social isolation may not be directly abolished by policy measures, given people's autonomy in leading their lives, but can be influenced. Acquiring social competences could be an inherent part of formal education and the extra-curricular activities offered by schools. Incentives provided to people for doing voluntary work, or at an institutional level, support to NGOs, voluntary associations and club can enhance social connectedness. In an old age, the structure and quality of long term care play a major role as well. The mental well-being needs to be an integral part of the objectives of these services, in addition to physical well-being.

Social contacts are clear happiness boosters. The problem is that the poor and the unemployed tend to have less of these (as shown in Chapters 6 and 10), so these groups may suffer from a circle of disadvantage. The poor suffer, because they are poor, and they suffer even more, because they have less social contacts. And because they suffer (they have low satisfaction), they are less likely to have social contacts (they are less likely to have the energy and motivation to reach out to others), which might ultimately also contribute to them staying poor (as social capital can enhance business opportunities or help with finding a good job). How to break this cycle of disadvantage? Awareness raising helps, with "personalised happiness strategies", which also respect the autonomy and preferences of individuals.

These "personalised happiness strategies" may evoke the collaboration of e.g. labour office professionals, social workers and mental health professionals. These strategies could include training and education options, providing participation in peer groups (learning, sports, volunteering), or perhaps family or personal therapy as well, as often these most personal factors stand behind the failure to succeed in society.

Why are social contacts, peer groups important? Peer groups were shown to be powerful e.g. in case of Alcoholics Anonymous (AA), not only due to the group support with helping to stay sober, but also due to the engagement of those who already broke the pattern of addiction. The volunteering work of cured alcoholics is at the core of the functioning of the AA groups. This very perspective of helping others is part of the cure, as it gives a sense of direction and meaning in addition to the well-being benefits of giving.

Action for Happiness, a Registered Charity in the UK[57], initiated a social movement, making a very intelligent use of new social media (Facebook, twitter, and also engaging people to sign up and be part of an internet community). It includes support for those who feel unwell: they offer advice for those who are depressed or suicidal in an easily accessible language, and give practical advice on the types of support available, including talking therapies, medicines, specialist care or emergencies. Such practical help in a format which creates trust, as shown in Box 7.1, can save lives. This way of intervention could also be applied as part of health prevention, but needs to find a more popular social outlet than the official website of the national health system.

Box 7.1: Practical advice to those who are "unhappy" – a UK example

Source: Actions for Happiness, http://www.actionforhappiness.org. Access date: 10 July 2011

[57] The Board includes Prof. Richard Layard, London School of Economics, Geoff Mulgan, founder of Demos and previous director of Government's Strategy Unit, Head of Policy in Prime Minister's office, and Nic Marks, the founder of the Center for Well-being at the New Economics Foundation, and others. Website: www.actionforhappiness.org

III. „At the top“ empirical analysis

Privileges may be regarded as a form of segregation as well. In addition to the social exclusion problem described earlier, the lack of social cohesion may also mean the segregation of an elite group from the majority society, in terms of either lifestyles or institutions (Barry, 2002). This phenomenon is usually referred to in relation to the United States of America and the main features of the problem are that the few using private schools, private health care system or even police type services have little interest in financing and supporting the public service provider system, at the same time they do have a very strong political interest asserting capability. Ultimately, this will then lead to a change of the role of the state, which is gradually ceasing to reflect the majority society's preferences concerning 'social solidarity'.

Methodologically, it is difficult to capture the richest by ordinary household surveys, and thus there are relatively few exploratory studies on the subject. The recent volume by Atkinson et al. uses income tax records and discusses the dramatic changes that have occurred at the top of the income scale throughout the 20th century (Atkinson and Piketty 2007).

On the other hand, there are "rich" social groups with outstanding social participation. These are people with intense social contacts or political activities. We may also include here those who report a high level of happiness. Social networks tend to provide support and information flow, and tend to bring good jobs, wives, health and happiness (Helliwell 2006). Our friends influence us, but so do the friends of our friends (Christakis and Fowler 2009).

8. Top incomes in a global perspective

Katrin Gasior, Orsolya Lelkes

Global wealth is very unequally distributed. In 2002, the richest 10 per cent of the *world population* had 120 times higher *incomes* than the poorest 10 per cent (Bergesen and Bata 2002). Moreover, the richest 0.25 per cent owns as much *wealth* as the rest of the world population (Beaverstock et al. 2004). There are significant gaps across world regions. Davies et al. (2007) provide estimates on the global distribution of household wealth.

Box 8.1: Definition of household wealth

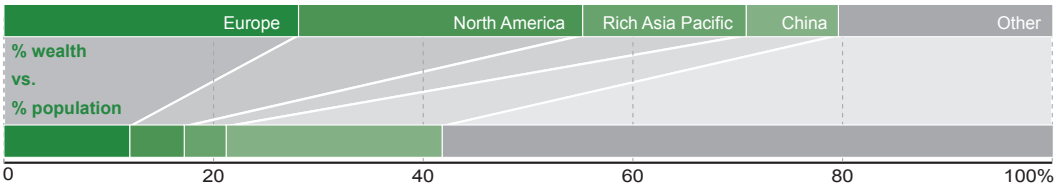
Household wealth = Financial assets + non-financial assets - liabilities

The OECD collects national household balance sheets to measure the household wealth in terms of ownership of capital. Sources and methods differ across countries, especially for non-financial assets.

Data is collected via household surveys, censuses or administrative data or in an indirect way by calculating the residuals from independent totals by deducting the estimated holdings of other sectors. Further details can be found in Davies et al. 2007.

"Rich" regions like North America and Europe together own more than 55 per cent of the global wealth but comprise of only 17 per cent of the world population (see Figure 8.1). The rich Asia-Pacific country group, including Hong Kong, the country with the highest mean wealth in the world, as well as Japan and Singapore, with 4 per cent of the world population, owns more than 16 per cent of the global wealth. On the other hand, China lags behind compared to its population share. The share of the Chinese population is 21 per cent, surpassing that of North America and Europe together, while they own just 9 per cent of the global wealth. Other parts of the world fall significantly behind: there is not much left for the remaining 58 per cent of the world population.

Figure 8.1: Share of world population vs. share of world wealth, 2000



Source: Davies, Sandström, Shorrocks and Wolff (2007).
Note: household balance sheets are used to calculate wealth.

Although the super-rich are a global minority in terms of numbers, they are of utmost social importance due to their impact on (1) overall economic growth and (2) overall income inequality, as well as due to their significance as global players (Atkinson, Piketty and Saez 2011:7 & 10). The wealth constitutes a potential tax base, although often it is exactly this social group which has a relatively small tax burden due to the high share of capital incomes (which tend to have lower tax rates then wages), their political influence and their higher international mobility.

Top 1 per cent income concentration in OECD countries

One indicator to show inequality and the situation of the super-rich is the *gross income share of the top 1 per cent* within a country. A recent landmark study by Atkinson et al. (2011), building on earlier work by Kuznets (1953), uses administrative income tax databases, combined with external data on the total population and the total income, to estimate the concentration of gross incomes within countries.

Box 8.2: Tax databases to calculate top income shares

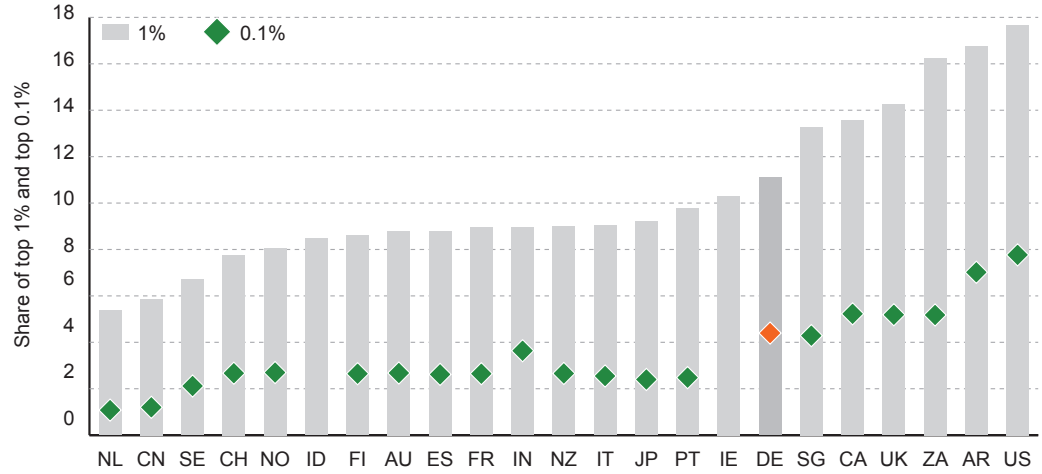
By using administrative income tax databases one can analyse the concentration of wealth rather than the rich themselves.

The definition of gross income varies across countries and over time due to different tax laws and changes in tax laws. Furthermore, capital gains are treated differently across countries and dataset require adjustments before they can be used for economic research. For more details on methodological issues see Atkinson 2007.

Figure 8.2 shows the share of the *top 1 per cent* as well as the share of the top 0.1 per cent of 23 countries all over the world. The share of the top 1 per cent ranges from 5 per cent in the Netherlands, to 11 per cent in Germany, up to more than 17 per cent in the United States. With this Germany is one of the European countries with the highest income concentration, superseded only by the United Kingdom.

The difference between the top one per cent and the top 0.1 per cent highlights the *inequality within the rich themselves*. The *top 0.1 per cent* in *Germany* owns 4 per cent of the total gross income. While a very small share of the population already owns a disproportional share of incomes, a much smaller share – the "extraordinary" rich – owns an even more disproportional share of incomes. This is not only the case in *Germany* – where almost 40 per cent of the top one per cent share of incomes actually belongs to the upper 0.1 per cent – but a global phenomenon.

Figure 8.2: Top 1 per cent vs. top 0.1 per cent share of total gross income, most recent data



Source: Alvaredo et al., The World Top Incomes Database[58].
Note: Income tax database used, capital gains excluded where possible.
Most recent refers to 2009 in Sweden; 2008 in the United States; 2007 in South Africa; 2006 in Norway and France; 2005 in Spain, New Zealand, Portugal and the United Kingdom; 2004 in Indonesia, Finland, Italy and Argentinia; 2003 in Canada;

[58] http://g-mond.parisschoolofeconomics.eu/topincomes, access date: 24/05/2011.

20002 in Australia; 2000 in Ireland and Canada; 1999 in the Netherlands, India and Japan; 1998 in Germany and 1995 in Switzerland.

The tax data used for these calculations is administrative data that includes *only taxpayers*, which are just a part of the population. This limits comparisons between the super rich and the total population. In addition, tax avoidance and tax evasion is an issue as well. Beside its limitations, *income tax data* seems to be a good alternative to *household survey data*, which often leads to dissatisfying results when it comes to the income situation of the super rich.

An alternative study, based on the German Socio-Economic Panel Study (SOEP), finds a higher income concentration in Germany: the richest one per cent owns 20 per cent of the total income in *Germany* (Grabka & Frick 2007: 668).

Box 8.3: German Socio-Economic Panel Study (SOEP)

The SOEP collects representative data for the population aged 17 and older, living in private households. Capital includes:

- real estate property
- financial assets
- assets from private insurances
- business assets
- tangible assets (only valuables such as gold, jewellery, mintage or object of art) and
- debts.

Source: used by Grabka et al. 2007 and 2008, as well as in Harmann 2009.

The super-rich are usually underrepresented in surveys but the SOEP takes that into account by including a sub-sample of wealthy households. The SOEP uses a broader definition of income, which covers real estate property, financial assets, assets from private insurances, business assets and tangible assets such as gold, jewellery mintage and object of art, and debts. Depending on the definition of income and data source, the estimated extent of income concentration can be very different. This comes as no surprise, given the measurement difficulties and data constraints. A comparison of aggregated SOEP data and the German “Vermögensstatistik” shows that most of the results are very similar. Nevertheless, financial assets are highly underrepresented and only 50 per cent is captured. Grabka and Frick (2007) point to the different components of capital captured that partly lead to the differences.

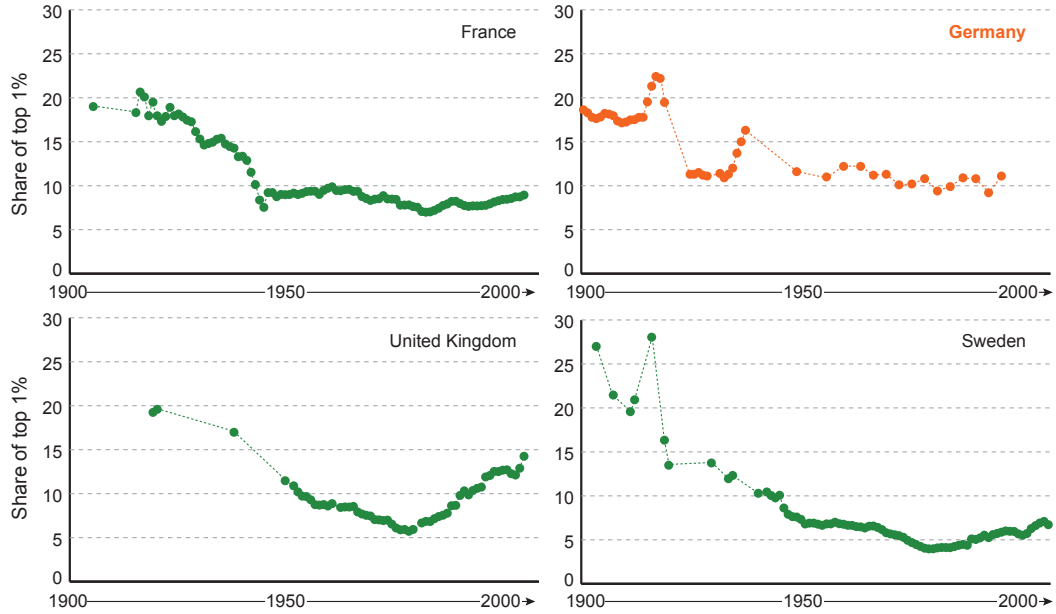
How much money does one need to be among the rich, to be among the upper one per cent? According to Davies et al. (2008: 7), an adult needs a minimum wealth of $2,138, which is the value of financial assets and non-financial assets less liabilities, to be among the wealthiest 50 per cent of the world, $61,000 to be part of the top 10 per cent and $510,000 to be among the top 1 per cent. Even though these numbers refer to the year 2000 and should be somewhat higher today, the amounts are surprisingly low in Western European standards.

Nevertheless, membership of the super-rich club is relatively exclusive. In 2000, 8 per cent of the wealthiest 10 per cent of the world were *Germans*, followed by 7 per cent Italians, 6 per cent British and 4 per cent French (Davies et al. 2008: 15). The German share is only overruled by the United States (25 per cent) and Japan (20 per cent). By definition, this share is influenced not only by the wealth per capita, but also by the size of population, and the level of inequality in a country.

Long-term trends in top income shares

Perhaps surprisingly, Atkinson, Piketty and Saez (2011) find that most countries have experienced rather modest increase in top income shares since World War II following a sharp decrease in the top 1 per cent income share in the first half of the 20th century. The analysis is based on administrative income tax data, as mentioned before. The authors identify four country clusters based on the geographic and cultural similarities in the evolution of top income shares. The evolution in *Western English speaking countries* (United States, Canada, United Kingdom, Ireland, Australia and New Zealand) displays a U-shape with a relatively steep decrease in the annual top 1 per cent share from 1910 till 1950 in most countries, a relatively flat decrease in the following decades with the lowest share in 1970/1980 and a relatively steep rise afterwards. As shown by Figure 8.3 the share of the top 1 per cent in the United Kingdom was more than 19 per cent in 1918 and decreased till it reached its lowest point in 1978 (6%). Since then it has risen continuously, comprising a share of 18 per cent in 2008.

Figure 8.3: Share of top 1 per cent over time in four selected countries: France, *Germany*, United Kingdom and Sweden, 1900 – 2000 (2009)



Source: Alvaredo et al., The World Top Incomes Database.

The second group consists of *Middle European countries* (France, Germany, Switzerland and the Netherlands) as well as Japan. In comparison to the Western English speaking countries, the evolution of top income share follows an L-shape, starting with a relatively high share in the beginning of the 20th century, followed by a relatively steep decrease till the post-war period and since then relatively stable shares. Germany had a top income share of almost 20 per cent in 1900. After a short period of increase, shares went down to 11 per cent during post war period and stayed rather stable between nine and 11 per cent since then most recent year for Germany in the database is 1998).

The evolution within the *third group (Sweden, Finland, Norway as well as Spain, Portugal and Italy)* and the *fourth group (developing countries)* is quite similar but developing countries are more heterogenic than the North and South of Europe. Nevertheless, both groups show an evolution in top income shares that is a mixture of a U- and L-shape where the first decades of the 20th century are much more pronounced than the last (see for example Sweden in Figure 8.3).

Focusing on the period after World War II, the figures show that dispersion has increased. In 1949 eleven out of seventeen countries had a top 1 per cent share between 8 and 12 per cent, three countries - Sweden, Finland and Japan – were just below eight per cent and the Netherlands and Ireland had been slightly above 12 per cent (Atkinson, Piketty and Saez 2011). Argentina is an outlier with the highest share of more than 19 per cent. Taking into account possible errors of margin, there has been little difference in the top 1 per cent share across countries around 1949. Around the year 2005, only eight out of seventeen countries have a top 1 per cent share between 8 and 12 per cent. Two countries are new members of the „8-12 per cent club": Japan, where the share has increased to 9%, and Ireland, where it has decreased to 10% these. On the contrary, other countries have lost their membership due to a decrease (Switzerland and the Netherlands) or an increase (Singapore, Canada and the United States) in their top income group shares. Although shares are still high in Argentina, the United States have taken over the position of the country with the highest share (17%). *Germany* remained rather stable, comprising a slight decrease from 11.6 to 11.1 per cent, which is not likely to be statistically significant. Note however, that income tax data is only available till 1998 for Germany.

Based on a different data source and definition, recent figures show an upward trend over the last two decades in Germany. According to SOEP data, the number of Germans with incomes of 200 per cent of the median or more[59] has increased about one third, from 5.3 per cent in 1986 to 6.4 per cent in 1996 up to a share of 9.2 per cent in 2006 (Grabka & Frick 2008: 103).

Changing income composition: formerly inheritance, now work and investment

While capital income made up the biggest part of wealth in the first half of the 20th century, now it increasingly comes from work and investment. Before 1949, the fall in the top income share was a "capital phenomenon", and upper income groups below the top percentile lost relatively less during the crisis. In the second half of the 20th century, top income shares show an increasing trend. The gains now mostly stem from labour income (Atkinson, Piketty and Saez 2011: 5). Different from earlier times, wealth today arises more and more from work and investment and less from inheritance. The so-called "global bourgeois" (Wolff 1996) invests in real estate, financial securities and/or at the stock market. The role of inheritance decreased from 32 per cent in 1984 to 13.5 per cent in 2003, according to the Forbes list (Beaverstock et al. 2004). Simultaneously, markets such as software, finance, publishing and media, accounted for 45 per cent of wealth creation in 2001 (ibid.). While the income structure remained rather stable in 1984-2000 in *Germany*, it has changed remarkably recently. Due to the increasing importance of income from investment and self-employment, a high number of middle-income group members moved up to the high-income elites (Grabka & Frick 2008: 104).

Nevertheless, the rich are far from being a homogenous group. Imbusch (2009) differentiates four groups of the rich, based on the role of capital and income. The first type is the "old rich" (Alter Reichtum), where wealth is passed on across generations and exists for a long time in history. This category consists of very old dynasties of families that do not even have to work and can live from purely financial gains on inherited capital. Capital incomes play an important role in this group, while income from work is insignificant. The second group is called "working rich" (Arbeitende Reiche), where wealth is – at least to some parts - achieved through own efforts. The working rich ranges from simple income millionaires to capital millionaires. Thus, inherited capital still plays a prominent role. The third and fourth group are somehow the outsiders of the "rich community". First of all, the

[59] Only persons living in private home included, 200 per cent of the median refers to the household net income of the previous year.

typical “typical new rich” (typische Neureiche), the so-called self-made millionaires that have accumulated wealth but their habitus and life style has often not adapted to their relatively new position in society. The fourth group are the “success rich” (Erfolg-Reiche) such as top athletes and celebrities.

In conclusion, the typology once more points to the heterogeneity of the rich. Frank (2007) summarizes the situation of the rich as the following: The rich…

> *“…formed their own virtual country … and with their huge numbers, they had built a self-contained world unto themselves, complete with their own health-care system (concierge doctors), travel networks (Netjets, destination clubs), separate economy (double-digit income gains and double-digit inflation), and language (“Who's your household manager?”) … The rich weren't just getting richer, they were becoming financial foreigners, creating their own country within a country, their own society within society, and their economy within an economy” (Frank 2007: 3).*

The rich often have homes in different places, park their wealth in tax-friendly countries or may invest their money all over the world and therefore rather live in “Richi$tan”, how Frank calls this virtual country, than in their country of residence. This higher geographical mobility of the rich makes it more difficult to measure their wealth or to impose taxes on it.

Frank furthermore points out, that the rich are not just privileged in financial terms but also in other aspects of live. In later sections of the report we will explore privileged social positions in other aspects of live, including access to health care.

Conclusions

Global wealth is very unequally distributed. In 2002, the richest 10 per cent of the *world population* had 120 times higher *incomes* than the poorest 10 per cent. Moreover, the richest 0.25 per cent owns as much *wealth* as the rest of the world population.

Germany is found to be one of the European countries with the highest income concentration, superseded only by the United Kingdom (out of the 23 countries analysed). According to a recent study by Atkinson et al. (2011), analysing the concentration of gross incomes within countries, the share of the *top 1 per cent* ranges from 5 per cent in the Netherlands, to 11 per cent in Germany, up to more than 17 per cent in the United States. The difference between the top one per cent and the top 0.1 per cent highlights the *inequality within the rich themselves*. The *top 0.1 per cent* in *Germany* owns 4 per cent of the total gross income.

An alternative study, based on the German Socio-Economic Panel Study (SOEP), finds a higher income concentration in Germany: the richest one per cent owns 20 per cent of the total income in *Germany* (Grabka & Frick 2007: 668). The SOEP uses a broader definition of income, which covers real estate property, financial assets, business assets and tangible assets as well.

Exploring long term trends in top income shares, Atkinson, Piketty and Saez (2011) find that most countries have experienced rather modest increase since World War II following a sharp decrease in the first half of the 20th century. The authors identify four country clusters based on the geographic and cultural similarities in the evolution of top income shares.

Germany belongs to the second group of *Middle European countries* (together with France, Switzerland and the Netherlands) as well as Japan. In comparison to the Western English speaking countries, the evolution of top income share follows an L-shape, starting with a relatively high share in the beginning of the 20th century, followed by a relatively steep decrease till the post-war period and since then relatively stable shares. Germany had a top income share of almost 20 per cent in 1900. After a short period of increase, shares went down to 11 per cent during post war period and

stayed rather stable between nine and 11 per cent since then (most recent year for Germany in the database is 1998).

Long term trends suggest a restructuring of incomes, with the rising importance of income from work and investment compared to inherited capital. While the income structure remained rather stable in 1984-2000 in Germany, it has changed remarkably recently: the share of capital incomes and self-employment incomes has risen. This resulted in an upward income mobility among middle-income groups, who moved up to the high-income elites.

9. Health: privileges in access to health care

Ulrike Waginger

Better educational opportunities and better income, mostly combined with better housing and overall life situation as well, can be regarded as privileges which are also key factors for health outcomes.

People of high socio-economic groups presumably have experienced a good health education already in early life and tend to be surrounded by peers whose attitudes support a healthier life style. This may include more physical activity and weight consciousness, less tobacco and alcohol abuse and more preventive health measures taken and possibly lead to better health in general. People from higher socio-economic groups also tend to have the skills to understand how to access health care services as well as the financial resources to bypass public service shortfalls by making use of private services.

Chapter 4 explored the relationship between health and income, showing clear disadvantages for those in lower income groups. However, material wealth is not the only determinant of health. Educational attainment may play an even greater role for health outcomes. Higher educational level may lead to higher income, but education as such has also a direct influence on health. This chapter will examine the relationship between educational attainment and health outcomes, focusing on the highest socio-economic groups. It will further investigate access barriers to health services faced by those at the top.

Is better education leading to advantages in health?

In order to demonstrate the relationship between education and health the following sections will evaluate the situation of people with higher educational level in comparison to less educated groups. First, the subjective health in general will be analysed, followed by details on limitations of daily activities and chronic disease.

Table 9.1: Self-perceived general health[60] by educational attainment, EU-27, 2009 (% of respondents)

	Very good	Good	Fair	Bad	Very bad
By gender					
Females	21,2	44,1	24,2	8,4	2,1
Males	25,4	45,9	20,6	6,5	1,6
By age group					
16-24	49,3	43,7	5,8	0,9	0,3
25-34	36,8	51,7	9,1	1,9	0,4
35-44	27,1	53,7	15,1	3,4	0,7
45-54	17,3	51,0	24,0	6,4	1,3
55-64	11,5	42,5	33,1	10,7	2,2
65-74	7,0	34,2	40,6	14,6	3,6
75-84	4,5	23,4	42,3	22,8	7,1

[60] The data on self-perceived health refer to the auto-evaluation of the general health state (i.e. any temporary health problem is not considered) by respondents using a scale from "very good" to "very bad" (Eurostat Metadata 2011).

85+	4,2	21,1	38,4	26,2	10,1
By educational attainment (ISCED 1997)[61]					
Level 0: Pre-primary education	5,8	21,2	35,2	28,6	9,2
Level 1: Primary education or first stage of basic education	8,2	32,0	37,4	17,6	4,9
Level 2: Lower secondary or second stage of basic education	21,0	44,0	24,6	8,2	2,1
Level 3: Upper secondary education	24,1	48,1	20,9	5,7	1,2
Level 4: Post-secondary non-tertiary education	26,3	49,0	18,8	4,8	1,1
Level 5: First stage of tertiary education (not leading directly to an advanced research qualification)	31,7	50,1	14,7	3,0	0,6
Level 6: Second stage of tertiary education leading to an advanced research qualification	39,4	46,6	11,0	2,6	0,4
Total	**23,2**	**44,9**	**22,5**	**7,5**	**1,9**

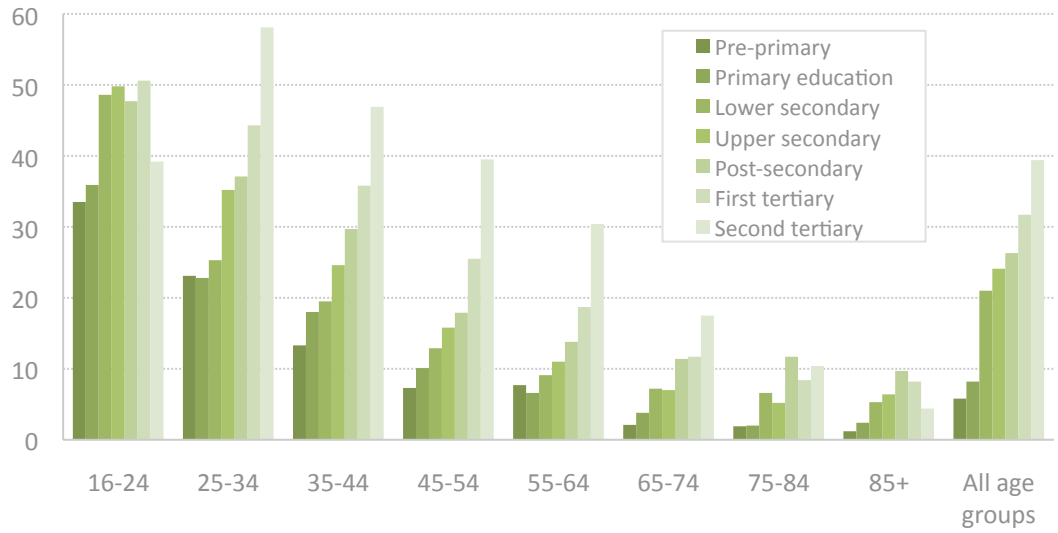
Source: EU-SILC 2009 (hlth_silc_02) - version from 25 July 2011; accessed 28 July 2011.

Chapter 4 already showed the clear relationship between income and health. However, health is not only influenced by the amount people make for a living, it may be even influenced further by their educational attainment level. Higher education presumably leads to better income, but also has by itself an effect on health (Fonseca 2011). Furthermore, people from low income groups who could achieve a certain level of education are still more likely to report better health than those of lower education levels (German Federal Government 2010:102).

Thus, differences in educational attainment are expected to lead to different health outcomes. The way people judge their health in general (which was shown to correlate well with their actual health status; Siegrist 2006), correlates strongly with their educational achievements. As shown by Table 9.1, there is a striking relationship between educational attainment and health outcomes. People with higher educational levels were much more likely to consider themselves in very good health compared to less educated groups. Only 5.8% of those of pre-primary education level perceived their health as “very good” compared to 39.4% of those in the highest education group (second stage of tertiary education).

[61] Educational attainment was graded according to the *International Standard Classification of Education* (ISCED-97 classification) in the version of 1997; (Eurostat Metadata 2011).

Figure 9.1: Self-perceived general health by educational attainment (ISCED 1997 classification), EU-27, 2009 (% respondents in very good health)

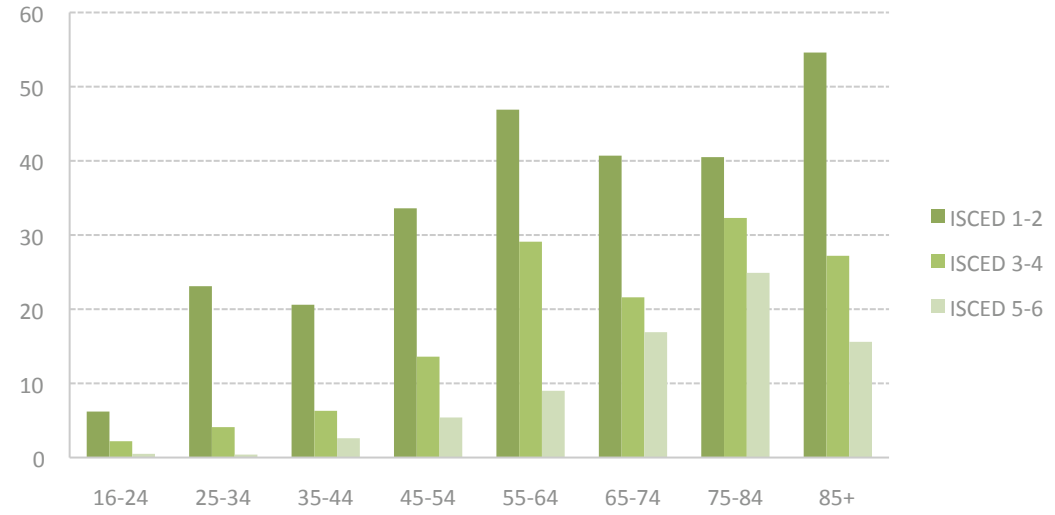


Source: EU-SILC 2009 (hlth_silc_02) - version from 25 July 2011; accessed 28 July 2011.

The almost linear relationship between the level of education attained and the health status perceived becomes even clearer when examining data by age group. In almost all age groups, people of higher educational status benefit from significantly higher rates of very good health than those of lower attainment levels. Differences in health outcome between groups of different educational background were extremely large for people of working age: those with higher education reporting up to 5-fold better health than those with lowest education. For the youngest age group, with people from 16 to 24 years, the group of second tertiary education was not the one experiencing the highest levels of very good health. A possible explanation is that these young adults were in the midst of their education or have at best just ended their attainment level. Second tertiary education was not highest for those aged 85 and over either.

Gender differences were small (compared to the differences by educational level) with women expressing lower levels of general health in all groups.

Figure 9.2: Self-perceived general health by educational attainment and age group, Germany, 2009 (% respondents in bad or very bad health)



Source: EU-SILC 2009 (hlth_silc_02) - version from 25 July 2011; accessed 17 September 2011.

With respect to Germany, the relationship between educational attainment and subjective health by age groups (see Figure 9.2) is similar to the results for EU-27 countries in total. There is a clear disadvantage for lower education groups in comparison to higher education groups. In all age groups those with higher educational attainment reported lower levels of poor health than those with lower education level.

Strikingly, those with highest education levels (ISCED 5-6, i.e. with tertiary education) of the age group 65-74 experienced lower levels of bad or very bad health than younger individuals (between 25 and 44) belonging to lower education groups. As already seen in Figure 9.1, any higher level of education reduced the perception of poor health clearly. Overall, reaching a certain level of education (supposedly at least secondary education level) made a clear difference for health outcome.

Effects of education on health are also direct, as people belonging to groups of higher education also tend to have a healthier life-style and better access to health services. Fonseca and Zheng (2011), for instance, found causal evidence that more years of education led to a lower probability of reporting poor health.

Improved education thus may be a crucial way of tackling health inequalities, and the improvement of education may have an even stronger impact on people's health outcome than health care policy measures as such. It is therefore crucial to include non-health related policies into overall strategies for diminishing health inequalities.

Prevalence of limitations in daily activities and long-standing illness among the privileged

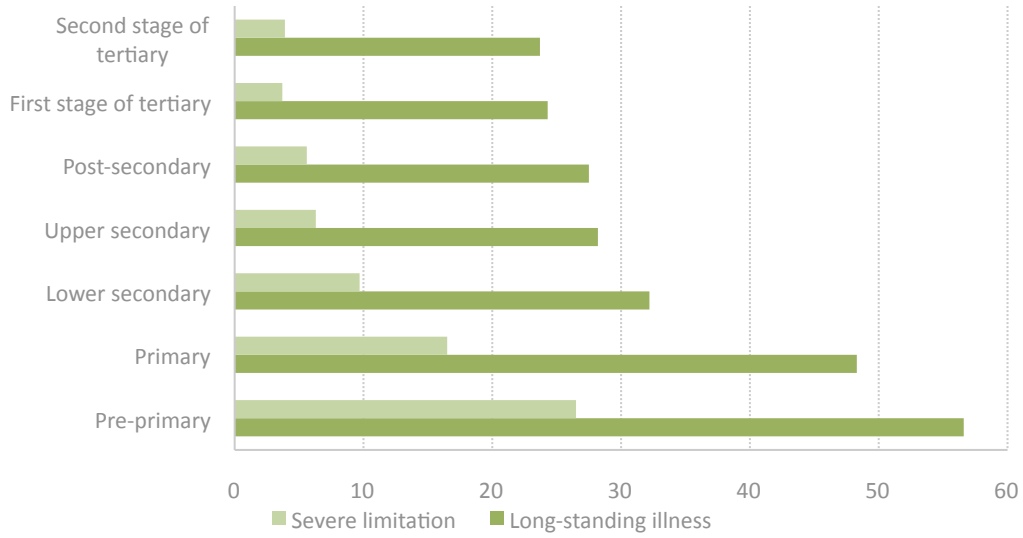
We also explored whether people of higher socio-economic status experienced better health also in terms of fewer limitations in their daily activities and less chronic disease. For this, the questions

focusing on activity restrictions[62] (of at least 6 months) and long-standing health problems[63] were analysed by educational attainment levels and by income groups.

Higher socio-economic groups, including both educational attainment (Figure 9.3) and income (Figure 9.4), showed significantly lower levels of impairments than people of lower socio-economic groups. Individuals with higher educational level reported only half as many chronic conditions and less than one sixth of severe limitations of daily activities.

These rates differ by gender: females with higher education level (post secondary level until second tertiary) were more likely to experience better health than males. This gender pattern reversed among those with lower educational attainment (lower than upper secondary), where women had worse health than men (for details see Table A.15 and Table A.16 in the annex).

Figure 9.3: Prevalence of limitations in daily activities and long-standing illness by educational attainment, EU-27, 2009 (% respondents)

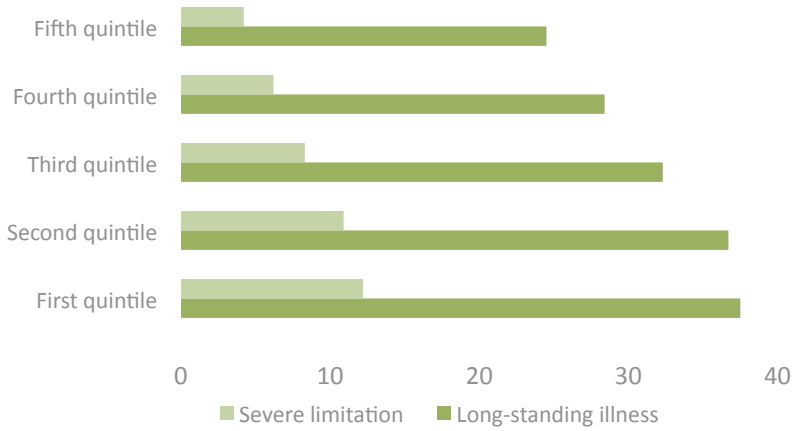


Source: EU-SILC 2009 (hlth_silc_07 and hltl_silc_05) - version from 25 July 2011; accessed 30 July 2011; (educational attainment according to ISCED-97 classification).

[62] The data on chronic (long-standing) illnesses or conditions refer to the self-declaration by the respondents of whether they have or have not a chronic (long-standing) illness or condition (hltl_silc_5 and hltl_silc_11); (Eurostat Metadata 2011).

[63] The data on limitation in activities due to health problems refer to the self-evaluation by the respondents of the extent of which they are limited in activities people usually do because of health problems of at least the last 6 months (numbers shown are those for strongly limited; other categories were limited and not limited); (hltl_silc_7 and hltl_silc_12); (Eurostat Metadata 2011).

Figure 9.4: Prevalence of limitations in daily activities and long-standing illness by income, EU-27, 2009 (% respondents)



Source: EU-SILC 2009 (hlth_silc_12 and hltl_silc_11) - version from 22 February 2011; accessed 30 July 2011.

Similar patterns prevailed by income: high income groups were less likely to express limitations in daily activities or chronic health problems than those in lower income classes. Across all income groups, women showed higher rates of severe limitations or chronic disease than men (see Table A.17 and Table A.18 for numerical results).

Do the privileged also experience unmet medical needs?

Analyses of unmet needs for medical and dental examinations show a clear advantage of people belonging to the highest income class. Only 4.9% of the people in the highest income group perceive their medical needs unmet (4.5% for dental needs), compared to 10% (11.9% for dental needs) in the lowest income group. This indicates that over 95% of the people who are really well off feel their needs met (see Table 4.2 and Table 4.3 in chapter 4).

In most European countries, **costs** play only a minor role as cause of unmet needs for people who are well off, as expected (0.5% unmet medical and 1.3% unmet dental needs). However, there are country differences: people of high income groups still face difficulties in meeting their medical demands in some Eastern and Southern European countries, while Central and Northern European countries have only minor gaps in the coverage of people's needs.

Interestingly, **waiting lists** are a common problem for all income groups and there are not fewer hurdles for people in the highest income classes. Of course, in some countries people who are well off have options to bypass waiting lists for elective treatments and elective surgeries (due to inappropriate provision of service), for instance by informal payments, by using private services or by having a private insurance, which helps to minimise waiting times (the situation of access barriers due to waiting times in selected countries is discussed in more detail in chapter 13).

Barriers due to **distances** from health services are less of an issue for people in the highest income group. Only 0.1% of people belonging to the highest income quintile considered the travel to health services as too far. Richer people are usually less dependent on public transports as they are more likely to be car-owners or able to cover expenses for a taxi if public transport is not available.

People of high income groups are also less affected by the lack of nearby public health service provision in less populated areas, as they - apart from finding travel easier - may also make use of private services (i.e. are less dependant on public sector services). In some remote areas the provision of services is of course still problematic (e.g. in Norway, 0.6% of respondents in the highest

income group feel their medical needs unmet due to distance). For older age groups the gaps in close service provision are becoming more relevant even for those who are well off (see Figure 4.12, p. 85).

Conclusion

Higher socio-economic groups (higher educational attainment and income) tend to have systematically better self-perceived health, including subjective health, limitations in daily activities and chronic conditions. The relationship between education and health was very strong with higher rates of very good health for those with highest socio-economic status: 39.4% of those in the highest education group (second stage of tertiary education) perceived their health as “very good” compared to 5.8% of those of pre-primary education level. Similar results were also found for income classes, with people with higher income experiencing better health than those of lower income. People of higher education and higher income were also less likely to be affected by functional limitations and long-standing illnesses when compared to those of lower education or income level.

People belonging to higher income groups were less affected by barriers of access to health care, such as out-of-pocket payments, waiting times for health services or the transport to health services, giving the overall impression that income did matter for reducing barriers in access to health care.

In conclusion, results confirmed a clear relationship between socio-economic status and health outcome indicating health advantages for those who are well off and/or attained higher education. Findings also indicated that the privileges of high socio-economic groups in access to health care result fewer perceived gaps in health services.

10. Connected: active political and social participation

Orsolya Lelkes

This chapter builds on the theoretical discussion and empirical analysis of Chapter 6, which explored social isolation. This chapter will focus on the positive aspect of the social participation indicators (those who are very intensely engaged in social contacts), complemented with further ones (trust), and with indicators of political participation.

We thus focus on the micro level concept of social capital, i.e. social networks between people (see the discussion on the definition and measurement of social capital in chapter 6, p.102). Social capital is regarded to be an "asset", as indicated by the word "capital", providing personal and social benefits, including access to information, informal help or jobs. The actions of one's peers and the group norm have a profound influence, and the impact is not always positive, as shown for example by the recent riots in England. In addition to our immediate connections, there is a more indirect network effect. Eating habits, health attitudes, sex norms are transferred to us through the friends of our friends, and we are influenced by people we do not even know personally (Christakis and Fowler 2009). The spread of these are influenced by the shape of the network, and whether there is connection between my friends (and their friends).

Social cooperation, including voting, political activities, volunteering, helping each other, keeping a promise or telling the truth, are the "cement of society", using Jon Elster's phrase, and are essential for a well-functioning social order. Our selected indicators highlight various aspects of social cooperation (social contacts and political participation), including its subjective assessment (trust).

Data and measurement

The analysis is based on the European Social Survey Data (ESS)[64]. We restricted the sample to 24 countries, including EU member states and Norway. The resulting sample includes 46 000 individuals. The sample size varies between 1215 (Cyprus) and 2725 (Germany), and covers the adult population aged 15 or over. The field work was conducted in 2008 or 2009, in Germany it was between August 2008 and February 2009. The final sample size for Germany includes 2 751 individuals after a response rate of 48%.

[64] The ESS4-2008 Edition 4.0 was released on 2 February 2011. Norwegian Social Science Data Services, Norway - Data Archive and distributor of ESS data.

Box 10.1: Key survey questions of interest in the Europen Social Survey (ESS)

TRUST: "Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?"

Answers: score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.
→ We focus on those who gave scores of 8, 9 or 10 to this question.

SOCIAL CONTACTS: "How often do you meet socially with friends, relatives or colleagues?"

"Meet socially" implies meet by choice rather than for reasons of either work or pure duty.
Answers: 1 never, 2 less than once a month, 3 once a month, 4 several times a month, 5 once a week, 6 several times a week, 7 every day.
→ We focus on those who answered "every day" or "several times a week".

POLITICAL ACTIVITIES. "There are different ways of trying to improve things in [country] or help prevent things from going wrong. During the last 12 months, have you done any of the following? Have you…

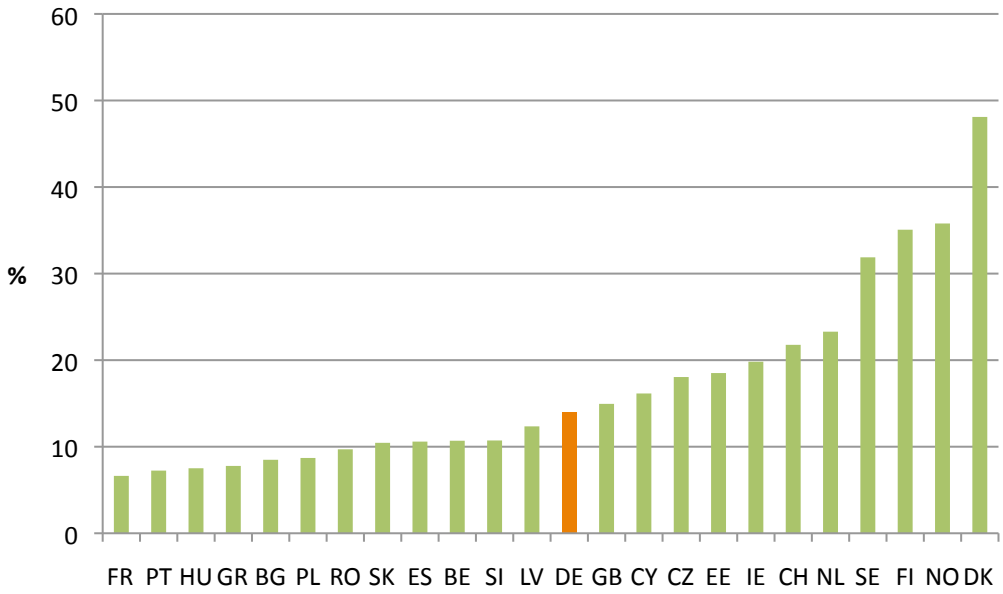
- contacted a politician or government or local government official?
- worked in political party or action group?
- worked in another organisation or association?
- worn or displayed campaign badge/sticker?
- signed a petition?
- taken part in a lawful public demonstration?
- boycotted certain products?"

Answers: yes or no.

Trust

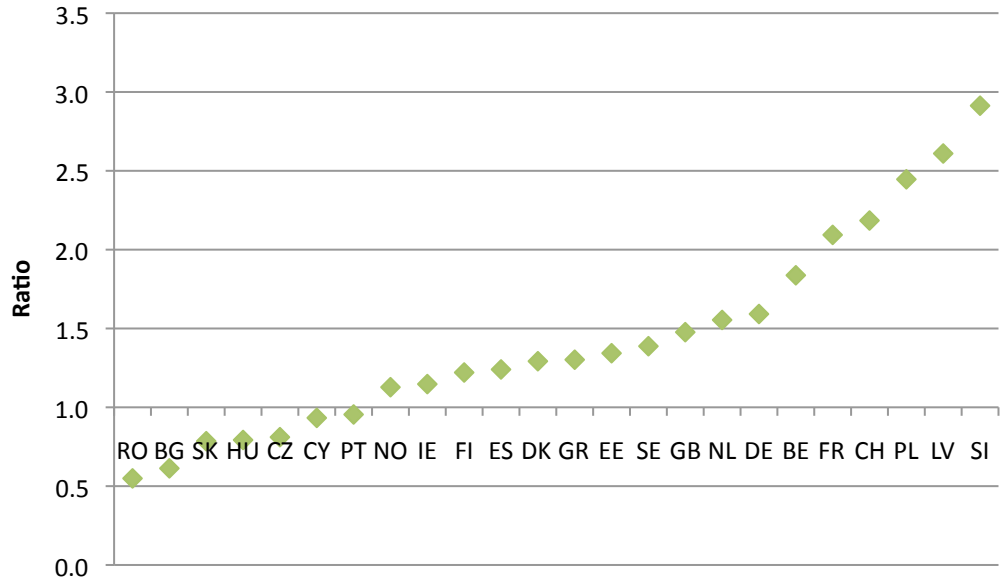
Trust is a key measure of social cohesion. In Germany, 14% of the population thinks that most people can be trusted (giving values of 8 to 10 on a scale of 1 to 10), which is about the average value in our sample of European countries (Figure 10.1). 2% of Germans responded with the maximum value of 10 on the scale (with answers ranging from 0.2% to 6.0% in other countries). In Sweden, Finland, Norway and Denmark, 30% or more people report a high level of trust. Denmark has the highest level of trust, with about half of the population being very trusting. This is not related to the particular cut-off point of our measure, as the Danes report the highest level of trust in case of alternative measures as well (using 9 and 10, or using only 10 as response categories).

Figure 10.1: General trust: share of the population who says that most people can be trusted, 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0

Figure 10.2: Trust by income level: ratio of individuals with high level of trust in the top income quintile group compared to the bottom quintile group, 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Note: Income quintile groups are created on the basis of total disposable household income adjusted for household size (OECD equivalence scale).

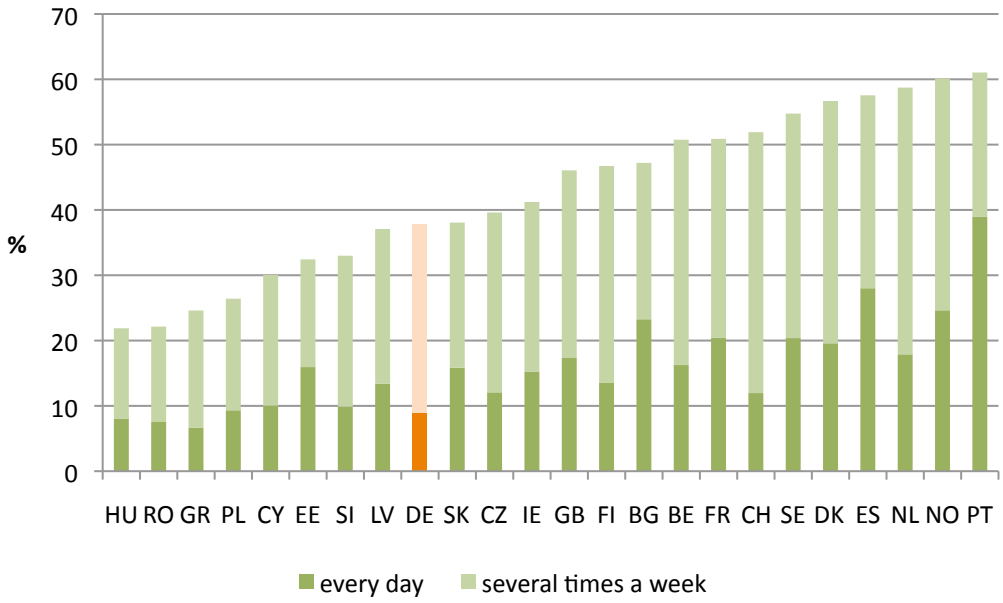
High income individuals are more likely to report a high level of trust. In Germany, 19% of the top fifth income group say that they can trust most people, in contrast to the 12% of the bottom fifth income group, so the ratio is 1.5 (Figure 10.2). Note that the difference across income groups is relatively smaller in Denmark, Norway and Finland, the most "trusting" populations in Europe, suggesting a generally high level of trust prevailing across various population groups. In contrast to the majority of countries, in a few ex-Socialist countries (Bulgaria, Romania, Hungary, the Czech Republic and Slovakia), but also in Cyprus and Portugal there is no such pattern across income

groups, or to the contrary, high income groups are less likely to trust others. Most of these countries have a low level of general trust.

Social contacts

Denmark still has an above average level of social contacts (with close to 60% of the population having social contacts at least several times a week), although not the lead country any more (Figure 10.3). Hungary, Romania and Poland have the smallest shares. The small estimated figure for Greece as well as for Cyprus might be a measurement error, as alternative survey results65 show that these countries have the highest social participation in the EU, with 70% of the population meeting relatives daily or weekly (Lelkes 2010). In Germany, 9% of the population meets friends, relatives or colleagues every day, and 29% meets them several times a week. This value is somewhat below the average in our sample of European countries, and also lower than in the Western neighbouring countries (France, Netherlands, Belgium, but also Switzerland), but higher in than in the Eastern neighbour Poland.

Figure 10.3: Intense social contacts: meeting friends, relatives or colleagues every day or several times a week, 2008

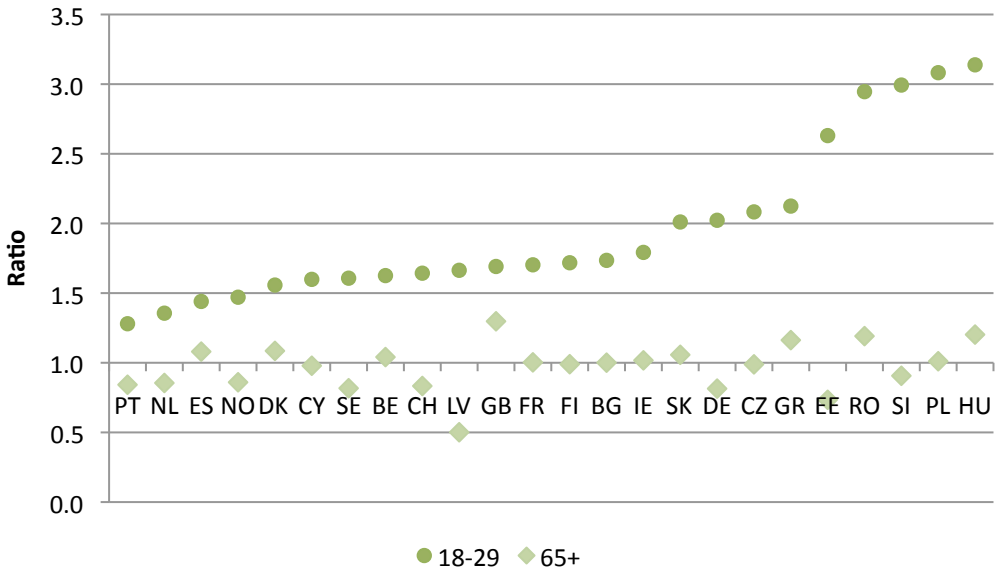


Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0

Young adults are more likely to engage in intense social contacts in all the countries (Figure 10.4). In Germany, they are twice more likely to have intense social contacts than the "middle aged" reference group. There is a great cross-country variation in the relative "advantage" of this group. In Hungary, Poland, Slovenia and Romania the ratio is three fold: young adults are much more likely to be very active socially. This is, however, high only in relative terms, as these countries have typically a low level of such population. In these four countries, 41-50% of young adults tend to have intense social contacts, which is not a particularly high figure by international comparison. In contrast, the age differential is relatively small in countries with a higher overall share of intensely engaged population. In Portugal, Spain and the Netherlands, 74-76% of young adults were found to have intense social contacts, and this is only 1.3-1.4 times higher than for the middle age category.

[65] EU-SILC 2006 special module on social participation.

Figure 10.4: Intense social contacts by age groups compared to the "middle aged" population (30-64 years), 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0

The elderly do not differ much from the middle age category (aged 30 to 64): the share of people with intense social contacts is about the same in the overall majority of countries. This suggests that while social isolation occurs more frequently among the elderly, a large share of this age group remains very engaged socially.

Political participation

We measure rather diverse facets of political participation, including political commitment as party membership, or simply an occasional action like signing a petition. Among these activities, people are least likely to work in a political party or take part in a public demonstration, and most likely to sign a petition, contact a politician and boycott certain products, although there is a large variation across countries. The share of the population who worked in a political party or action group varies between 1% (Hungary) and 9% (Cyprus) across the European countries in our sample. The range is much wider for signing a petition: 3% (Romania) to 47% (Sweden).

Germany has a relatively large politically active population in a European comparison. Over one in four Germans have worked in an organization or association and about one in three persons signed a petition or boycotted certain products during the past 12 months. Wearing a campaign badge is not particularly popular in the country, with only 5% of the population doing so.

Table 10.1: Political participation in the past 12 months, 2008

	contacted politician or govern-ment official	worked in political party or action group	worked in another organi-sation or association	worn or displayed campaign badge/sticker	signed petition	taken part in lawful public demon-stration	boycotted certain products
DE	16,9	3,9	25,9	5,0	30,7	8,1	31,0
BE	15,3	4,3	21,1	7,0	27,6	7,4	11,2
BG	5,0	3,6	1,8	2,5	6,5	4,1	3,5

CH	12,0	4,9	13,1	6,9	37,7	7,7	25,0
CY	20,2	8,8	6,6	7,1	6,3	2,3	6,1
CZ	15,5	2,3	9,1	3,7	15,2	4,5	7,4
DK	18,7	4,5	24,7	10,6	33,9	9,3	21,5
EE	11,1	3,0	5,3	5,3	8,0	2,1	5,6
ES	10,0	2,9	9,6	4,7	17,0	15,9	7,9
FI	21,1	4,1	34,1	15,3	32,3	2,5	30,3
FR	15,4	3,8	15,2	11,2	33,6	15,3	27,7
GB	16,9	2,2	6,6	5,7	38,4	3,9	24,3
GR	10,6	4,2	4,0	3,2	4,4	6,1	14,4
HU	8,6	0,8	5,1	0,8	6,8	1,8	5,9
IE	23,0	4,7	16,5	9,8	24,1	9,8	13,6
LV	11,8	1,1	2,8	4,2	5,5	6,5	5,2
NL	14,1	3,4	26,2	5,1	23,5	3,3	9,4
NO	21,5	6,1	27,8	26,1	37,8	7,2	22,5
PL	7,2	2,6	5,9	4,2	7,5	1,6	4,5
PT	6,7	1,3	2,7	2,7	4,9	3,7	3,2
RO	11,4	5,9	3,0	3,7	3,1	4,3	2,8
SE	14,8	4,4	27,0	18,4	47,2	6,5	37,3
SI	11,4	3,3	1,6	3,7	8,7	1,6	5,1
SK	7,2	1,9	5,7	2,2	22,3	1,6	6,9

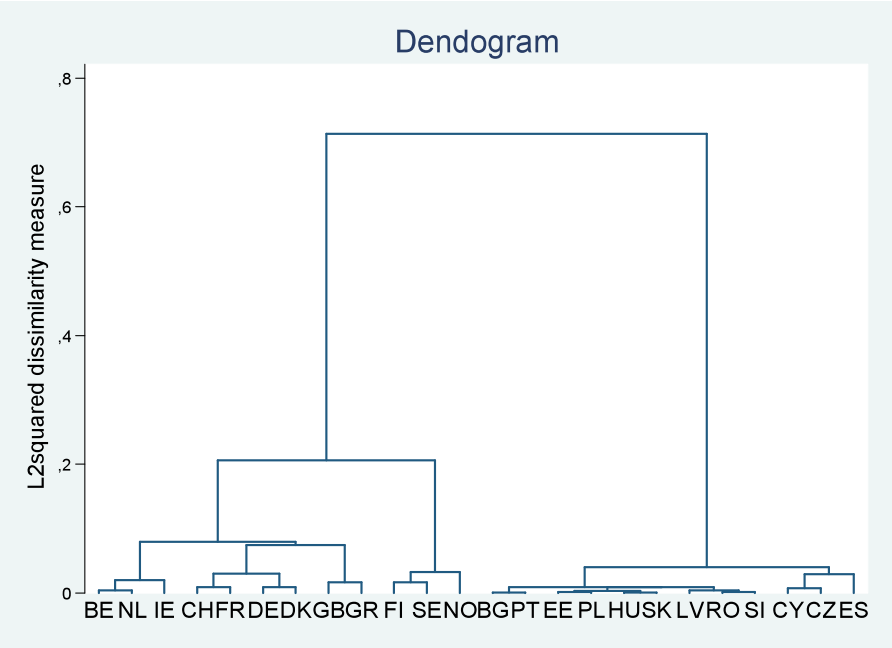
Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0

We explored the natural grouping of six indicators of political participation at a country level across the EU.

- All the Eastern European countries, together with Cyprus, Portugal and Spain constitute a cluster, characterized by low political engagement of the population Figure 10.5.
- The Nordic countries, including Norway, Finland and Sweden, have the highest and publicly most visible political engagement. The special feature of these countries is that a very high share work in non-political organizations (27-34%), contacted a politician (15-22%), boycotted certain products (23-37%), signed a petition (23-37%), or wore a campaign badge (18-26%), thus was openly and actively involved in political campaigns.
- The nine countries in between these two extremes exhibit relatively large activity in some aspects but less so in others and we can distinguish a number of subgroups here.
    - Germany together with Denmark, have the most active population within this group: one fourth of the population worked in a non-political organization. In addition, we found that German and Danish people tend to be active in more than one ways: one fourth of the population was engaged in at least two activities (we excluded signing a petition from this calculation, as it involves many people and requires little effort or commitment), which Is the highest share within this group.
    - Switzerland and France stand relatively close to Germany and Denmark. They have similar level of total engagement of the population (19-22% was active in at least two forms). The most marked difference is that somewhat less people worked in non-political organizations here (13-15%) than in the Germany and Denmark (25-26%).
    - Other, smaller clusters within this nine-country group include the cluster of Belgium, the Netherland and Ireland, and the UK and Greece. Greece seems to share little

with these other countries, given the low values of political engagement, except the relatively high percentage of those who are boycotting products. The clustering results are thus critically influenced by the variables included in the analysis.

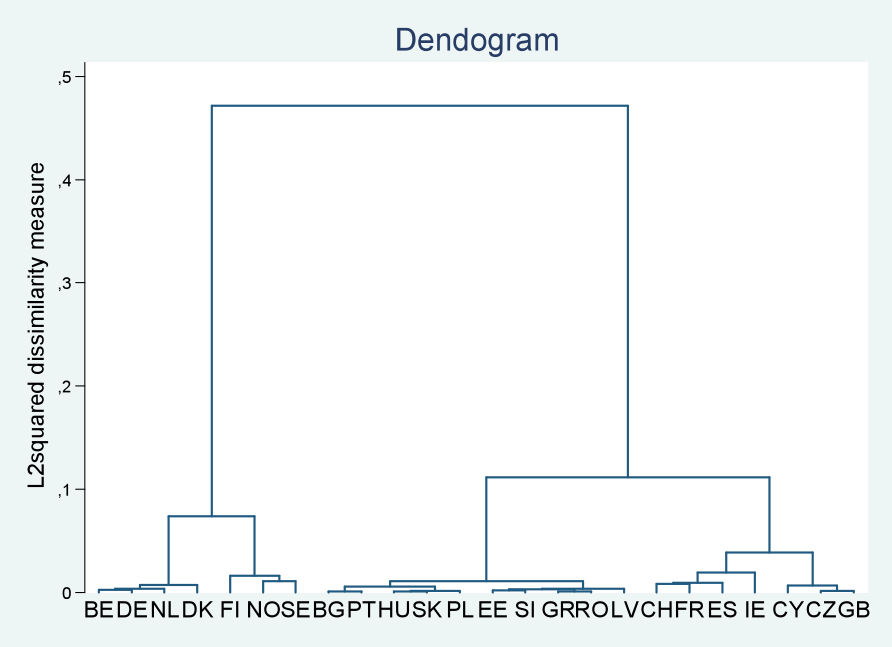
Figure 10.5: Tree diagram of political participation indicators (excluding signing a petition), 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: hierarchical cluster analysis with 24 cases (each country in the sample); the Ward's method is used, which minimizes the sum of squares of any pair of clusters to be formed at a given step; the country clustering of the six political participation variables is analysed.

In a sensitivity analysis, we omitted the variables of signing a petition or boycotting certain products, as these activities require little commitment and a large share of the population is involved, which alters the analytical results substantially.

Figure 10.6: Tree diagram of political participation indicators (excluding signing a petition and boycotting products), 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: hierarchical cluster analysis with 24 cases (each country in the sample); the Ward's method is used, which minimizes the sum of squares of any pair of clusters to be formed at a given step; the country clustering of the five political participation variables is analysed.

This alternative clustering identified four main groups:

- Eastern European (Bulgaria, Hungary, Slovakia, Poland, Estonia, Slovenia, Romania, Latvia) and some Mediterranean countries (Portugal, Greece) constitute a group with low political engagement.
- Switzerland, France, Spain, Ireland, Cyprus, the UK and the Czech Republic have a somewhat higher level, but in general still moderate social activity.
- In the country group of Belgium, Denmark, Germany and the Netherlands, political participation is relatively high. 21-26% of the population worked in an organization or association, which is much higher than in the previous groups.
- Political participation is the highest in the country cluster of Finland, Norway and Sweden. This group is identical to the "top group" identified in the previous cluster analysis.

This cluster analysis highlights the common patterns of these indicators across countries, and identifies Germany as a country with a relatively high political participation compared to other countries, although somewhat behind the top group of Finland, Norway and Sweden.

In the following section we explore the inequalities of political participation among certain social groups. We start with assessing the difference between high income and low income individuals.

Table 10.2: Political participation in the past 12 months by income groups: the ratio of the participation rate of the top income quintile group compared to the rate of the bottom income quintile group, 2008

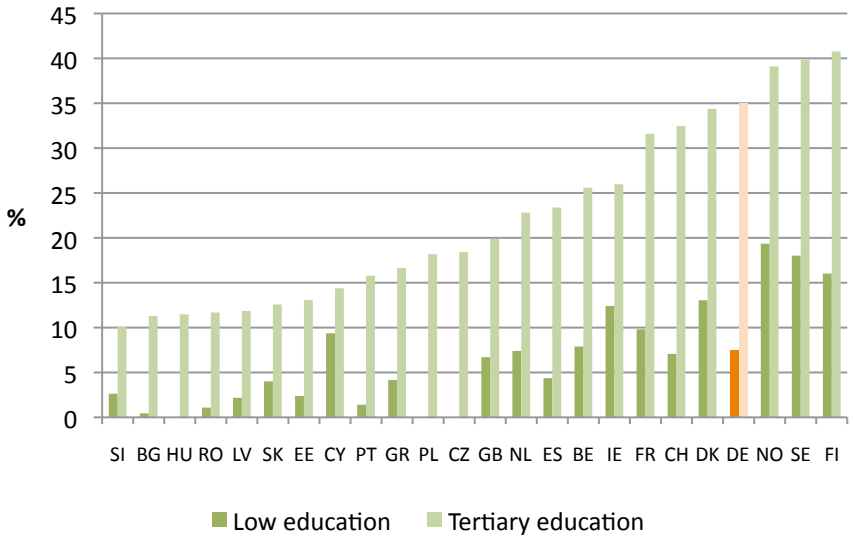
	contacted politician or govern-ment official	worked in political party or action group	worked in another organi-sation or association	worn or displayed campaign badge/sticker	signed petition	taken part in lawful public demon-stration	boycotted certain products
DE	2,3	5,1	1,6	0,9	1,4	0,9	1,7
BE	1,4	1,1	1,7	1,0	1,5	1,0	1,9
BG	1,0	1,5	2,9	2,7	5,4	6,6	3,3
CH	1,8	1,4	2,1	1,5	1,8	1,1	1,4
CY	2,8	2,0	1,1	1,0	1,8	0,9	2,9
CZ	1,1	2,1	2,8	1,9	1,3	3,3	1,5
DK	2,5	2,2	2,1	1,4	1,5	1,3	1,7
EE	1,3	1,9	3,2	2,8	2,5	1,9	2,3
ES	2,7	2,5	2,1	1,4	2,2	2,2	1,6
FI	1,6	0,8	1,5	1,3	1,3	1,2	1,2
FR	1,4	1,4	2,2	1,4	1,4	1,2	1,6
GB	1,6	2,8	2,4	1,5	1,5	1,6	2,6
GR	1,4	1,0	1,1	0,7	3,1	1,1	2,6
HU	0,7		1,5	1,2	1,2	0,8	2,8
IE	0,8	1,7	2,3	1,2	1,3	1,5	2,5
LV	0,9		2,0	3,6	1,1	2,2	1,3
NL	1,4	1,1	1,7	1,1	1,5	1,0	1,7
NO	1,4	1,0	1,3	0,8	1,0	1,5	1,4
PL	3,6	2,9	5,5	3,0	4,5	5,1	4,1
PT	2,0		3,9	0,8	2,8	10,4	1,7
RO	0,9	1,6	1,9	1,0	2,2	1,4	1,4
SE	1,7	1,4	1,6	1,0	1,0	0,9	1,3
SI	2,2	2,2	2,9	2,3	4,2	3,4	3,3
SK	0,5	3,4	1,3	0,2	1,0	3,1	0,6

Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0

High income individuals are more likely to take part in political action of any sort than those on low incomes (Table 10.2). In Germany, the difference is particularly high with respect to contacting a politician or working in a political party or action group. The higher participation of high income people may be partly explained by their higher education on average and thus the greater aspiration to influence policy outcomes. There may be arguments which could predict the opposite: we might expect *lower* political participation given the opportunity cost of such activities, i.e. the loss of income, which is higher for high income individuals (in absolute terms). Taking this argument to the extreme, the rich may as well buy such political products (paying for other people to work in parties or contacting politicians or simply donate money instead of participating in activities themselves) and thus earn more by working instead or enjoy more leisure time (depending on the personal preferences). The finding that they do not do this, highlights the intrinsic value attributed to such political activities and also the related personal satisfaction. In Germany, for example, the top income group is relatively active (compared to those on low incomes) in time intensive activities such as working in a political party or action group, with fivefold participation rates.

We explored the relationship between educational attainment and political activity, using an aggregate indicator of the latter, measuring a more intense engagement (two or more types of activities, excluding signing a petition). In a large number of countries, including Bulgaria, Hungary, Poland, the Czech Republic and Romania, the political participation of low educated groups is practically zero. This suggests that these groups are abstinent from politics and have little trust and motivation to influence political decisions. This may be due to the Communist inheritance of these countries, which left behind a weak civil society. In contrast to these countries, people with low education levels have a participation rate of 15% or over in the top three Nordic countries.

Figure 10.7: Political activity in the past 12 months by educational attainment, 2008



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Note: Political participation in 2 or more activities (out of 6, listed in Table 10.2) during the past 12 months

The participation rate of people with tertiary education varies between 10% and 40%, with lowest values in some Eastern European countries (Bulgaria, Romania, Hungary, Slovakia, Slovenia, Estonia and Latvia) and the highest values in the Nordic Finland, Norway and Sweden. This suggest that the Communist legacy prevails among highly educated people as well, even after nearly two decades of democratic political systems.

In Germany, the political activity of highly educated people is one of the highest in Europe, with over one out of three people being involved in several political activities. There is, however, a major social gap, as the political engagement is rather weak among those with low education levels, reaching only 8%. Although it surpasses the rates of Eastern-European countries, it is substantially lower than that of the Nordic countries.

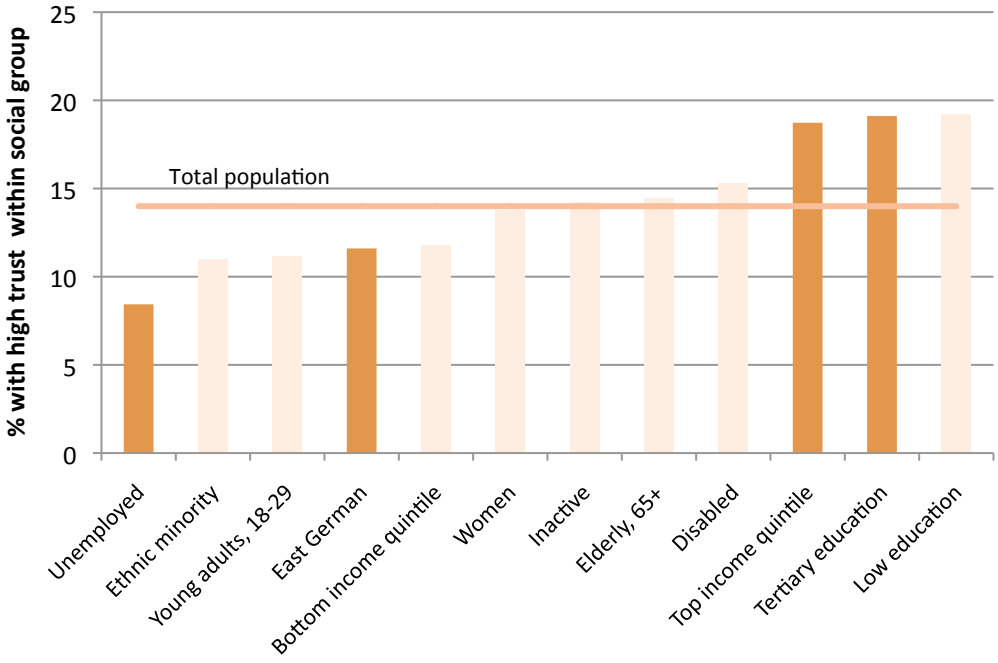
We explored the generational difference in political participation, but found no general systematic age pattern. Young adults tend to be less politically active than the middle aged population in most countries (including Germany), although there are several exceptions, where they have an above average activity level (the Czech Republic, Portugal and Cyprus). The elderly tend to be the lease active (in relative terms, compared to the national level) in Slovakia and Greece, and the most active in Ireland and the UK.

Intense social engagement in Germany

People with high income levels or high level of education are more likely to say that most people can be trusted (19% versus 14% among the total population, as shown by Figure 10.8). Although the average value is also high for those with low education, the confidence interval of the estimates is very wide, between 8% and 28%, partly due to the small number of observations, so the difference compared to the rest of the population is not statistically significant.

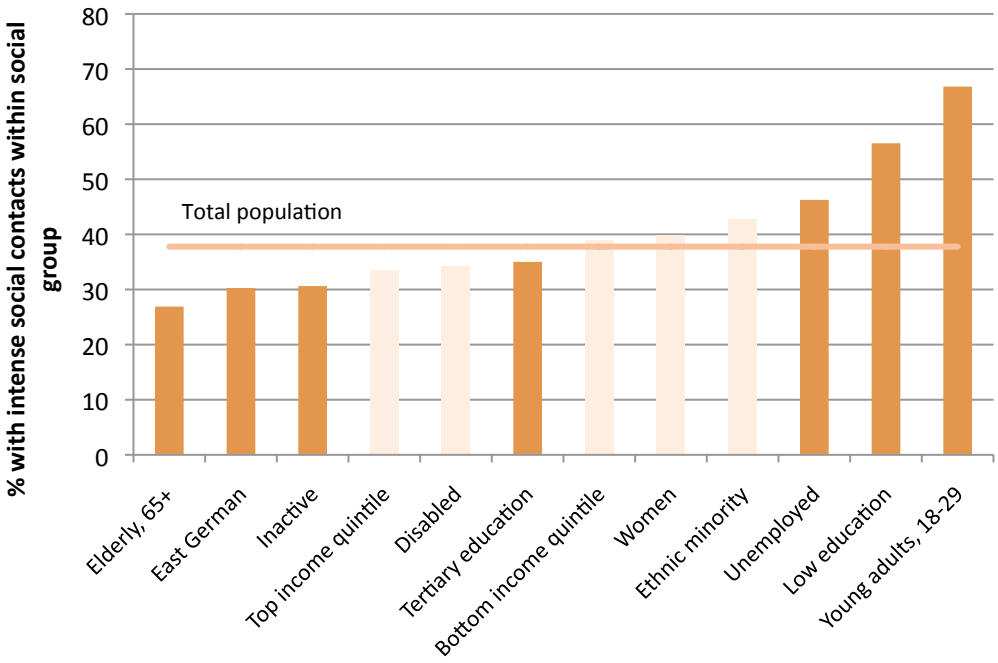
There is a significantly lower prevalence of highly trusting people among the unemployed and the East Germans. The value of East Germany may have a cultural heritage of the Socialist regime, similar to the relatively low values of other Eastern European countries (Figure 10.1).

Figure 10.8: High trust across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Note: Bars with lighter shading indicate that the difference between the means is not significant at a 10% level.

Figure 10.9: Intense social contacts across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Note: Intense social contacts: meeting friends, relatives or colleagues every day or several times a week. Bars with lighter shading indicate that the difference between the means is not significant at a 10% level.

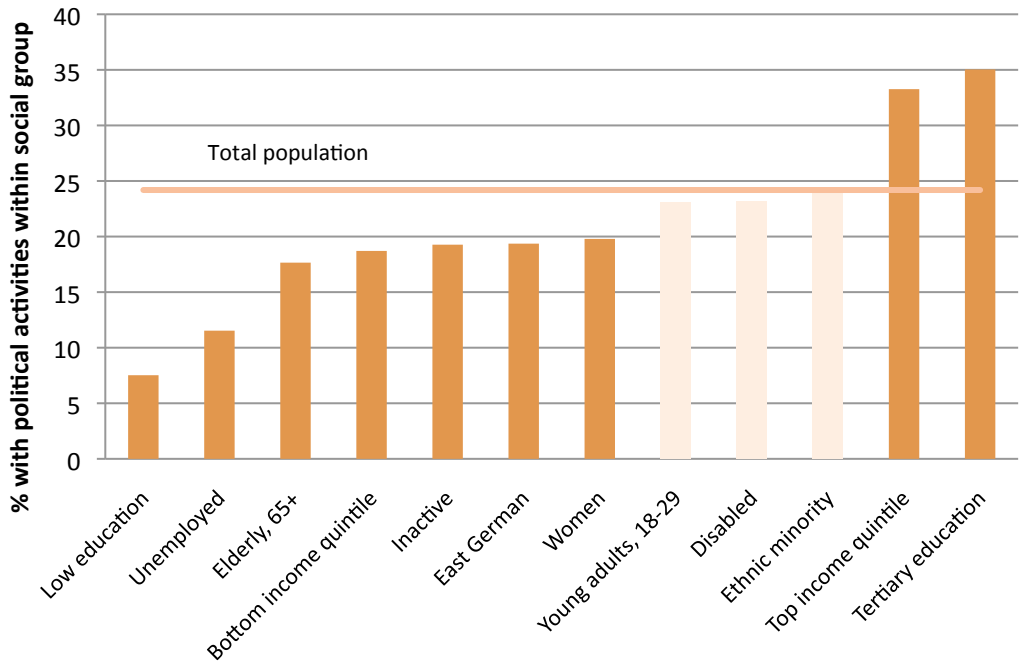
The elderly, those living in East Germany, the inactive population, and people with tertiary education are less likely to be engaged in frequent social contacts Figure 10.9. On the other hand, the unemployed, those with low education, and young adults are more likely to have intense social contacts. Comparing these figures with those in Figure 6.10 on social isolation (rare or no meeting) provides an interesting social profile of social contacts.

The elderly, the inactive and East Germans are more likely to be socially isolated and less of them engage in intense social contacts, which is a rather consistent pattern (Figure 6.10 and Figure 10.9). Similarly consistent findings refer to young adults, who are socially very active and very few of them are socially isolated.

The situation of the unemployed is polarised. Both social isolation and intense social contacts are more prevalent among the unemployed, showing great variation in the social networking of this group.

Highly educated people seem to prefer a golden middle way: they are less likely to have intense social personal contacts with friends or relatives, and in parallel, they are also less likely to be socially isolated. This group is probably more likely to use alternative, non-personal methods of personal interaction, including e-mails or social media.

Figure 10.10: Political activities across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Note: Intense social contacts: meeting friends, relatives or colleagues every day or several times a week. Bars with lighter shading indicate that the difference between the means is not significant at a 10% level.

High income and highly educated social groups are more likely to engage in political activities. In contrast, many groups at risk of social exclusion, including the unemployed, those with low education and low income play a little role in trying to influence politics affecting their lives. Similarly, the political engagement of East Germans, inactive population, the elderly (which largely overlaps with the former category of the inactive, given that a large part of the latter consists of pensioners), and also that of women remains below the national average. These differences were found to be statistically significant.

Conclusions

Trust. 14% of the German population says that most people can be trusted, which is about the average value in our sample of European countries. In Sweden, Finland, Norway and Denmark, 30% or more people report a high level of trust. High income individuals are more likely to report a high level of trust in most countries. In Germany, 19% of the top fifth income group say that they can trust most people, in contrast to the 12% of the bottom fifth income group, so the ratio is 1.5.

In Germany, those with high incomes or with high level of education are more likely to say that most people can be trusted. There is a significantly lower prevalence of highly trusting people among the unemployed and the East Germans.

Social contacts. In Germany, 9% of the population meets friends, relatives or colleagues every day, and 29% meets them several times a week. This value is somewhat below the average in our sample of European countries. In contrast to neighbours, the German value is lower than that in the "Western" neighbouring countries (France, Netherlands, Belgium, Denmark and Switzerland), but higher than in the Eastern neighbour Poland. The elderly do not differ much from the middle age category (aged 30 to 64): the share of people with intense social contacts is about the same in the overall majority of countries. This suggests that while social isolation occurs more frequently among the elderly, a large share of this age group remains very engaged socially.

In Germany, the elderly, East German residents, the inactive population, and people with tertiary education are less likely to be engaged in frequent social contacts. On the other hand, the unemployed, those with low education, and young adults are more likely to have intense social contacts. Comparing these figures with those on social isolation (rare or no meeting) provides an interesting social profile of social contacts. The situation of the unemployed is polarised. Both social isolation and intense social contacts are more prevalent among the unemployed, showing great variation in the social networking of this group. Highly educated people seem to prefer a golden middle way: they are less likely to have intense social personal contacts with friends or relatives, and in parallel, they are also less likely to be socially isolated. This group is probably more likely to use alternative, non-personal methods of personal interaction, including e-mails or social media.

Political participation. Germany has a relatively large politically active population in a European comparison. Over one in four Germans have worked in an organization or association and about one in three persons signed a petition or boycotted certain products during the past 12 months. Wearing a campaign badge is not particularly popular in the country, with only 5% of the population doing so.

The cluster analysis of political participation indicators classifies Germany as a country with a relatively high political participation (together with France, Switzerland and Denmark in one specification and in a group with Belgium, Denmark, and the Netherlands in another), although somewhat behind the top group of Finland, Norway and Sweden. Eastern European (Bulgaria, Hungary, Slovakia, Poland, Estonia, Slovenia, Romania, Latvia) and some Mediterranean countries (Cyprus, Greece, Portugal, Spain – depending on the selection of political participation variables) constitute a group with low political engagement.

High income individuals are more likely to take part in political action of any sort than those on low incomes. In Germany, the difference is particularly high with respect to contacting a politician or working in a political party or action group. The higher participation of high income people may be explained by their higher education on average and thus the greater aspiration to influence policy outcomes, despite the higher opportunity cost of free time activities. In Germany, for example, the top income group is relatively active (compared to those on low incomes) in time intensive activities such as working in a political party or action group, with fivefold participation rates.

There are pronounced differences by educational attainment. In a large number of countries, including Bulgaria, Hungary, Poland, the Czech Republic and Romania, the political engagement (measured as two or more types of activities, excluding signing a petition) of low educated groups is practically zero. This suggests that these groups are abstinent from politics and have little trust and motivation to influence political decisions. This may be due to the Communist inheritance of these countries, which left behind a weak civil society. In contrast to these countries, people with low education levels have a participation rate of 15% or over in the top three Nordic countries. The participation rate of people with tertiary education varies between 10% and 40%, with lowest values in some Eastern European countries, suggesting that the Communist legacy at times prevails among highly educated people as well.

In Germany, the political activity of highly educated people is one of the highest in Europe, with over one out of three people being involved in several political activities. There is, however, a major social gap, as the political engagement is rather weak among those with low education levels, reaching only 8%. Although it surpasses the rates of Eastern-European countries, it is substantially lower than that of the Nordic countries.

We did not find evidence for a general systematic age pattern in political engagement across countries.

With respect to social differences within Germany, we found that high income and highly educated groups are more likely to engage in political activities. In contrast, many groups at risk of social exclusion, including the unemployed, those with low education and low income play a little role in

trying to influence politics affecting their lives. Similarly, the political engagement of East Germans, inactive population, the elderly, and also that of women remains below the national average.

Policy implications. How can politics promote social cooperation and social engagement? Trust can be influenced indirectly. Transparency and accountability of public institutions, politicians and policy-makers plays a major role in enhancing trust in the political system as such. Adequate information on the functioning of these institutions is also vital, both as part of the communication strategy of these bodies, but also as part of the school curricula. In addition, school curricula and adult education that promote social skills and social cooperation may greatly enhance individuals's ability to function in communities and social networks. Financial and non-financial incentives for voluntary work are also likely to affect behavior, at least on the longer run. Many of these social patterns are deeply imbedded in the culture, so some of these changes may need time and consistent policy effort. Recent policy focus on the quality of life, including the acknowledgement of the value of free time (in addition to productive activities at the workplace), free time activities and social contacts is a vital step in this direction. In addition to the various levels and branches of government, employers and the representative bodies of employees also play a major role in this respect.

11. Subjective well-being: "bliss"

Orsolya Lelkes

This chapter builds on the theoretical and analytical discussion of Chapter 7, which explored the social patterns of low well-being. This chapter will focus on the situation of the "shiny happy people", those with above average self-reported life satisfaction or happiness. This complementary analysis will thus allow us to compare the correlates of "misery" and that of "bliss", or in other words, assess whether the same individual characteristics explain both low well-being and high well-being.

As mentioned earlier, there is already a wide ranging evidence on causes and correlates of happiness, given the booming interest in the field. Life satisfaction is found to be higher among more educated individuals and higher income people. The unemployed and individuals suffering from health problems have lower life satisfaction. The relationship between age and life satisfaction shows a U-shape, with lowest values in the middle age. Marriage and social relationships tend to make people happier.

This chapter will explore the situation of social groups in selected countries. With this, it may provide input for further in depth analysis, and ultimately also promote the greater use of this evidence in the policy-making cycle, including setting priorities, implementation and assessing the outcomes.

Data and measurement

The analysis will be based on the European Social Survey (ESS), which includes 46.000 individuals across 24 countries. Our key variable is life satisfaction, measured by the following question:

"All things considered, how satisfied are you with your life as a whole nowadays"?

This question is answered on a scale of 0 to 10, where 0 means extremely dissatisfied and 10 means extremely satisfied.

Self-reported happiness is used as a complementary measure, for checking the robustness of the findings.

In terms of terminology, subjective well-being is a general term, with several dozen specific indicators, including self-reported life satisfaction and self-reported happiness. In this chapter, subjective well-being is at times used interchangeably with these more specific measures.

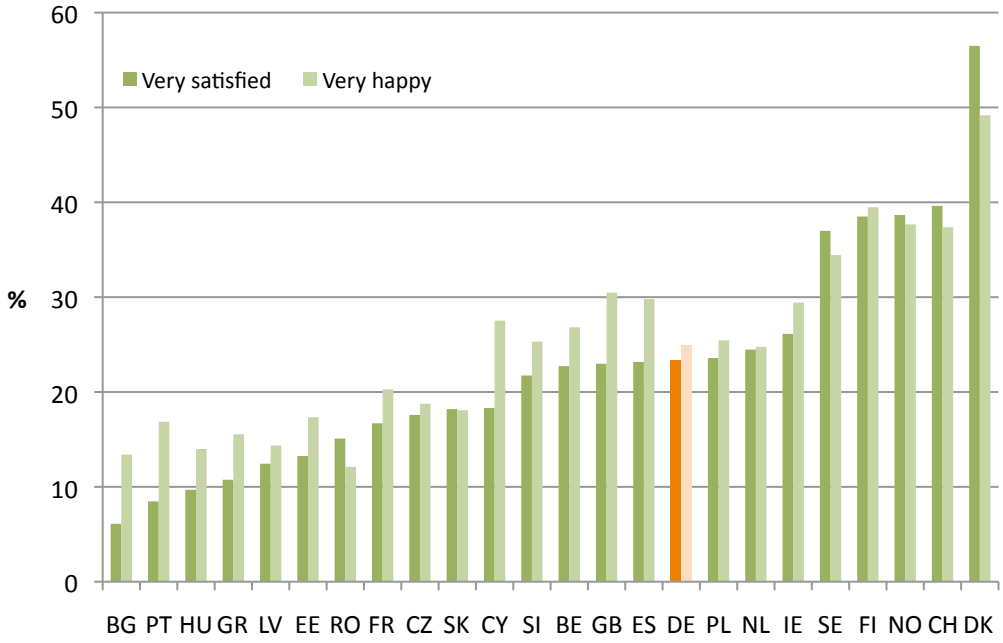
There is a positive skew in the distribution of subjective well-being: most people are found towards the "happy" end of the spectrum (see Figure 7.1 and Table A.13 in the annex). People are more likely to rate their own happiness high than their own life satisfaction. 10% say that they are extremely happy, while only 9% report to be extremely satisfied. 25% of the people are "very happy", while only 22% are "very satisfied". The same pattern holds for Germany, with 25% being "very happy" and 23% being "very satisfied" (for the overall distribution, see Figure 7.1 and Table A.13 in the annex).

Overview across Europe

Our measure of satisfaction ("very satisfied") used here includes all those who rated their own life satisfaction with scores from 9 to 10 (on a scale of 0 to 10). A similar coding is used for the definition of happiness ("very happy"). We chose this cut-off point as it is higher as the median values for the

two variables, which takes the value of 8 for self-reported happiness, and 7 for self-reported life satisfaction. Due to the positive skew of the distribution, the category of "very satisfied" is narrower than that of "dissatisfaction" was in chapter 7 (the former includes scores 9 and 10, the latter includes scores 0 to 3), but overall includes a larger number of people. 22% are classified as "very satisfied" here, in contrast to the category of "dissatisfied", which includes only 10% of the sample.

Figure 11.1: "Bliss" (population with very high subjective well-being) across European countries, 2008, % of population



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: "Very satisfied": self-reported life satisfaction scores of 9 and 10 on a scale of 0 to 10
"Very happy": self-reported happiness scores of 9 and 10 on a scale of 0 to 10

The largest groups of happy people can be found in Northern Europe (Denmark, Finland, Norway and Sweden) and Switzerland, where one out of three persons is very happy or very satisfied. It takes a longer search to meet very happy nationals in Bulgaria, Greece, Hungary, Latvia or Portugal, and an even longer search to meet very satisfied ones. (Perhaps it is even more so nowadays in countries affected by the austerity measures and the resulting social unrest.) These cross-country comparisons of happiness partly reflect differences in overall development (national wealth, the quality of public services, the level of income inequalities, recent economic and social changes, etc.). On the other hand, the reported level of happiness is likely to be exposed to cultural and linguistic differences across countries, so it appears to be more appropriate to compare the situation of specific social groups within countries. Note, however, that the well-being differences across social groups tend to be systematic across countries: as shown by the following charts, the unemployed, the disabled, ethnic minority groups and people living in low income households are less likely to report high subjective well-being. The existence of such cross-cultural pattern underscores the accuracy and validity of subjective well-being measures.

We have selected the following social groups for more detailed analysis:

- Age groups (young adults aged 16-29 and elderly aged 65 or more),
- Ethnic minority group (self declared, not differentiating between specific groups),
- Income groups (bottom income quintile and top income quintile),
- Educational attainment (below lower secondary and tertiary education),

- Disabled ,
- Labour market categories (unemployed, inactive),
- Active social participation (political engagement or intense social contacts).

The difference between men and women were not statistically significant in most countries, so the gender category was not included.

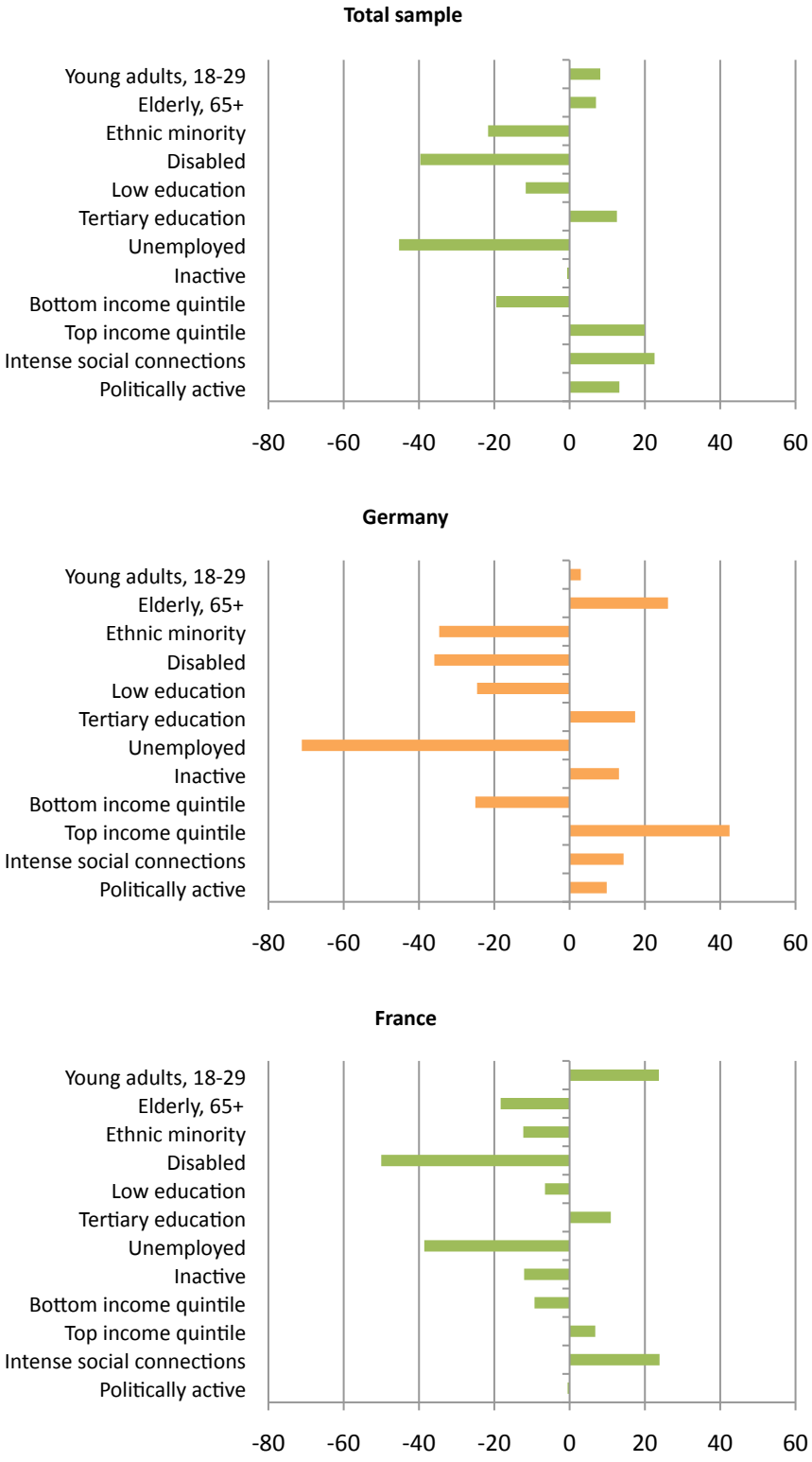
"Happy, shiny people" in France, Germany, the UK and Sweden

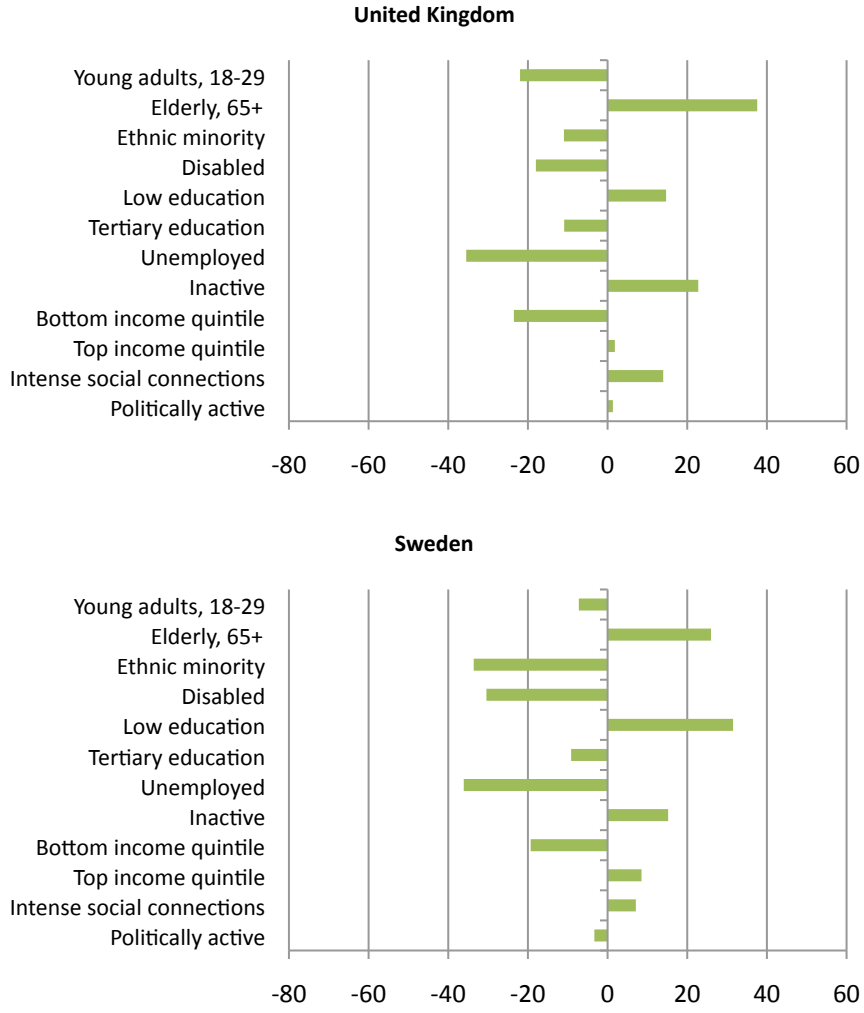
The data suggest that we have more knowledge on what makes people unhappy than what makes them happy. Unemployment, disability, ethnic minority status and low income tend to reduce the probability of being very satisfied by 20-40% (Figure 11.2). The effect of well-being inducing factors (intense social contacts, political engagement, high income, and high education) is smaller, ranging between 13% and 23% (compared to the average over the total sample of 24 countries). There is a U-shaped relationship between age and life satisfaction: young adults and the elderly are more likely to be very satisfied than the middle age groups. The difference between age groups was found to be statistically significant in the total sample.

There are general patterns across the selected four countries: the unemployed, disabled, ethnic minority groups and people living in low income households have a lower probability for being very content in France, Germany, the UK and Sweden. In contrast, however, there are only two groups with systematically higher well-being, those with intense social contacts and those with high incomes, although in the latter case the effect is weaker[66]. There is a considerable variation in the age pattern: while in France it is the young adults who are more likely to be very satisfied, in Germany, the UK and Sweden it is the elderly. Similarly, groups with higher education are found to have a higher prevalence for being very satisfied only in Germany and France. The positive relationship between low educational attainment and contentment in the UK and Sweden is perplexing, although statistically robust (and also holds if we exclude those below the age of 18). It highlights that often the interrelationship of various different personal characteristics matter, not just one single indicator. Political activity during the past year seems to increase the probability of contentment among Germans, but not among the French, the British or the Swedes.

[66] For the UK, the frequency of "very satisfied" among the top income quintile group is not significantly different from that among the general population. In both France and Sweden, it is only significant at 10% level.

Figure 11.2: Very satisfied population subgroups, compared to national (or in case of the first chart: total sample) average in selected countries, 2008, % difference





Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Very satisfied: self-reported life satisfaction scores of 9 and 10 on a scale of 0 to 10
% difference= ((group mean-national mean)/national mean)*100
Total sample refers to 24 European countries.
Politically active: Political participation in 2 or more activities (out of 6) during the past 12 months, including "contacted politician or government official", "worked in political party or action group", "worked in another organisation or association", "worn or displayed campaign badge/sticker", "taken part in lawful public demonstration", or "boycotted certain products".
Intense social connections: meeting socially friends, relatives or colleagues every day or several times a week.
Inactive: includes those in retirement, doing housework or those who are long term sick or disabled, and excludes those who are in full-time education.
Low education: less than lower secondary education (isced 0-1), for Germany: "Grundschule nicht beendet" or "Schule beendet ohne Abschluss einer weiterführenden Schule"
Disabled: those who say that they are hampered "a lot" in their daily activities by a longstanding illness, or disability, infirmity or mental health problem.
Ethnic minority: respondents saying that they belong to a minority ethnic group in the country.

We seem to know more about the relationship of personal characteristics and unhappiness, while the key to happiness appears to be somewhat more hidden. The relationship between demographic, labour market characteristics and personal activities is much stronger with respect to low well-being than with respect to high well-being. Comparing our findings on "very satisfied" groups with those who are "dissatisfied" (Figure 7.3 in Chapter 7 versus Figure 11.2), we find a much stronger relationship in the latter case. The unemployed and the disabled have a manifold probability of being dissatisfied. On the other hand, intense social connections or being in the top fifth income group (the identified "winner groups") increase the chance of high satisfaction only by 20%. Promoting high

well-being thus needs other focus and different strategies than alleviating misery.

"Bliss" across social groups in Germany

Only 7% of unemployed are very satisfied in Germany. This share is lower than among those with low income, highlighting the detrimental effects of joblessness on well-being. As shown in Chapter 7, 38% of the unemployed were found to have a very low level of satisfaction, being the most dissatisfied group in Germany.

15% of people with disability that severely hampers their daily activities are very satisfied. This is much below the national average on the one hand, but on the other, it highlights that some people can find joy in their lives despite their limiting circumstances, either due to adjusting mentally to their physical state (there is ample literature on this subject), or due to finding a purpose in their lives, or living with a suitable personal "happiness strategy".

Low education groups and people who say that they belong to an ethnic minority tend to have a relatively lower likelihood to be very satisfied on average. This, however, may be a statistical artefact: self-reported satisfaction scores vary a great deal in these groups and the number of observations is relatively low, so the average in these groups may not differ from that of the total population in Germany[67].

East Germans are less likely to be very satisfied (altogether 17%).

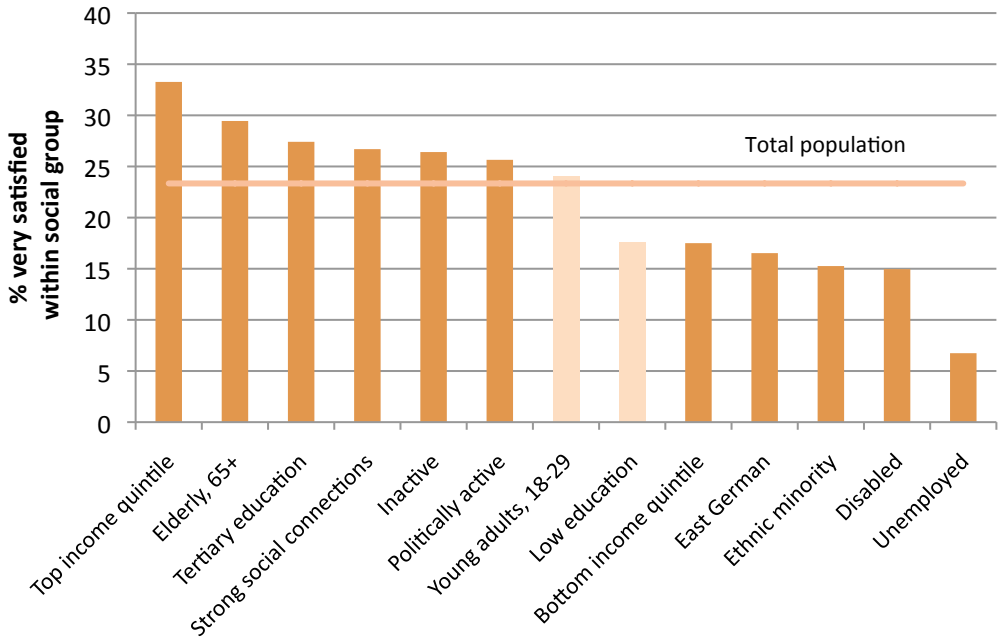
Over one in three persons in the top income quintile group regard themselves very satisfied in Germany. The elderly, the inactive, people with higher education, those living an intense social life or those who are engaged in political activities are more likely to be very satisfied. The situation of young adults does not differ significantly from that of the total population.

In Germany, we found no significant difference between men and women, so these results were omitted.

How much are these patterns confirmed by the alternative subjective well-being measure, self-reported happiness?

[67] More accurately, the difference of means is significant at 10% level for ethnic minorities and is not significant for low education (the confidence interval: 7-26%).

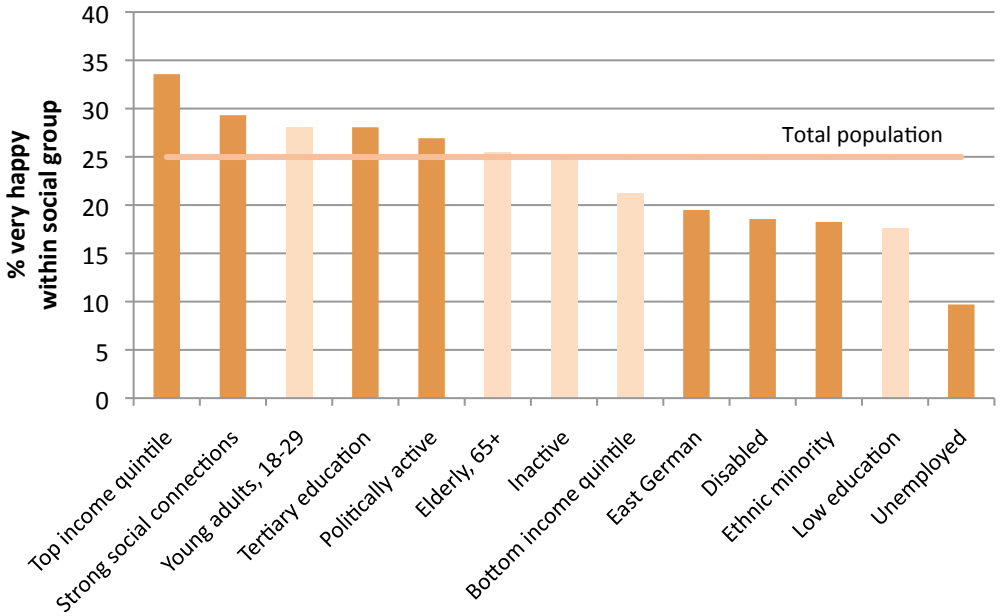
Figure 11.3: Share of very satisfied people across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Bars with a lighter shading indicate that the difference between the means is not significant at 10% level. "Very satisfied": self-reported life satisfaction scores of 9 and 10 on a scale of 0 to 10. Definitions of specific social groups: see Figure 11.2

Happiness seems to be much less related to external characteristics than life satisfaction. Although the social patterns appear to be similar at large on Figure 11.3 and Figure 11.4, the dispersion of responses to the self-reported happiness question is much larger, so we cannot capture a statistically significant level of happiness for many specific social groups. For people on low incomes we found a confidence interval of 17-26%, and for those with little education an interval between 7% and 26% (with 95% probability), which we cannot conclude that they are less likely to be very happy than the total German population on average. It is similar in case of age groups: the percentage of very happy is estimated to be between 23% and 31% among young adults and between 20% and 27% among those over 65: too wide dispersion of confidence intervals for a clear conclusion.

Figure 11.4: Happiness across specific social groups in Germany, 2008, % within group



Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Bars with a lighter shading indicate that the difference between the means is not significant at 10% level. "Very happy": self-reported happiness scores of 9 and 10 on a scale of 0 to 10. Definitions of specific social groups: see Figure 11.2

Happiness data, however, confirm that those who belong to the top fifth income group or have intense social contacts are more likely to be very happy. It is also confirmed that the unemployed have a lowest likelihood of being very happy (10%)[68]. Note that this level is higher than in case of satisfaction (7%), so the unemployed are more likely to say that they are very happy than to say that they are very satisfied. East Germans are also less likely to be very happy (19%), with a statistically significant difference.

This East-West "happiness" divide prevails since the early years of reunification, although with a gradually declining degree, as shown by GSOEP data (Noll and Weick 2010). According to Noll and Weick: "in East Germany SWB levels have been raising for some years until the late 1990s followed by stagnation since then" (ibid, p. 23).

Policy recommendations and conclusions

The empirical analysis suggests that we have more knowledge on what makes people unhappy than what makes them happy. Unemployment, disability, ethnic minority status and low income tend to reduce the probability of being very satisfied. The effect of well-being inducing factors (intense social contacts, political engagement, high income, and high education) is smaller and often not statistically significant for certain countries. Thus, these social categories reveal little on happiness inducing factors.

In Germany, unemployment is very strongly correlated to low well-being. The relationship seems to be stronger than in other countries. As shown earlier, 38% of the unemployed report a very low level of satisfaction and only 7% are very satisfied. The unemployed are thus the most dissatisfied social group in Germany (among those groups analysed here). This may be explained by the high levels of unemployment and the long duration of unemployment. Losing previous entitlement to social

[68] The estimated means for these three groups significantly differ from the population mean (at 1% level).

benefits “hurts” more than never having it, due to our psychological bias, also called as the “endowment effect” or “status quo bias” (see also the discussion in chapter 7). Happiness research highlights that the negative effects of unemployment go beyond that of pure income loss, and highlight the psychological costs on the short run, as well as a long term scarring effect, which prevails even after reemployment. Unemployment seems to lower self-esteem and be detrimental to social networks as well (chapter 6). Thus, based upon our findings and the well-being literature, reducing unemployment and increasing the probability and speed of reemployment would clearly be on the forefront of the German policy agenda.

Low income, disability is not necessarily related to lower subjective well-being. 15% of people with disability that severely hampers their daily activities say themselves to be very satisfied. Although this figure remains below the national average, it highlights that some people can find joy in their lives despite their limiting circumstances. How? Activities and relationships can provide an “exit strategy” into happiness, as these determine much of it, more than income or external circumstances. The active inclusion of these groups needs to entail more opportunities for social engagements, voluntary work, valued free time activities, and last, but not least, access to employment. Providing flexible and accommodating employment opportunities is fair and socially inclusive, and is also expected to increase personal life satisfaction.

East Germans have a systematically lower level of subjective well-being. According to Noll and Zweck, the “confidence in the performance of welfare state institutions and trust in the political and legal system seem to be crucial to explain the differences in SWB levels between West and East Germans” (2010, p. 24). Increasing trust and confidence involves not only improving the performance of institutions, but rather making them more responsive to specific needs, engaging in consultation and dialogue. In addition, providing information on the functioning of public institutions and the political system may enhance transparency and thus boost confidence.

Individuals themselves play a major role in determining their own happiness. In addition to individual’s ability to influence their life circumstances (e.g. making efforts to find a job, buying a house) and actions (how much time to spend with friends), they can largely alter their well-being by the interpretation of life events (see e.g. Lyubomirsky 2008). Western neuroscience has now confirmed what Eastern wisdom has known for a long time: happiness is a skill we can learn. On the other hand, people do not want to be told what is good for them, especially not by their political leaders. Providing incentives, information and a general social momentum, however, may ultimately contribute to changing norms and behavior. Social movements based on individual commitment may also be a way forward, as argued by Richard Layard, the proponent of the Action for Happiness, a recent British non-governmental organization.

Happiness, mental well-being, human flourishing[69], meaning in life are the ultimate goal for the overall majority of people. Other things, such as status, power, and income are rather means to reach this end, rather than things people want to acquire simply for their own sake. The extent to which people are happy is thus an essential quality of society, and is therefore a concern for policymakers.

What is the role of governments, in promoting the happiness of citizens? Social institutions systematically influence happiness. Frey and Stutzer (2002), in their quantitative analysis using Swiss data, show that direct political participation of citizens via popular referenda and federalist decentralization increases happiness. They argue for establishing those fundamental social institutions which lead to the best possible fulfillment of individual preferences. Specific government measures do affect the happiness of citizens. Well-being indicators thus enable governments to evaluate the welfare effects of their programs directly. For this, however, there has to be a clear role of these indicators in the policy-making cycle, with a clear causal link between a policy and its

[69] It refers to the classic Greek notion of “eudaimonia”, which was used as a term for the highest human good.

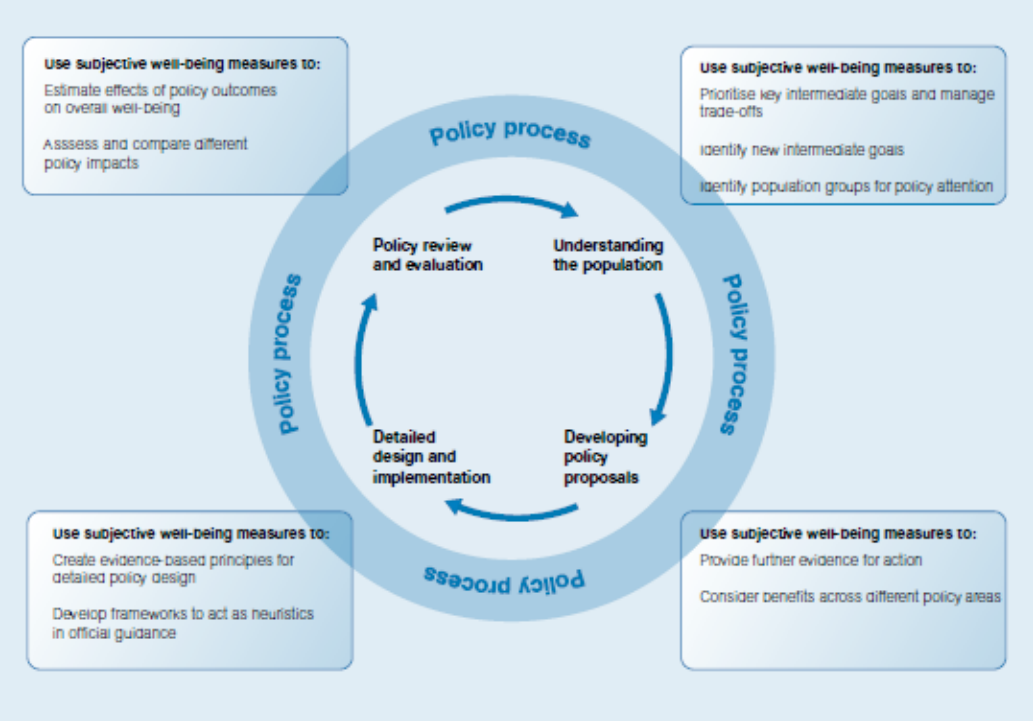
outcome.

In the UK, the Office for National Statistics is currently preparing new variables of well-being, following a national consultation on the issue. These are likely to include not only the life satisfaction question, but also a hedonic question (happiness) and a "functioning" question related to meaning and feeling valuable. The use of well-being indicators in politics can have very positive effects if certain criteria are met. The main benefit that these indicators express issues which matter to the people. Note, however, that these indicators would capture public confidence if they are clearly linked to political performance (assessment and feedback in the policy process) and if there is a trust in data and measurement.

In contrast to the UK or France, where the use of well-being indicators are in the forefront of recent and ongoing policy efforts, this issue has not yet gained political priority in Germany. There is thus much scope for an increased use of well-being indicators in Germany across the policy-making cycle (Box 11.1):

1. Understanding the population,
2. Developing policy proposals,
3. Detailed design and implementation,
4. Policy review and evaluation.

Box 11.1: Subjective well-being indicators in the policy cycle



Source: New Economics Foundation (2011)

This chapter has contributed to understanding the population patterns, by identifying social groups for policy attention. The following steps of developing policy proposals, with detailed monitoring and assessment is yet waiting. Throughout these steps, subjective well-being measures can help with setting priorities, provide evidence for action and can assess effects of policy outcomes.

IV. The policy world: best practices and policy recommendations for Germany

12 Early childhood education and care

Pieter Vanhuysse

This analytical section follows up on the international comparative section 3, in which we described empirical evidence on access to early childhood education and care a cross different countries. In the present section, we review and discuss the best available evidence from economics and social policy on the socio-economic and educational costs and benefits of ECEC policies and we highlight in particular some key US ECEC pilot programs. These programs provide simultaneously the best practice of high-quality intensive ECEC and the best economic evidence for the costs and benefits of ECEC programs, as these pilot programs, unlike any programs available in EU countries, were based on randomized participation. In concluding, we offer policy prescriptions for EU member states and provide parallels between these ECEC randomized pilot programs and the larger, subsidized, universal-access ECEC approaches of Nordic countries such as Sweden and Denmark.

In recent years, there has been in increasing awareness among academics and policymakers of the strong importance of human capital in improving the economic wellbeing of persons and nations. Spearheaded within economics by James Heckman, the 2000 Economics Nobel Laureate, and within comparative social policy by Gosta Esping-Andersen, social scientists have emphasized that policies aimed at boosting human capital contribute to a nation's economic welfare in at least two ways: by increasing (future) workers' ability to invent, adopt, or diffuse new ideas and technologies, and by raising workers' output per unit of time (see e.g. Heckman 2000; 2004; Carneiro and Heckman 2003; Heckman and Masterov 2007; Esping-Andersen 1999; 2002a, 2002b, 2002c; 2008; 2009; Bonke and Esping-Andersen 2011). As we show below, in this respect early childhood education and care (ECEC) policies are a particularly promising avenue for improving human capital and increasing equality of opportunity in society.

12.1 The new human capital paradigm in economics and social policy: the role of ECEC programs

Cumulative evidence from economics indicates that even when viewed from a *purely* economic point of view, early childhood programs constitute an efficient use of tax revenues (Heckman 2000; 2004; Carneiro and Heckman 2003; Heckman and Masterov 2007). Compared to randomly assigned controls, participants in these programs score systematically better on a wide range of variables measuring educational achievements and high school graduation rates, and, later on in life, employment rates, monthly earnings, welfare receipt status, and crime rates. While early childhood intervention programs may seem expensive in absolute terms, they are cost-efficient once we incorporate the wide range of future benefits that they yield, both to individual participants and to society at large.

Policies targeting the first years of childhood can also be goal-effective, because they intervene at a time when most neural and cognitive progress and priming is made. Ability gaps across socioeconomic groups open up at early ages, both for cognitive skills such as educational outcomes and IQ, and for noncognitive skills such as perseverance, motivation, and self-control. Human capital deficits do not arise primarily from parental credit constraints at the time of children's adolescence, but rather from inadequate learning environments in the family much earlier in life. Even economists from the notoriously neo-liberal and pro-market University of Chicago, such as Carneiro and Heckman (2003) do not shy away from drawing strong, if consistent, conclusions in favor of state intervention to mitigate the effect of poor family environments: 'Paternalistic interventions in the early life of children in certain dysfunctional families may be appropriate' (164).

Another scientific impetus in favor of ECEC approaches comes from comparative social policy and empirical sociology. Paradoxically, the increasing democratization of education since the 1960s has generally *failed* to reduce the role of parental inheritance (family background) in determining children's cognitive development and educational attainments.[70] Moreover, the UK is a worrying example to this effect. As Blond (2011) notes, Britain in 2010 had the highest correlation between parental income and outcomes for children, and thus the lowest rate of social mobility in the entire OECD. Moreover, young children in the highest income group are about seven times less likely to have clinically relevant socio-emotional problems by age 3, and this gap increases further by age 5. In addition, the gap between rich and poor children in terms of speaking abilities also increased by as much as 50% between ages 3 and 5 (ISER 2011).

A rare exception to this intergenerational immobility (or 'constant flux') pattern can be found in Nordic countries such as Sweden, Norway and Denmark, which have been most proactive in investing in universal policies to improve children's cognitive abilities. In all three countries, the effect of social inheritance is below-average, and is declining over time, especially for the age cohort born in 1970-75 – the first cohort to have enjoyed near-universal levels of childcare access (Esping-Andersen 2009: 135; also Shavit and Blossfeld, 1992; Erikson and Goldthorpe, 1992). Moreover, unequal material circumstances in early family environments clearly lead to unequal parental investment in high quality child care both in terms of parenting and in terms of third party care (Bonke and Esping-Andersen 2011; Hurst et al. 2008). Esping-Andersen (2009, 2002b) therefore argues that since the material aspects of childhood still tend to be strongly correlated with marketable cognitive abilities, it follows that the *quality* of childhood matters ever more for long-term life chances.[71] Indeed, intervening after primary school starting age may be too late for making a significant impact (Hanushek 2003). As Esping-Andersen (2009: 121-122) puts it: 'there is now a general consensus that the really important mechanisms of social inheritance lie buried in the pre-school ages. For most children this is also the period where they are most 'privatized', depending almost exclusively on the family milieu. … This is where the really important effects lie buried.'[72] The next section discusses the best available knowledge on randomized high intensity pilot programs for human capital.

Evidence over time from randomized high intensity ECEC pilot programs: cognitive and behavioral effects

The best social-scientific evidence to date on the various cognitive and behavioral effects, as well as the economic costs and benefits, of ECEC programs comes from the ECEC pilot programs that were set up in selected American cities in the late 1960s and 1970s, such as the Perry Preschool Program (Ypsilanti, Michigan), the Syracuse Preschool Program, the Abecedarian Program (Carolina), and the much larger Head Start Program. One important advantage of these programs was that they were (with the exception of Head Start) based on *randomized* participation. That is, within the total identified target population (typically, all children of a certain age cohort in pre-identified low-SES neighborhoods), participation in the ECEC program (the experimental group) and non-participation in the program (the control group) were determined randomly – typically by lottery. This allows for a better measurement of the ECEC program effects, since important socio-economic and environmental factors (such as neighborhood quality, and parental SES) affecting outcomes of

[70] See Shavit and Blossfeld (1992); Erikson and Goldthorpe (1992).

[71] In addition to this, marriage choices remain as homogamous as ever, resulting in a clustering of life opportunities within households and a polarization between households. For instance, both the relative share of two-earner households and that of no-earner households are on the increase in a number of European countries, with straightforward consequences in terms of these groups' poverty rates (Esping-Andersen 2009; 2002b, pp. 39, 42).

[72] Dysfunctional family environments in turn lead to dysfunctional social behavior among young people. In the UK, 70 percent of young offenders today come from one-parent families and a third of all prisoners come from families so dysfunctional they were taken into care by the state (Blond 2011).

relevance were controlled for and self-selection and other sources of participant bias were avoided (Barnett 2002; Heckman 2000). A second major advantage of these pilot programs was that, unlike anywhere in EU member states with the exception of Nordic countries, they were started early on in the 1960s and 1970s, thus allowing proper longitudinal analysis by following the members of control and experimental groups (who had initially been very young children) over the course of their life time as they consecutively attained school age, high school age and further on in the labor market. Thus, by the mid-1990s the first studies of the long-term effects of ECEC programs could be studied, as participants had by then reached labor market age.

Evidence from these studies indicates that early intervention policies can have long-lasting positive effects on children. The most important review and meta-analysis of these studies to date is Barnet (1995), who reviewed altogether 36 studies explicitly focusing on the *long-term effects* of both small-scale and large-scale ECEC programs for disadvantaged children that had started decades earlier with participants at age 4 or earlier. Barnett (1995) generally concludes that these programs produced very sizable lasting benefits. These long-term effects were measured in terms of (a) IQ, (b) school achievement, (c) social adjustment (class room behaviour, aggression, crime, delinquency) and, with most overwhelming effects, (d) grade retention and (e) placement in special education. For instance, most model programs produced IQ gains that were sustained until school entry at age 5, at which time 10 of the 15 studies reported improvements of 4 to 11 points and in one case of 25 points. IQ improvements persisted the longest – into adolescence - in the two cases where infants had been enrolled in full day educational child care programs.

Moreover, 5 out of 11 relevant studies found statistically significant positive effects on achievement in reading and mathematics beyond third grade, with effects lasting as long as junior high school in two cases (Barnett, 1995, p. 35, 40). All five studies that had follow-ups until after high school age found that ECEC programs had a large positive effect on high school graduation rates (Barnett 1995, p. 41). Lastly, regarding grade retention and placement in special education, the positive effects of ECEC programs were strongest of all. All but one relevant study of small-scale model programs and 8 out of 10 relevant studies of large-scale public programs, which are typically less funded and less intensive, found statistically significant improvements (see also Barnett, 2001).

Focusing on one pilot program in particular, the Abecedarian Project, which provided full-time year-round classes from infancy though pre-school, Campbell et al. (2002) and Bracey and Stellar (2003) report that by age 21, participants in the Abecedarian program had completed more years of schooling than controls (12.2 vs 11.6), more of them were still in school 42 vs 20%) and more had enrolled in four-year colleges (36 vs 14%). Similarly, Heckman (2000, p. 29) reports that compared to randomly assigned controls, participants in the Perry Preschool Program, which intensively treated disadvantaged Michigan children at ages 4-5, systematically recorded statistically significant differences with respect to a wide range of variables regarding:

(a) education (better achievements at ages 9 and 15, lower rates of classification as mentally retarded, and higher high school graduation rates),
(b) employment: 50% vs 32% were employed at age 19, and average monthly earnings were 1,129$ vs 766$ at age 28,
(c) crime: fewer individuals had been arrested by age 19 (31% vs. 51%) and many times fewer individuals had had multiple (5+) arrests by age 28 (7% vs 35%),
(d) welfare: fewer individuals had received welfare both at age 19 (18% vs 32%) and at age 28 (59% vs 80%).

By age 27, significantly more Perry participants than control group members had earned high school degrees or the equivalent thereof (71 vs 54%) and preschoolers were also likely to earn more, to own their own homes, and to have longer and more stable marriages. Members of the control group were arrested twice as often as Perry participants, and five times as many control group members (35%) had been arrested five times or more.

Barnett (2002) argues that pre-kindergarten education for disadvantaged children can greatly increase their cognitive abilities, leading to long-term increases in achievement and school success and can have positive effects on children's long-term social and emotional development, reducing crime and delinquency. However, to reap all of their potential benefits, pre-kindergarten programs for disadvantaged children must be intensive and high-quality, and they must emphasize both cognitive and social development.

As Heckman (2004; 2000) notes, the key message for policymakers regarding ECEC programs is that the earlier the intervention, the better the results. One of the reasons why the first years of childhood are so crucial is that they are the time when most neural and cognitive progress and priming is made, often irreversibly so. Ability gaps between individuals and across socioeconomic groups open up at early ages, for both cognitive and, equally importantly, noncognitive socio-emotional skills (such as perseverance, motivation, and self-control). Importantly, these gaps are strongly correlated with family background factors, such as parental education and maternal ability. When controlling for these family variables, the ability gaps are almost eliminated (Ramey and Ramey 2000; Heckman 2004).

The role of family background (including variables such as parental style, parental SES, and two parents' involvement) in promoting children's cognitive and emotional development and their school achievements is well documented. Children from single-parent families (and typically also those from stepfamilies) obtain fewer years of education and are more likely to repeat grades or drop out of school, to commit crimes and to use drugs. Being from a single-parent family not only lowers a child's own math scores, but students from schools with a high proportion of single-parent children had significantly lower math and reading scores than those from schools with more two-parent children (Pong et al. 2003).

Given that the family plays such a crucial role in shaping these abilities, the most effective remediation strategies are those that supplement family resources particularly for very young children from disadvantaged environments. Enriched early interventions at the youngest ages can partially compensate for adverse family environments. The Abecedarian Project provided precisely such an enriched intervention for disadvantaged children starting at age 4 months. Specifically, the Abecedarian program was center-based, operated 10 hours a day, five days a week, fifty days a year. It included free transportation, with teacher/child ratios between 1/3 (for infants and toddlers) and 1/6 (in years 4 and 5), and its curriculum emphasized especially language development. The children who participated (having been assigned randomly to the program between ages 6 and 12 weeks) scored consistently higher than those who do not, even many years after the Abecedarian intervention was discontinued (Heckman 2004).

However, while an early start is crucial, continuity is needed subsequently. The psychological products created in the first two life years will be preserved only if the environment sustains them. There is some evidence that providing add-on programs after early childhood can make an extra difference to the extent that the treatment is extensive enough, *but only on condition that the children received ECEC* during early childhood (Barnett 1995, p. 42). In Barnett's (1995, p. 44) meta-analysis, subsequent fade-out of ECEC program effects were clear and unambiguous only in the case of IQ (see also Arnold and Doctoroff 2003). At the same time, prolonged effects do occur with respect to school achievement and success as well as socialization, even without subsequent school intervention.

The economic costs and benefits of ECEC pilot programs

While early intervention policies can achieve significant and long-lasting effects, they also carry a price tag. Such policies may be expensive, but crucially, they prove to be very high value for money when their cost is compared to the wide range of benefits they provide to individuals and societies.

Barnett (1995, p. 45) reports a conservative cost/benefit analysis of the returns to investment in the Perry Preschool Program estimates the measured benefits (in terms of child care, K-12 and adult education, college, employment, crime and welfare) at 8,814$ for the program's participants and at 61,972$ for the general public, and the total benefits (which include, in addition projected benefits in terms of earnings, crime and welfare) at respectively 19,569$ and 88,433$. Given that the Perry program cost about 12,356 (1990) dollars per child, this amounts to a *net present value* of the program of 19,569$ per participant and, in addition, 76,077$ for the general public. Heckman (2000, p. 26) reports that *by age 27, every dollar spent on the Perry program had returned 5.70 dollars; and returned 8.70 dollars over the remainder of the participant's life* (see also Carneiro and Heckman 2003; Heckman and Masterov 2007).

Barnett and Masse (2006) estimate a *benefit/cost rate of 7/1 for the Perry program and of 4/1 for the Abecedarian Pro*gram. Children who took part in the Abecedarian program earned an estimated $143,000 more over their lifetime than those who did not. In addition, the *mothers* of children who participated would earn an estimated $133,000 more, as a result of the fact that mothers with stable child care availability tend to establish better, longer-term and more productive relationships with employers. In addition, teenage mothers whose preschool children participated in the Abecedarian program were more likely to be employed and to have skilled or semi-skilled jobs. By the time their children reached 54 months of age, these mothers were more likely to have graduated high school, to have received post-secondary education, to be self-supporting, and less likely to have had additional children subsequently (Masse and Barnett 2006). Lastly, the *children* of children who participated in would earn an estimated $48,000 more, as a result of the fact that higher earnings of their parents (Barnett and Masse 2006; see also Bracey and Stellar 2003).

Conclusions and policy prescriptions

Overall, the economic research on the key role of early childhood and family environments is compelling (see also Bowles et al. 2005), and it is consistent with recent evidence from neuroscience and developmental psychology (Knudsen et al. 2007). In a major review comparing the economic costs and benefits of the entire portfolio of potential policies to improve human capital in the economy (including investment in early childhood learning and in adolescent learning, training programs for displaced workers, tax benefits, and schooling subsidies), James Heckman (2000) concludes unambiguously that high intensity ECEC policies are both effective and highly cost-efficient. The reason is that the youngest have a longer time horizon over which to reap the subsequent benefits of human capital policies (see also Heckman 2004; Heckman and Masterov 2007). In other words, early childhood social policies may seem expensive, but when taking into account the wide range of future benefits both to participants and to society at large, these preventive social policies are a great investment and cost-saving. The case for strengthening and complementing family environments is further bolstered by evidence from comparative social policy (Esping-Andersen 1999; 2002b; 2009; Gornick and Meyers 2003) and the sociology of education (Pong 1997; Pong et al. 2003). Cumulatively, these bodies of research indicate that failing family environments may be more important than failing schools in explaining the emotional development, academic motivation and educational success of children.

Important prescriptions for public policy follow from this evidence. Efforts directed toward families may be a more effective way of improving school performance than direct expenditures on 'standard' schooling inputs such as teacher salaries, teacher quality, class size, and spending on pupils and school equipment. This is even more important given the increasing awareness that investments in education at ‘normal’ school ages are often unexpectedly ineffective (e.g. Hanushek 2003).

This evidence review above provides further grounds for advocating state investment in the earlier years. Yet, as we have seen in section 3, EU and OECD countries today still tend to spend more on pre-primary school services than on truly early-childhood care services which target the age group where intervention is likely to be more effective (Figure 3.5 and Figure 3.6). In fact, state spending commitments on early childcare amount to only 0.1 percent of GDP in countries such as Slovakia, Germany and the Netherlands, but to *six, seven and eight times as much in Nordic countries* such as respectively Sweden, Iceland and Denmark. Second, if we are to activate the employment of mothers, we need to reduce the prices of childcare. Here again the Nordic countries show the lead. Moreover, concerning the quality of preschool programs, a number of explicit policy prescriptions follow from the cumulative evidence on ECEC pilot programs (Barnett 2002):

1) Class sizes and child-teacher ratios must be kept low.
2) Teachers must be highly qualified, with at least a bachelor's degree and with specialized training in early education, and must be paid well.
3) Curricula must be intellectually rich and sufficiently broad to address children's developmental needs in all domains.
4) Programs must engage in an active partnership with parents and accommodate their needs, including their needs for childcare.
5) Programs should start no later than age three.
6) Resources should be focused primarily on disadvantaged children.

Of course, no country thus far has implemented exact copies of the ECEC pilot programs studied here on a truly nation-wide scale. Yet, as we have seen at length in section 3, within the EU Nordic countries such as Denmark, Sweden and Finland are the outstanding best practice model to follow, as they effectively *already* apply Perry Preschool or Head Start-type programs on a national scale. By providing publicly subsidized daycare with low class sizes (Figure 3.7) and realizing high attendance rates even for very young children (Figure 3.3), they actively enable mothers to work, thereby reducing long-term welfare dependency, and enlarging the tax base. Poverty among children (Figure 3.1) and among single-parent families (Figure 3.2) is much lower than in other welfare regimes, whereas mothers' labor market participation rates (Figure 3.4) are significantly higher.

As we have seen, attendance rates for pre-primary school age children (aged 3-5) in EU countries vary from under 60 percent in Anglo-Saxon countries (Australia, Canada, USA) and Croatia, Greece, Poland, and Switzerland, to near-universal (over 90 percent) in Belgium, Estonia, France, Iceland, Italy, New Zealand, Slovenia, Spain, Sweden and the UK. But importantly, *attendance rates for the truly crucial age group - children aged between 0 and 2 – are much lower everywhere except for the Nordic countries*, ranging from close to zero in post-communist countries and around 10 percent in Greece and Austria to over 40 percent in France and Iceland. Only in the Netherlands do ECEC attendance rates reach a level close to 50 percent for the very young children, while they reach over 60 percent in Sweden and over 70 percent in Denmark (Figure 3.3). And only in the Nordic countries are nearly all young children placed in centre-based care (as opposed to individual carers, as in France), with guaranteed access to high-quality full-day subsidized care (Esping-Andersen 2009). Belgium, Slovenia and the four Nordic states are the only EU countries that provide a state entitlement to ECEC before age 3. And *only in the Nordic countries are policies designed so as to ensure there is no gap between the end of parental leave and the start of an ECEC entitlement*. In sum, countries such as Sweden and Denmark clearly provide the best overall policy model for increasing human capital, and thereby equality of opportunity early in life, through investment in ECEC.

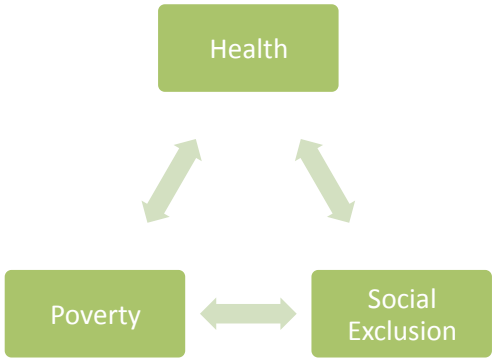
13. Health care

Ulrike Waginger

Equitable access to high-quality healthcare constitutes a key challenge to health systems throughout Europe. Significant inequalities in health between socio-economic groups are apparent in all countries where relevant data is available (Mackenbach et al. 2011). Differences in people's health may be due to various inherent factors, such as people's lifestyle, their access to and the quality of healthcare (Eurostat 2010).

The access to health care services greatly influences people's health, and ultimately affects their risk of social exclusion. In addition, poor quality of public services also affects marginalized people more than others, as they are not able to compensate by making use of private services. If the quality of public health care is poor, inequalities in health will occur even in systems where health care provision is universal.

Figure 13.1: The close inter-relation of health, poverty and social exclusion



Source: (Stegeman and Costongs, 2003

Health, social exclusion and risk of poverty are closely linked (Figure 13.1). Social exclusion can not only be provoked by poor health, but it may also itself reinforce health problems - for example, where the form of social exclusion results in barriers to healthcare. Not being able to access necessary and adequate care or to pay for medical treatments can exacerbate poverty and social exclusion. Achieving equal access to health care is one way the health sector can contribute to reducing social exclusion.

In chapter 4 and 9, the prevalence of poorer general health was shown to be higher among people with lower income and lower educational attainment. People of lower socio-economic groups can expect to live up to 15 years less in good health than people of higher socio-economic groups (Costongs and Stegeman 2003).

A prevailing relative gap in life expectancy between lower and upper socio-economic groups has been reported to have further widened in the past decades in several European countries. Several causes were identified accounting for this unexpected widening of socio-economic mortality inequalities in a study of six European countries (the United Kingdom, Italy, Finland, Sweden, Norway and Denmark): the differential mortality decline for cardiovascular diseases between these socio-economic groups and an increased mortality due to other causes (lung cancer, breast cancer, respiratory disease, gastrointestinal disease and injuries) became apparent in the lower socio-economic group (Mackenbach 2003).

The economic cost of health inequalities is a huge burden on European economies. Mackenbach et al. (2011) illustrated that welfare losses related to health inequalities amount to an estimated monetary value of 980 billion euro per year, which represents 9.4% of GDP. Health related inequalities are responsible for over 700.000 deaths per year and 33 million cases of ill health in the European Union as a whole. According to the calculations of Mackenbach et al. these losses due to health inequalities account for 20% of the total healthcare expenditure and 15% of the total costs of social security benefits.

Even if issues related to health and social policy remain the primarily responsibility of governments of EU Member States, a coordination of national healthcare policies is promoted by the European Union via the Open Method of Coordination (OMC). Within this approach, a particular focus is put on access, quality and sustainability (EU key objectives can be found in Box 13.1 below).

Box 13.1: EU key objectives to address health-related social exclusion

I. Access to health promotion, disease prevention, and curative care
- shorter waiting times
- reaching all parts of the population through universal insurance coverage and affordable care
- reducing geographical differences in availability and quality of care
- addressing cultural and language barriers to using services

II. Quality
- more patient-centred care
- effective and safe treatment and equipment
- greater use of evidence-based medicine and health technology assessment (EUnetHTA)
- greater use of effective prevention programmes for cancer, cardiovascular diseases, and infectious diseases (vaccination) amongst others
- better integration / coordination between: primary, out-patient and in-patient secondary and tertiary care; medical, nursing, social and palliative care

III. Sustainability

More rational use of financial resources via:

- greater use of generic medicines
- focusing on primary care – referral systems to secondary care
- reducing in-patients, increasing out-patients
- simplifying administrative procedures
- concentrating specialised care in centres of excellence
- strengthen health promotion and disease prevention

Avoiding under-resourcing of health care systems and establish a viable contribution base:

- better coordination of care
- ensure sufficient human resources for health through: good training; motivation and working conditions; addressing imbalances in different categories of staff

Reasons for coordinating healthcare at EU level

1. Health outcomes in the EU are strikingly different according to where you live, your ethnicity, gender and socio-economic status.
2. The EU is pursuing a "health-in-all-policies" approach. EU structural funds can be used to support healthcare reform and capacity-building in regions which need particular assistance.
3. High demand for healthcare staff in some countries is draining qualified resources from others, underlining the need for an EU-wide approach.
4. Some common challenges: Ageing population

Access for all to technological progress and greater patient choice must be balanced against financial sustainability. Spending on health care in EU countries is growing faster than their national wealth. Priorities have to be set, and greater value for money achieved.

Source: website of the European Commission: http://ec.europa.eu/social/main.jsp?catId=754&langId=en; accessed 14 July 2011.

Barriers of access to health care across European countries[73]

Barriers of the access to health services can result in health inequalities and can thereby lead to social exclusion. As providing access to health care is key to reduce health inequalities, improving the access to health services is a policy area of great concern to national governments. In chapter 4, analyses of quantitative health indicators showed a clear relationship between lack of access to health care, age and income. The proportion of people with unmet medical needs was shown to vary significantly across countries (see chapter 4).

Barriers to health care may have various causes. Although public programmes are offered in most European countries, not every individual is covered by these services, which may raise the need for private coverage, or worse, leave people uncovered. Even if an individual is covered by public programmes, the scope of goods and services provided may be limited, and not every health service needed may be covered by the respective public programme. The requirement to pay for a share of costs can constitute a barrier particularly for people at-risk-of-poverty.

Geographical barriers, which may occur when services are available only at a certain distance, may become problematic for vulnerable groups. Older persons, for example, can experience difficulties in making use of such services, if they are not able to travel alone or if public transports are either not available or too expensive. Finally the way services are provided may also constitute a hurdle for some individuals, e.g. if pre-registration via telephone is necessary, which may affect people with communication problems (in terms of hearing or speaking). This section will review barriers to the access of health care from a European comparative perspective. An overview of good practice policies that aim to overcome these access barriers will be given in the next section.

Box 13.2: Barriers of access to health care for people at risk of social exclusion

- not everyone is covered by public programmes
- not all services are covered by public programmes
- some costs need to be covered by individuals
- available services are too distant
- the way services are provided may constitute a hurdle for some individuals

Barriers to health care in terms of coverage

In Europe, two main types of public programmes prevail: a tax-financed National Health Service (NHS) and a statutory social health insurance funded model as well as combinations of the two. Most European countries offer such mandatory public programmes. One exemption is the Netherlands, which introduced a compulsory scheme of private health insurance in 2006.

Public programmes usually offer universal or near-universal coverage for basic health risks to all legal residents and citizens. In some countries this coverage is extended to asylum seekers and legal immigrants with a resident status. This is the case in the UK and Spain, where a tax-financed public programme covers a broad package of services uniformly for people of all groups. Other countries, however, exclude these groups. The Finish municipal health care, for example, covers all residents,

[73] This chapter largely draws upon findings of the HealthQUEST study, which was commissioned by the European Commission, DG Employment, Social Affairs and Equal Opportunity under the 2002-2006 Community Action Plan on Social Inclusion, including its country reports and the summary report "Quality in and Equality of Access to Healthcare Services" published by Huber et al. in 2008. Information was updated by using data from the Mutual Information System on Social Protection (MISSOC) database of the European Commission.

but excludes asylum seekers without a residency permit, illegal immigrants and temporary foreign workers (Huber et al. 2008). In Greece, it is against the law for doctors to treat illegal immigrants (Stegeman and Costongs 2003).

Overall, European public programmes provide a comprehensive and almost universal coverage, but some gaps remain affecting vulnerable groups in particular. Germany addressed the problem of uninsured residents (the numbers were estimated to have increased from 0.2% in 2003 to 0.4% or 300,000 people in 2005) through a health care reform in 2007. In the new system, introducing a universal coverage, there is the general obligation for all currently uninsured persons to register with a public or private insurance fund. Such an obligation did not exist previously, which increased the risk of being uninsured for some groups, such as self-employed people with limited income and often irregular life careers, divorced or widowed women, who were not working and not under contract with an insurance fund, and unemployed people, who were reclassified and thereby lost their automatic right to health insurance coverage. The new regulations benefit these groups of uninsured people, who may be at risk of poverty but not eligible to social assistance (Huber et al. 2008).

One potential gap in the new German system is that those who were insured with a private insurance provider before loosing their health care coverage cannot re-integrate in the social insurance system. Women who lost their co-insurance from a privately insured partner due to divorce suffer from this new regulation also. As the cost of private insurance can be as high as the most expensive contract under the public insurance system this may cause difficulties particularly for people at risk of poverty.

Gaps in coverage of goods and services in public programmes

Limitations in coverage of health services under public programmes are mostly due to budgetary pressures and criteria for determining inclusion are usually based on evaluation of need, appropriateness, effectiveness and cost-effectiveness. In the comparative study of eight European countries (the United Kingdom, Germany, Finland, Greece, the Netherlands, Romania, Poland, Spain) during the HealthQUEST project, Huber et al. (2008) reported a very comprehensive coverage of preventive health services, primary health care services, hospital services as well as maternity services by public programmes free of charge to all the entitled individuals. Common limitations in coverage include non-prescription drugs, travel vaccination, non-conventional treatments (such as acupuncture and other complementary medical treatments) and cosmetic surgery among others. Fertility treatments, abortion and euthanasia are often excluded on moral or bio-ethical grouds and sometimes give rise to “service tourism” (patients may choose to travel to countries providing the services).

Typical gaps in the provision of health services are the restricted coverage for dental and ophthalmic services as well as the limited access to specialised services (which are often restricted through a visit of a general practitioner, who functions as a “gatekeeper”). Especially for the provision of dental services huge country variations in terms of coverage can be found. Full coverage is often limited to young individuals (until age 16 or 18) with adults having to cover most costs privately. These costs of private treatment are often very high and may become a barrier of access in particular to people of low income groups.

In the case of Romania, 95% of dental services are provided by private practices, which are located mainly in urban areas, yet public services include only school clinics and internal networks of some ministries, leaving a major gap in the provision of dental services especially for people at risk of social exclusion. A similar situation is prevalent in Spain, where public services cover only infant dental health care and only diagnosis and extraction for adults. All other dental health services are provided by private practices, leading to a situation where only those who can afford will make use of dental services. Studies on the utilisation of dental services have revealed a pattern of inequity, with lesser use of services among lower socio-economic groups (Rodriguez-Sanz et al. 2006 cited in Huber et al.

2008): 46% of respondents of a 2005 *Living Conditions Survey* stated financial reasons for being unable to have dental treatment. A tendency of dentists to shift to the private sector is also noticeable in the UK, leaving a growing number of patients unable to find a dentist who would offer services covered by the NHS. The UK tried to tackle this issue with a payment reform in 2006, which guaranteed dentists a minimum income, however, problems of access are still frequent (Huber et al. 2008).

These gaps in provision of services at times cause a situation, where those who can afford opt for private health services. Thus, financial capacity to pay for services determines the individual's access to health care (in particular to dental health care) and fosters inequalities in health, resulting in the social exclusion of vulnerable groups.

Another barrier of access arises when services that in principle are covered by public programmes are simply not available, which presents another major hindrance for those socially excluded, who may be less able to receive treatment elsewhere (i.e. to travel or to choose private treatment).

Cost-sharing requirements as barrier of access to health services

The need for private expenditure, including private health insurance, occupational health care and out-of-pocket expenditure, may constitute a barrier of access to health care for groups at risk of poverty. The risk of social exclusion is particularly high when private payments are required to benefit from adequate health care. Especially those groups with high risk of social exclusion are affected by the financial burden of health care costs.

Private spending plays an important role in EU Member States, and the share of private expenditure as a share of total health expenditure has increased in the EU-15 over the last 15 years with out-of-pocket expenditure accounting for the largest share of expenditures. Also the share of private spending has increased in several countries recently.

Even if population coverage under the public system is high in most countries, some countries, like Greece, Poland, Romania and Spain present high levels of private health expenditure putting financial pressure in particular on those at risk of poverty. Research on Greece has shown that high private expenditure disproportionally affects socially disadvantaged groups, such as low income groups, older people, disabled and immigrants. In Greece, private expenditure increased in the last years to over 50% of total health expenditure, with Greece being among those countries with highest levels of health expenditure relative to GDP. A major share of private spending in Greece is due to informal payments. Studies on Finland showed that an increase in cost sharing of public health care over the last 15 years led to tighten access barriers for low-income households. Also in Poland an extremely high share of expenditure for health care is covered by out-of-pocket payments. These private payments have increased since the early 1990s from 10% to 35% (Huber et al. 2008).

Germany, on the contrary, performs very well in keeping out-of-pocket expenses relatively low by comparison with other countries through providing a more extensive financing of public and private health insurances. Nevertheless, a rise in co-payments on pharmaceuticals has taken place in the last years affecting particularly those with more extensive need of medication such as people with chronic disease.

Box 13.3: Private expenditure consists of

- private health insurance
- occupational health care
- out-of pocket expenditure:
  - Cost sharing requirements of publicly provided goods and services
  - Expenditure for over-the-counter goods (e.g. non-prescription drugs)
  - Expenditure for services not covered under the public programme
- Informal payments

Out-of-pocket payments apply for services and goods not covered or only partly covered by public programmes. Goods and services which are not or only partly covered by most European public programmes include prescription drugs, dental services and prostheses, physiotherapy, hearing aids and glasses among others. The largest share of co-payments apply for pharmaceuticals (including cost sharing for prescription drugs), followed by ambulatory and outpatient service cost and medical goods (including spectacles, hearing aids and medical non-durables). In most countries, emergency and hospital in-patient services do not affect private spending.

Co-payment for *prescription drugs* is handled very diversely in European countries: some countries provide a basic package of prescription drugs free of charge (like the UK and the Netherlands), others charge up to 58% of coinsurance (like Finland). Disadvantaged groups are often excluded from co-payments, such as children, pregnant women, older persons, people with low income, or people with severe or chronic illnesses. Over-the-counter drugs and complementary drugs are usually not covered by public insurances.

Few countries have co-payments for visits to a *general practitioner*, who is under contract with the public health programme. One exemption is Germany, where a charge of 10€ for every first visit in a quarter applies. Children are exempted from this co-payment and it is omitted for patient referrals. Also Finish health centres may charge a fee of 13.70€ for doctor's appointments, with an upper limit of 27.40€ per year (MISSOC 2011). Children are also exempted from this co-payment. In Austria, a charge of 10€ applies for the "e-card", an electronic sickness insurance card, which proves the entitlement of a patient towards the doctors. Exempted from the costs are children, retirees and materially deprived people.

As already mentioned above, *dental health care* as well as dental prosthesis is usually only partially covered by public programmes, affecting especially those with financial constraints. Vulnerable groups in need of dental prosthesis, which often includes older persons, may find it difficult to cover such cost.

A broad variation in coverage and co-payments can also be found for *medical aids and appliances* between EU Member States. High co-payments pose financial burdens in particular on disabled and on older people, as these groups often have a greater need of medical aids (including incontinence material, wheelchairs, glasses and hearing aids among others). For glasses a co-payment usually applies, but children and those of low-income groups are often exempted (like in the UK). In Germany, only children until age 18 and those with severe vision impairment are exempted from co-payments, while all others have to cover their vision aids completely.

Geographical barriers of access to health services

Geographical barriers can impose significant hurdles to the access of health services for people at risk of social exclusion. They are of a particular strain for those belonging to vulnerable groups. Those particularly affected by lack of these services are apart from functionally impaired people, such as disabled and older persons, also lone parents and larger families, who may find it difficult to use

public transport, to cover travel expenses or to organise childcare. However, gaps in service provision are also an issue for those who live in deprived areas with limited service availabilities and insufficient public transports.

Variations in geographical access barriers within countries are substantial and exceed those observed between countries (OECD 2007). Obviously, these gaps are less serious for smaller and well-populated countries than for very large countries with sparse population in remote areas. Geographical barriers include *transportation* to health services, *regional variations* in health service provision and *rural-urban* inequalities.

People at risk of social exclusion depend more than others on public *transport* to access health services. The provision of adequate and sufficient transport services as well as the financial support to cover transportation costs is therefore crucial to ensure access to health services for these vulnerable groups. Some people with functional impairments may need further assistance, such as support with accessing public transport or the provision of special transportation services.

Transportation to health care services may constitute a barrier for vulnerable groups, if transport services are only limited or not available, if costs are not covered by public programmes and if support needed is not provided (i.e. functionally impaired persons may need transportation even if services are geographically close).

Studies from the UK identified difficulties in accessing distant services and primary care out-of-hours services for older people, when access to public transport is limited. Accessing distant services was also found to be more difficult for lone parents and larger families due to problems in arranging support and care. Transportation problems are also becoming an issue particularly in remote rural areas in Finland due to the geographical centralisation of health care and the ageing of the population.

Regional disparities within countries were shown to be even greater than those observed between countries (OECD 2007). Regional disparities exist in smaller and more densely populated countries, like in the Netherlands, while larger countries, like Finland, find it difficult to achieve regional equity in health service provision. Significant regional differences can lead to a limited access to health care in particular for vulnerable groups at risk of social exclusion.

Research in the UK has indicated that the distribution of hospitals influences the use of certain services. Those living closer to health centres use their services more after adjustment for need (e.g. of coronary care units). The influence of distance on the utilisation of services was higher for preventive services (such as screenings) than for curative treatments.

When examining regional variations in Germany, substantial differences between former Eastern German and Western German regions are still visible, with a far higher concentration of physicians in the western part of the country. Yet there are slightly more hospital beds and a far higher investment per acute bed in the Eastern part of the country, reflecting an agreement in the State treatise which was installed after the reunification of the country in 1990 with a view to reducing regional inequalities in acute hospital infrastructure (Busse and Riesberg 2004 cited in Huber et al. 2008).

Inequities of health service provisions particularly between *rural and urban areas* can be found in many European countries, as services are often concentrated in urban areas. The question of how to provide accessibility to health services for the rural population, particularly for those living far from more densely populated areas, is of concern to many countries. This is also due to the more fragile economic and demographic situation experienced in rural areas where more people may be affected by poverty and social exclusion.

In Finland, the distribution of private services in urban areas as well as difficulties of public hospitals to attract enough physicians and other skilled staff in remote rural areas, have led to geographical inequity in the provision of health services and regional differences in the use of hospital services. Due to the substantial inequality in the regional distribution of physicians in Germany, which are

largely located in urban areas in the Western part of the country, there are certain areas in the Eastern part of Germany which appear to be undersupplied and will become more so if measures are not taken to counteract the situation (Ramboll Management 2005 cited in Huber 2008).

According to own analysis shown in chapter 4.3.3, distance to services were a minor issue in EU Member States in comparison to cost or waiting times, with only 0.2% of the population considering the main reason for unmet medical needs that services were too far to travel.

Organisational barriers

Organisational barriers to health care services include waiting times and delays for accessing all types of health services, excessive time spent in waiting rooms and the lack of services to pre-register for appointments. These barriers of access were shown to limit demand and restrict healthcare expenditure. Evidence from the HealthQUEST study indicated that the way health care is organised may influence the accessibility and use of services with consequences for vulnerable groups, such as older persons in particular.

In Poland, for instance, physicians are responsible for a large number of patients (with limits as high as 3000 patients per GP) resulting in long times spent in the *waiting rooms*. Patients have to come early (sometimes already at 5 or 6 a.m.) to be given a number enabling them to see a doctor later in the same day, or are required to come back another day in case there are too many patients. There is no possibility of pre-registration of any kind, causing problems in particular to people who are sick or suffer from functional impairments, when obliged to come to a GP's surgery at least twice. In addition, working hours are not always adapted to patients needs generating difficulties for the working population in particular.

A number of EU Member States face barriers to access caused by *waiting lists for elective surgery and other specialist care*. A study on SHARE data analysing waiting times for cataract surgery in 10 European countries, found that 56.3% of the Spanish patients, 31.8% of Greek patients and 17.9% of German and Dutch patients had to wait longer than three months for the required surgery. For some countries there is evidence that these waiting times increase access barriers particularly for those at risk of social exclusion. Research from the UK has indicated that socio-economically deprived people and those of older age groups had received lower priority for treatment and consequently experienced longer waiting times. A study on coronary heart surgeries showed that people of a lower socio-economic status had to wait on average three weeks longer than those from higher socio-economic groups, as their need for surgery was likely to be classified as less urgent. Similar findings were also true for ophthalmologic interventions with significant disadvantages for those from deprived areas as well as for women aged 70 and above. Studies from the Netherlands also suggested that vulnerable groups, particularly older persons with functional limitations were more likely to be affected by waiting list, which may worsen their situation. People waiting longer than the norm (without any obvious explanation, which accounted for 20% of all people waiting) were predominantly older people registered for hip replacement, knee replacement or cataract surgery (Huber et al. 2008).

One reason for long waiting times found in some countries might be the insufficient numbers of hospital beds and general practitioners. This is the case, for instance, in Spain and in Poland, where the supply of hospital beds and of general practitioners is below European standards. In Greece, long waiting lists for specific hospitals and interventions exist particularly in urban areas. These long waiting times can be bypassed by informal payments, creating disadvantage for those unable to pay. A number of NAPs expressed concern over waiting times for medical treatment and elective surgeries provided under public programmes.

Figure 4.10 and 4.11 (see chapter 4) reflect the large variation of waiting times for medical and dental health services across European countries, with waiting times accounting for more than 50%

of unmet medical and dental needs in some countries (Finland and the UK). One key problem is the perception of some countries that organisational barriers are a less important factor for determining access to health care in comparison to cost-sharing and other access issues.

Examples of good practice to improve access to health care

In recent years the European Union has initiated and funded a number of programmes and initiatives to promote and facilitate the sharing of good practice policy examples among EU Member States and providing practical policy advice. Projects like In Good Health[74], Closing the Gap[75], Eurothine, Gradient and Determine[76] as well as studies such as the HealthQUEST[77] study were commissioned by the European Commission, DG Employment, Social Affairs and Equal Opportunity, and helped establish a broad knowledge base to build future plans on these findings. Selected good policy examples which could serve as an example for Germany are presented in the next section.

Policies and initiatives to increase health care coverage

Even if health care coverage is – with a few exceptions – universal and mandatory for all citizens in European Member States, a number of people still lack health care coverage under public programmes. These groups of people often include those who live on the margin of society and who are particularly vulnerable to be excluded from health coverage.

A good policy initiative of increased coverage for people at risk of social exclusion was a measure taken by local authorities in the Netherlands. By negotiating collective agreements it was possible to provide broader service packages at a reduced cost for people on social support. As cost for the insurance is deduced directly from their allowance, people have no risk of loosing their coverage due to neglected payments.

Germany recently introduced a system of universal coverage with the general obligation for people who are currently uninsured to register with a public or private insurance fund. Persons uninsured mainly comprised the self-employed, formerly privately insured and those with statutory health insurance who did not pay their contributions for more than 2 months. The system may benefit in particular those who are at risk of poverty, which according to Rabbata (2005, in Riesberg and Wörz 2008), most uninsured persons are expected to be, and who are not entitled to social assistance or do not access it. However, it is the individual's responsibility to register with a sickness fund, which may pose hurdles for some vulnerable groups who have difficulties with understanding or administrative procedures.

Policy to improve the coverage of services and goods within public programmes

Policy initiatives to extend service coverage under public programmes are particularly relevant for people at risk of poverty, as they lack the financial capacity to use private services.

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[74] The EU project *In Good Health – Linking Social Inclusion and Health – from Practice into Policy* was coordinated by EuroHealthNet and NHS Scottland between 2002 and 2005.

[75] *Closing the Gap – Strategies for Action to Tackle Health Inequalities*, another EU project, took place from 2004-2007. It was also coordinated by EuroHealthNet and the German Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA).

[76] *Determine* (2007-2010), the successor of Closing the Gap revealed a database of European good practice examples, which is accessible under www.closing-the-gap.org. The project coordination was performed by EuroHealthNet.

[77] The *HealthQUEST* study was commissioned under the 2002-2006 Community Action Plan on Social Inclusion. Analyses of results of the study were published by Huber, M., et al. (2008).

One good practice example to improve service coverage is provided by Finland with the expansion of public dental care to all age groups. Starting in 2001, dental health care was expanded by removing all age limits to access services and thereby entitling adults to dental care, expanding reimbursements for private dental care, as well as defining a maximum waiting time of 6 months for non-urgent dental care. Evaluations of the reform showed that between 2001 and 2004, the proportion of people who had made use of dental health care in the previous 12 months had increased from 57% to 61%, self-reported oral health had improved and more people perceived their dental health needs as met. The number of people receiving reimbursements for the cost of private dental care had doubled. Interestingly, the increased use of services was seen in particular for the middle level education group. Even if use of services also improved for those of lower educational attainment, uptake of services remained higher in middle and high level education groups.

Another example was set by Poland by introducing regulations to cover specific treatments, even if patients are uninsured. The conditions covered include specific communicable diseases, mental health, and drugs and alcohol abuse therapies.

Policies to reduce cost sharing as barrier of access to adequate health care

As discussed in chapter 4.3, financial costs are a major barrier to access adequate health care for people at risk of poverty. Mitigating the financial burden that cost sharing may pose for vulnerable groups is one key aspect of attaining more equity in access to health services. A variety of examples can be found on how low income groups may be protected against income losses due to cost participation in health care. In many European countries *exemptions from co-payments* apply for disadvantaged and vulnerable groups, such as children, older persons, disabled persons and people at risk of poverty.

In the UK, for instance, those belonging to low income groups are exempted from cost sharing. Exemptions also exist for families with children, pregnant women and women in the first year after giving birth as well as people over the age of 60 and recipients of benefits among others.

The Netherlands compensate low income groups via a *Health Care Allowance* (*Zorgtoeslag*) for their increased health care costs resulting from a recent reform of the health system. People with lower income are provided with tax compensation in order to facilitate the payment of insurance contributions.

Payment ceilings were introduced by the Finish government to allow low income households (including many older persons) to cope with financial burden of health care expenses. However, the ceiling is rather high with 40% of household income.

Another good example of cost limitation for vulnerable groups is provided by Spain – retired people aged 65 and over, individuals with chronic disease as well as people with disabilities are eligible for free medication and reduced rates of cost sharing.

Policies to reduce geographical barriers of access to health services

Geographical barriers of access to health services were identified as important by most European countries. The reduction of regional differences, including the uneven distribution of health care facilities and professional staff, is a priority in most National Action Plans (NAPs).

Policy measures to *reduce transportation barriers* include the alleviation of cost, the reduction of travel hurdles and the provision of a health service network, which ensures that the nearest facility is never too far.

One example of good practice is provided by Finland, with the coverage of treatment-related transportation costs over a certain limit. Travel expenses to health services exceeding EUR 9,25 for

single visits or a ceiling of EUR 157,25 per year are reimbursed by the Finish NHS (MISSOC 2011, data update on 1 July 2010). These compensations are usually based on the expenses for reaching the nearest health centre or hospital with the least expensive means of transport. In areas with no public transportation, taxi expenses are also covered by this policy. The British NHS supports people at risk of poverty by providing a hospital travel cost scheme as well as a patient transport service to ensure service access. Criticism has been raised, however, that these services as well as their eligibility criteria are not well publicised.

In Germany, service provisions to guarantee access to public transports for those at risk of social exclusion have deteriorated recently. Since the introduction of unemployment benefit II, benefits are paid out as a lump sum and the amount for public transportation is too low (particularly for children). In addition, a co-payment applies for transports to health services, which has to be paid for children also (Riesberg and Wörz 2008).

Some examples of innovative nationwide policies to *reduce regional differences* are provided by the Finish government. These included the establishment of national guidelines for access to care, incentives to foster cooperation and promote financial mergers between municipalities, in order to expand their population base. By introducing the *Act on Restructuring Municipalities* (2007), Finland has supported restructuring and financial mergers of municipalities with the aim to create a firm structural and financial basis to secure the organisation and provision of services in the future. The act stipulates that primary health care centres should have a catchment area of at least 20,000 inhabitants (which was only the case for one forth of all health centres in 2007). This centralisation of health services was necessary as smaller municipalities faced financial difficulties in trying to provide high-quality health and social care to their residents or failed to provide appropriate quality of care. Reducing geographical inequalities in the provision of high-quality health services was also undertaken by the enactment of maximum waiting times and the extension of supervising functions of the National Authority for Medico-Legal Affairs.

In Spain, past processes of decentralisation of services to adapt health care to local needs has been found to increase regional differences in service provision. Reducing these geographical inequalities has been one key objective of the recently implemented Spanish initiatives. To address regional disparities, the Spanish NHS has developed countrywide portfolios of common standardised services and established a social cohesion fund to compensate some regions. The aim of these measures is to improve co-ordination among Autonomous Communities and thereby promoting an equal access to technologies across Autonomous Communities. The concept includes the transferral of patients to better equipped health centres outside their own regions to guarantee equal access to technology. Within this arrangement a special model was created by some Autonomous Communities by establishing High Resolution Specialist Centres with diagnostic facilities, emergency, rehabilitation and sometimes even primary health care units. These measures attempt to help solving the problem of waiting lists and ever-increasing hospitalisation cost by improving access to diagnosis and treatment for people living in remote areas. The objective is to provide a maximum of diagnosis resolution in a minimum time period and to guarantee especially to citizens of remote areas access to an integrated and high-resolution health care service in less than 30 minutes.

The controversial question discussed by many European Member States whether to decentralise or recentralise health services is important in particular for those at risk of social exclusion. Not all small units can provide high-quality services, however, long distances to services may present a barrier to access for some vulnerable groups. The centralisation of services to improve cost efficiency and quality of health care may mean longer distances to health services for some (rural) areas. Decentralisation of service provision on the other hand, may still result in regional inequities due to difficulties in providing financially affordable high-quality care and in attracting enough health professionals to small scale service facilities. The Finish model of recentralisation of services with a clear master plan to ensure coverage of all municipalities/areas and with the support of

transportation cost to ensure accessibility may be one good model to respond to significant regional differences.

Policies to improve organisational barriers

Poor organisational practices may lead to delays in receiving primary care and to long waiting times for medical services. Initiative to reduce organisational barriers and improve access to health care services include the improvement of *out-of-hours services* and the reduction of *waiting times for elective treatments* and of *waiting times for elective surgeries*.

To facilitate access to health care services and to minimise time constraints, Greece recently initiated outpatients units of hospitals to open in the afternoon with co-payments for patients. A further service in the form of *24-hours* walk-in centres has been considered also. However, the requirement of cost-sharing limits access particularly for people who are at risk of poverty.

In the UK, NHS Walk-In Centres and a nurse-led 24-hour telephone advice and consultation service (*NHS Direct*) were implemented to provide out-of-hour services and to improve overall access to health services. However, it was found that the NHS Direct service was significantly under-used by poorer socio-economic groups and those with communication difficulties (hearing or language problems). Additionally, this service was less likely to be used by older persons, who appeared to prefer to consult their GP.

Successful initiatives to reduce *waiting times for elective treatments* were implemented in several countries. Finland introduced regulations to set maximum waiting times for primary care and non-acute specialist care. Waiting lists have been an issue for long time in Finland and are still the main reason for unmet medical and dental needs (see analyses chapter 4.3.2). For people from higher income groups it was common to bypass this situation by making use of private health services. With the right for every resident to access primary care within a defined limit (and to access secondary specialist care based on needs assessment) these inequalities in health care have been successfully reduced since 2005. Regional inequalities like differences in waiting times between municipalities were also partially addressed. Greece introduced one-day clinics for cancer patients, which significantly reduced waiting times for cancer related surgeries. The charge of co-payments raises once again concerns over their positive effects on reducing inequalities in health service provision.

In the Netherlands, an agreement between all stakeholders (health care professionals, health care providers, health care insurers and government) on acceptable waiting times for elective treatments and care helped reducing waiting times for hospital admission by 17% between 2002 and 2004. Within these 'acceptable waiting times' 80% of patients should be seen. However, acceptable waiting times are rather high compared to Central European standards with a set maximum of 4 weeks for a first appointment for acute care or hospital services as well as for assessment and diagnosis. The UK introduced similar recommendations for maximum waiting times for certain kinds of patients, such as cancer care. Again, a maximum waiting time of one month for an urgent referral for suspected cancer seems very long when compared to Central European standards.

Conclusions

European Member States have developed a number of policy measures to provide equal access to health care services, in particular to more vulnerable groups in society. Some general recommendations can be derived from good policy examples presented in this report:

- Combining efforts and facilitating the collaboration of all key players involved is often key to the success of a policy measure.

- Reducing health inequalities may not only require action in the health care system, but also in many other policy areas, such as education policies. A co-ordination of policy measures to reduce health inequalities across governmental departments may therefore be useful.
- A further evaluation and investigation of gaps in (access to) health service provision to provide equal access to health services for all and to enable tailored prevention and health promotion for people at risk of social exclusion would be helpful.

Tackling health inequalities in society is crucial to reduce social exclusion. However, as country structures are diverse and cultures different there is not a single right way to reduce health inequalities (Judge 2006, WHO 2005).

In general, Germany provides a very comprehensive health care system in comparison with other EU Member States. However, health inequalities are prevailing even in very well-organised welfare states and a number of people are still facing barriers of access to health services. The following recommendations can be given to eliminate some of the hurdles identified:

The recently introduced mandatory universal health insurance system in Germany aims to reduce the prevailing number of people without coverage. Gaps in *health care coverage*, however, may still appear for those people who are not able to tackle the organisational barriers (such as administrative procedures for registering with an insurance fund) or who lack understanding of their duties and rights. It is therefore essential that information on the right to health insurance coverage as well as on obligations and administrative procedures is easily accessible, in particular for those groups who are at risk of social exclusion. These groups include people with low educational attainment, the illiterate and those facing language barriers as well as other vulnerable groups, such as people with mental health problems. It should be therefore evaluated which groups fail to obtain a regular insurance status and special support should be provided to eliminate access barriers faced by people at risk of social exclusion.

In comparison to other EU Member States, Germany offers a rather generous health system in terms of low *co-payments*. As they disproportionately affects low income groups, exemptions for people with low income help reducing the financial burden and increase access to health care services particularly for these vulnerable groups. However, gaps can be found in the provision of some services, such as dental prosthesis and visual aids, which have to be covered by patients almost completely. Especially older persons often already face high expenses for health services and may not be able to cover the total cost for these medical aids by themselves. Since the ability to see and to hear is crucial for remaining independent, integrated and actively involved in society, it would be therefore important to provide further exemptions to ensure that all older persons are able to afford medical aids without limitation.

The recent rise in co-payments on pharmaceuticals has affected especially those people with an extensive need for medicals, such as patients with chronic diseases (which again are more likely to be older persons). Introducing a clear cost sharing ceiling, like the one presented for Finland, would help avoid financial constraints and reduce the risk of poverty particularly for these groups.

The provision of full coverage of *transportation services* to access health care services (especially for children) would be one way to support lone parents and larger families at risk of poverty.

Similarities found in successful national policy measures in terms of reducing *regional and rural-urban inequalities*, were to combine efforts of all players involved in addressing the common aim of reducing access barriers to health care. Particularly when addressing inequalities in the provision of health services in rural areas, it may be helpful to be inspired by examples of good policies from Finland and Spain, where collaborations on a local level have helped to overcome short-comings of financial nature and professional resources.

Distribution of health services will remain one key area to achieve equity in access to health services in Germany. Particularly the substantial discrepancies in the distribution of physicians between

(rural) Eastern and Western parts of the country will be an issue to be solved in the coming years. Incentives offered to physicians and other health professionals may help Eastern regions to become more attractive for employees in the medical field.

14. Labour market chances for older workers

Katrin Gasior and Pieter Vanhuysse

In this section we discuss key indicators of both employment and employability chances among both older women and older men (defined as those in the age group 55-64) by comparing Germany with four selected EU countries between 1995 and 2009: Austria, Sweden, Finland and the Netherlands. Economic theory posits that the labour market chances for older workers differ significantly from those of workers of all age groups, as a result of at least three characteristics that are specific to older workers as compared to younger workers (Saint-Paul 2009). First, the remaining career time of older workers is more limited, as they are expected to leave their job and retire relatively soon. Second, the productivity of older workers is generally likely to be lower (Kotlikoff and Ghokale 1992; Lazear 1990; Skirbekk 2008). Third, relative to younger workers, older workers have a human capital which is more specific to their current job and/or firm and less general and/or movable to other firms and sectors, as they have spent a greater fraction of their career acquiring those specific skills through learning-by doing. As we show below, these key characteristics of older workers have a number of implications for their labour market chances.

Labour market activation rates of older workers, 1995-2009

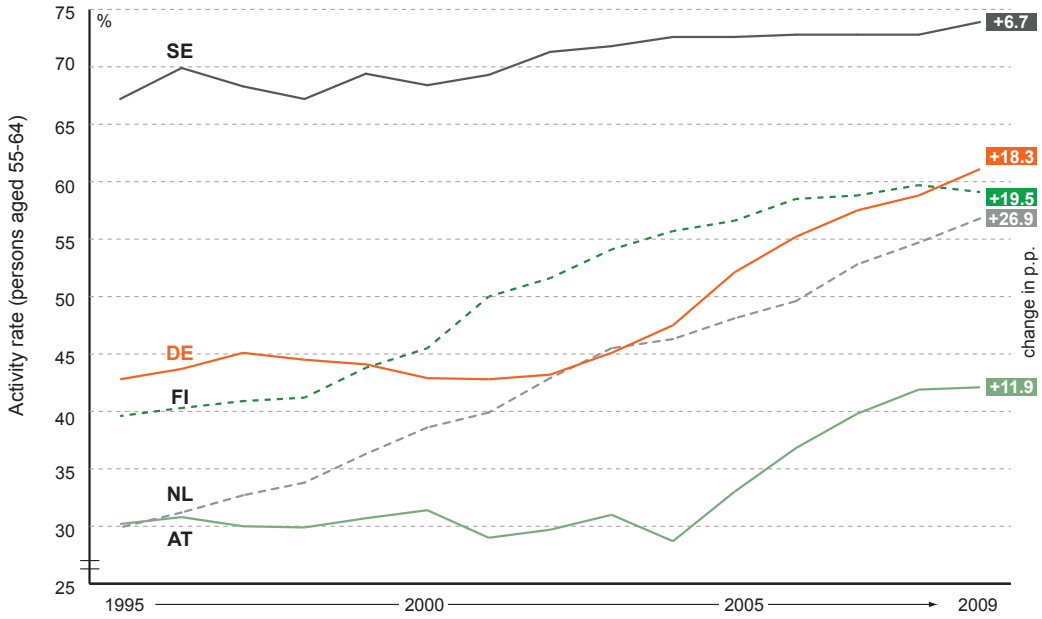
One way of assessing the labour market situation and specifically the urgency of labour market activation among older workers, is by comparing the employment rates for elderly women and elderly men in a given country against its degree of old age dependency today (this is the number of 65plussers as a share of those aged 15-64). Both for women and for men, Germany is in a moderately problematic position, as it has activation levels for both older men (70 percent) and older women (51 percent) that are significantly above EU average levels (respectively 58 and 38 percent), but in a context of old age dependency rates (31 percent) that are also well above EU average levels (25 percent) (own computations from 2009 Eurostat data). In this respect the Swedish and Dutch cases are the healthiest from a policy perspective as they combine lower old age dependency rates with lower (Sweden) or similar (Netherlands) older worker activation rates.

There have been numerous policy efforts aimed at increasing the labour market chances of older workers in the EU since the 1990s, when there was a growing awareness of the cultural and structural reasons underlying often systemic low labour force participation rates among older cohorts. The OECD, for instance, argued that 'an early retirement culture […] has become part of the German landscape since the late 1970s, and [causes] the relatively low employment rate of older workers' (OECD 2005: 103). In Germany, there have been numerous reforms since the late 1990s to get rid of early retirement incentives and increase labour force participation rates of older workers (e.g. Hering 2012; Sciubba 2012). Yet the average age of exit from the labour force increased only gradually, from 60.6 years in 2001 to 61.3 years in 2004, which was the last year before the seminal Hartz IV reforms[78] (on which more below), which subsequently contributed to a further increase to 62.2 years by 2009 (Eurostat database). As Figure 14.1 shows, as a result of a growing awareness and policy prioritization, labour market activation rates of elderly workers have indeed been going up in

78 The Hartz reforms had three major cornerstones (Jacobi and Kluve 2006; Kemmerling and Bruttel 2006; Sciubba 2012; Hering 2012): to improve labor market efficiency by introducing market mechanisms in placement services; to activate the unemployed on the pull side via incentives to work and on the push side by making unemployment less attractive by reorganizing benefit systems and introducing a broad range of sanctions for not finding jobs; and to increase employment demand by deregulating the temporary work sector, exempting fixed-term contracts, and exempting dismissal protection.

Germany, as in all five country cases since the mid-1990s. After a long period of status quo, there have been very significant improvements in Germany since the mid-2000s, with activity rates of elderly workers going up markedly by over 18 percentage points, reaching 61 percent in 2009 (compared to 44 percent in both 1995 and 2002) – which newly established Germany as the second highest achiever in our five-country sample.

Figure 14.1: Activity rates of persons aged 55-64, 1995-2009



Source: Eurostat database (accessed 20 May 2011).

In cross-country comparison, Austria is a clear laggard regarding the levels of activation, as well as regarding the starting point of increases (only around 2003-2004). The Dutch labour market for elderly workers has clearly seen the highest increases – a remarkable rise of about 26-27 percentage points in the decade and a half since a set of 1995 reforms kicked off a ‚Dutch miracle.' Sweden records somewhat smaller increases over time than the other four cases, but that is only because it remains the older worker activation champion not just as compared to Germany but in the EU at large, with an activity rate of around 74% (and 70% for employment rate). Indeed, given the longstanding record of Sweden in maintaining comparatively high participation levels for older men and women for many decades, one might speak of a 'best practice culture' in this respect. All in all, the developments shown in Figure 2.1 regarding older worker activation since the mid-1990s can be considered as policy success within the increasing ‚activation paradigm' in social policy across the EU (Armingeon 2007; Tepe and Vanhuysse 2011; Bonoli 2010).

Another way to track older workers' labour market activation levels is by checking country levels against the EU's Barcelona and Stockholm targets. According to the 2001 approved Stockholm target, EU member countries should have increased the employment rate of persons aged 55 to 64 up to 50 per cent till 2010. Sweden has already achieved this goal before 2001, followed by Finland in 2004 and the Netherlands and Germany in 2007 (see left hand side of Table 14.1 and Figure 14.2). Austria, by contrast, has still not achieved the 50 per cent threshold.

Here too, the German case can thus be qualified as a success story, if a rather recent one. Moreover, Germany performs well in recent years not just within the five-country sample. Within the larger EU-27 Germany ranked altogether fifth as regards employment rates for older workers in 2009, behind Sweden, Estonia, Denmark and the UK. Moreover, when comparing progress in this regard between

2000 and 2009, Germany ranked second-highest within the EU-27 after Bulgaria (own computations from Eurostat data, accessed 20 July 2011).

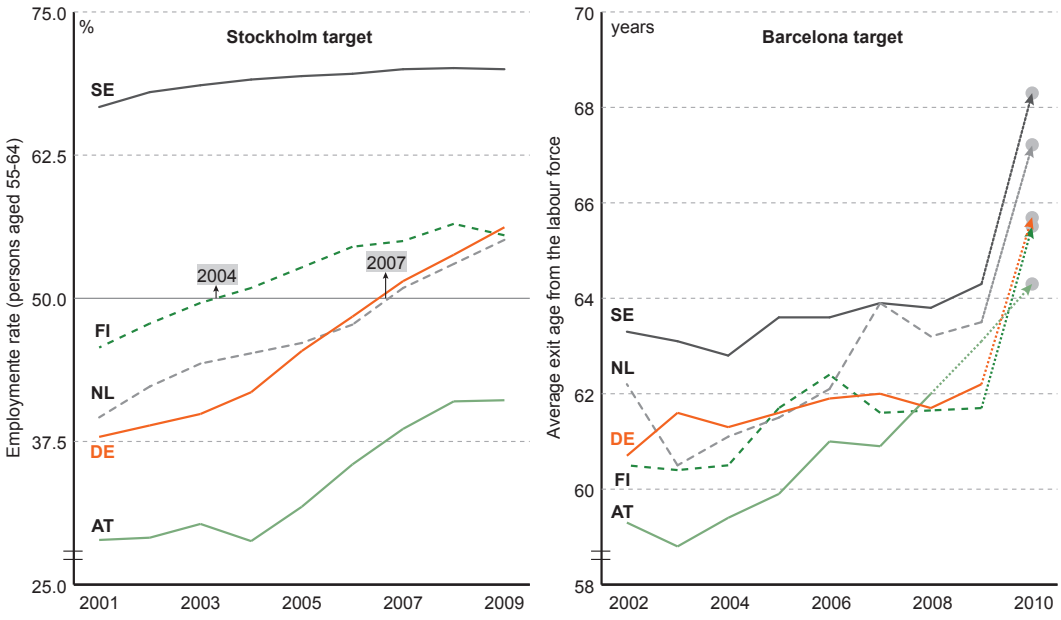
Table 14.1: Barcelona and Stockholm target

	Stockholm target: 50% employment for workers aged 55 to 64 by 2010			Barcelona target: gradually increasing the average age of retirement by five years till 2010		
	2001	2009	achieved in	2002	2009	% achieved
Germany	37.9	56.2	2007	60.7	62.2	30.0
Austria	28.9	41.1	Not yet. 2015?	59.3	60.9*	32.0
Netherlands	39.6	55.1	2007	62.2	63.5	26.0
Finland	45.7	55.5	2004	60.5	61.7	24.0
Sweden	66.7	70.0	before 2001	63.3	64.3	20.0

Source: Eurostat database, accessed 20 May 2011, own calculations.
Note: * 2007 data (for Austria).

The Barcelona target, decided in 2002, focus on the average age of retirement. EU member countries should gradually increase the average exit age from the labour force by five years till 2010. The threshold is based on the country values in 2002 and thus differs from country to country. For Germany, it implies a target of 65.7 years as the average age of retirement. For the other countries, the target ranges between 64.3 (Austria) and 68.3 (Sweden). The right hand side of Table 14.1 and Figure 14.2 shows that all countries in focus are relatively far from achieving the set target. Germany has achieved 30 per cent by 2009, Austria 32 per cent (by 2007), although starting from a lower level. Sweden has only achieved 20 per cent, Finland 24 per cent, and the Netherlands 26 per cent.

Figure 14.2: Employment rate of persons aged 55-64 (2001-2009) and average exit age from the labour force (2002-2009)



Source: Eurostat database, accessed 20 May 2011, own calculations.
Note: average exit age from the labour force: no data for Austria in 2004, 2008 and 2009; no data for Germany in 2005 and no data for Finland in 2008.

The older worker labour market activation successes shown in Figure 2.1 and Figure 14.2 can be accounted for by various policy reforms pursued at various times. Perhaps the most coherent and most wide-ranging example of such a package of labour market policies aimed at activating older

workers were the Hartz IV reforms in Germany, which can be clearly linked to the upward rise in older worker activation after 2003-2004 seen in Figure 2.1 (Jacobi and Kluve 2006; Kemmerling and Bruttel 2006; Hering 2012).[79] Second, the activation successes shown above depend on significant policy inputs, which in turn are determined by the larger macro-fiscal and socio-economic environment in a given country. Tepe and Vanhuysse (2011) find that across the OECD, budget deficits tend to systematically reduce labour market activation policy spending, but unemployment rates do systematically increase activation policy spending. This indicates a high degree of reactiveness to spending needs, at least when the fiscal context allows. This was clearly visible in countries such as Austria and Germany during and after the 2008-2009 crisis. Far from cutting back on active labour market policy spending, these countries kept up spending levels and maintained many workers in employment, often in short-term jobs.

Long-term unemployment and the willingness to work of older workers

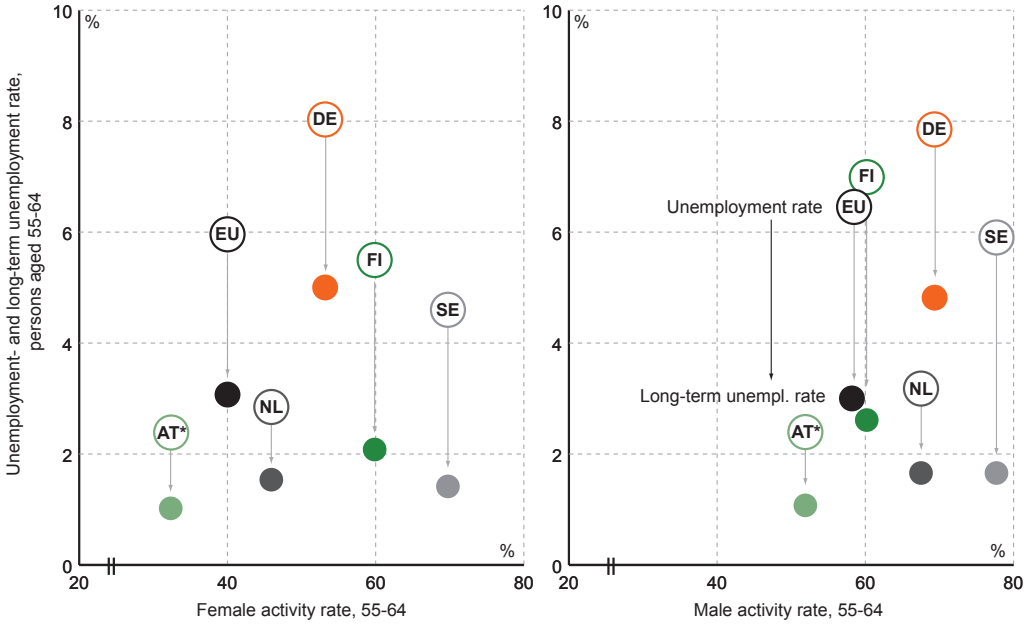
A particular worry for activation policies is the level of long-term unemployment among elderly workers – i.e. unemployment spells over more than one year. While unemployment itself is not necessarily an unambiguously bad trait for labour markets, as it might indicate flexibility, dynamism and high turnover (Saint-Paul 2000, 2002, 2004), unemployment in older age often leads to long-term unemployment and therefore is clearly a policy problem which can lead to many add-on social problems (Gallie and Paugam 2000). For instance, exploring longitudinal data on Germany and ten other West European countries, Gallie et al. (2003) find strong evidence of vicious cycles of social exclusion over time, in that unemployment significantly increases the risk of poverty, which in turn makes it more difficult for people to return to work. Avoiding such social exclusion cycles is therefore an important additional rationale for policy efforts aimed at avoiding employment loss among older workers.

Figure 14.3 shows the unemployment rate and long-term unemployment rate by gender of the five countries in focus as well as the EU27-average. Germany stands out as a high-risk labour market for older workers, as it has not just average-level activity rate for both men and for women, but also the highest unemployment rate (at 8 percent) and the highest long-term unemployment rate (at above 5 percent) in the sample.[80] In contrast, Austria as well as the Netherlands have relatively low unemployment rates. The long-term unemployment rates are low as well and below the EU27-average of 3 per cent.

[79] See footnote 1. A number of other, prior, policy reforms undoubtedly contributed further, including the 1992 pension reforms which increased the retirement age without deductions and stipulated equal retirement ages for women and men, the 1996 acceleration of the 1992 reform path, the 2001 reform of invalidity pensions and the 2006 increase of the statutory retirement age (see for instance Seeleib-Kaiser et al 2009, Stiller 2010). We are grateful to Volker Schmitt for pointing this out.

[80] It is important to note in this context, however, that this comparatively high unemployment rates for German older workers I at least in part the result of closing the exit path to disability pensions (on which more below). Consequently the *combined* ratio of those with disability pensions and those older workers who are unemployed would show Germany in an internationally more favourable light.

Figure 14.3: Activity rate and (long-term) unemployment rate of men and women aged 55-64, 2009
Employment rate of persons aged 55-64 (2001-2009)



Source: Eurostat database, own calculations.
Note: * (long-term) unemployment rate in Austria refers to men and women.

The share of the long-term unemployed of all unemployed shows the risk of slipping into long-term unemployment once having lost the job. Older workers in Finland and Sweden face the least risk of getting long-term unemployed, with a share of 27 and 39 per cent of the unemployed aged 55-64 being long-term unemployed. Compared to these countries, the risk in Germany is clearly higher. In Germany, 60 percent of the unemployed aged 55-64 are long-term unemployed. The share in Germany is not just higher compared to other countries in the sample but also higher than the EU-average.[81]

It should be noted that labour market mobility is particularly low among older workers everywhere in the OECD. Most new hires among older workers tend to be workers who change jobs, rather than previously unemployed or inactive workers (OECD 2006). Inactivity, in particular, is a one-way street for most older workers: once older workers leave the labour market, they are very unlikely to get back into it subsequently. This indicates that different forms of retirement and inactivity might be the preferred pathways for elderly workers in these countries. Social and labour market policies thus often allow older workers to voluntarily quit their jobs.

Beyond the extra leisure time and freedom and the lower stress levels associated with being retired, there are many positive and negative influences of labour market exit on happiness and subjective wellbeing levels (see Table 14.2). But since there are also a number of reasons why people with low levels of subjective wellbeing are more likely to retire earlier, this complicates any causal assessment. One key reason for the prominence of voluntary job loss among older workers may be the higher sense of subjective well-being (or quality of life) associated with having the choice to decide one's own labour market status. While employed people generally record higher subjective well-being levels than those who are no longer active, among the latter group those persons who had some degree of agency and control over their labour market exit clearly record higher levels of well-being (see e.g. Herzog et al 1991).[82] Choosing to exit the labour market, in addition to providing more

[81] But see footnote above.

[82] For instance, investigating the relationship between the choice of workforce participation or non-participation and physical and psychological well-being among 1339 participants over 55 in the Americans' Changing Lives Survey (which

leisure time and pension benefits, may thus lead to higher levels of subjective well-being as opposed to waiting to be forced out. Analyzing 1167 questionnaires of employed, unemployed and retired men and women aged 50-74 in Britain, and distinguishing between those voluntarily lacking employment (like willingly early retired) and those whose unemployment was imposed (e.g. those forced to retire early), Warr et al. (2004) found that the ability to choose one's current role is significantly associated with higher subjective well-being. In addition, in a study of over 15000 people in 11 countries, Waginger (2009) found that subjective health, depression symptoms, and quality of life is generally lower for people who left the labour market early, even after controlling for those who left early because of health problems. Waginger also reports that forced early exit is associated with still lower levels of well-being than chosen early exit.

Table 14.2: Likely effects of labour market exit on levels of subjective well-being

Positive effects	Negative effects
More leisure time	Lower income
More freedom to allocate time	Fewer contacts with weak ties
Fewer work-related expenses	Loss of self-esteem
Less work stress	Loss of job satisfaction
Less commuting stress	Mental/cognitive deterioration

Source: adapted from Chapple (2011), p. 97.

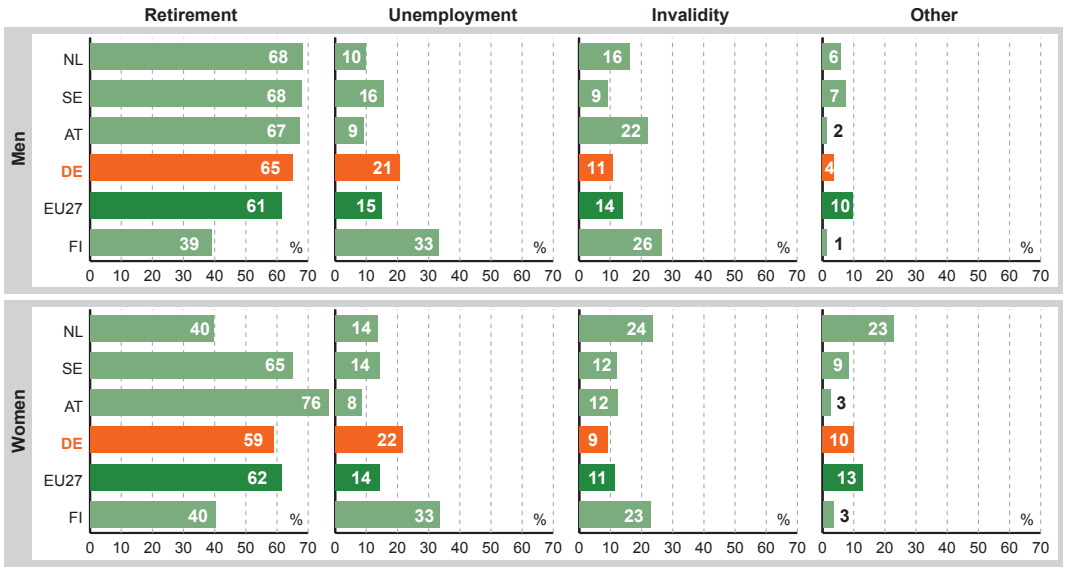
Moreover, in addition to not necessarily increasing subjective well-being, early retirement also appears to lead to mental retirement (Rohwedder and Willis 2010). Retirement is associated with significant cognitive decline, as the likely result of living less cognitively stimulating retirement lives as compared to working lives. Suggesting a causal argument from retirement to cognitive decline at the macro-level, Rohwedder and Willis 2010) show that countries with a more permissive early retirement scheme do not just have fewer older workers working, but also record lower average cognitive scores on word recognition tests for this age group.

Employment protection and exit ways of older workers

Pensions appear to be the dominant pathway out of jobholding for elderly men everywhere – most so in the Netherlands, Sweden and Austria, where it accounts for respectively 68, 68, and 67 percent of cases, compared to 65 percent in Germany (see Figure 14.4). The same picture with minor modifications is also true for elderly women. For women, too, pensions are clearly the dominant pathway out of jobholding everywhere – most so in Austria and Sweden, where it accounts for respectively 76 percent and 65 percent of cases, compared to 59 percent in Germany. In the case of both men and women in Finland, unemployment (33 and 33 percent) and invalidity (26 and 23 percent) are large alternative pathways.

oversampled in the 60+ group), Herzog et al. (1991) found that it was not the amount of work that affected the well-being of retirees, but the choice of current role (i.e. being employed or retired). Those people whose current employment (respectively retirement) status was personally preferred showed higher levels of well-being than those whose current role was imposed. The ability to retire voluntarily was associated with higher life satisfaction and less cognitive decline than exiting the workforce involuntarily. Even if the latter findings were statistically significant for the over 65s only, the results showed consistency in so far as the feeling of control over one's choice was related to higher health and well-being (see also Waginger 2009).

Figure 14.4: Pathways out of employment: main status just after leaving last job or business in 2006 of not employed persons aged 50-69 who have been employed at age 49



Source: LFS, ad-hoc module (Eurostat)

Sometimes, one pathway out of jobs initiates a concatenation of further pathways, leading in the end to permanent labour market exit. For instance, older workers under some circumstances may have the option first to go on disability or sickness leave, until they qualify for early retirement, and then for regular retirement (Ebbinghaus 2006). In Germany in the early 2000s, for instance (that is, before the Hartz reforms), only one in four men retired at the statutory age of 65, whereas three in four retire early through special schemes. Policy incentives clearly matter in determining the use of multiple sequential labour market exit pathways. High levels of unemployment benefits, for instance, are likely to be more damaging to the employment rate of older workers than to that of younger workers (Saint-Paul 2009).[83] Economic theory predicts generally lower exit rates from unemployment in the case of generous unemployment benefits, as well as a stronger "duration dependence" - that is, exit rates from unemployment will tend to fall with the length of the unemployment spell (Saint-Paul 2009).

In the same vein escaping from unemployment into (early) retirement or sometimes into invalidity pension schemes is frequently used pathway. As a result, long-term unemployment rates are often lower in countries where escaping into inactivity is relatively easier than in countries *where pathways into early and disability retirement schemes are closed*.[84] In the OECD, the countries that have most significantly reduced general disability benefit recipiency rates in recent years as compared to the 1990s are Finland, the Netherlands, Luxemburg, Poland and Portugal, whereas Germany belongs to a group of countries which have seen stable recipiency rates, and countries such as Belgium, New Zealand and Norway have seen strong increases (OECD 2009). But among the older workers age group specifically, the steepest reductions in disability recipiency levels since the 1990s have been recorded in the Netherlands (4 percent), Denmark (4.5 percent), Poland (6 percent) and still more so in Finland (10 percent), Luxemburg (9 percent) and Portugal (10 percent) (OECD 2009, p. 39). As regards reductions of inflows into disability benefit recipiency (as a percent of the working age population), The Netherlands and Hungary have clearly recorded by far the most significant success:

[83] Similarly, when sickness benefits were significantly increased in Sweden in 1997, they soon led to a doubling of the number of sickness benefit recipients, which in many cases represented a first step to permanent labour market exit (OECD 2003).

[84] Thus, one likely reason for the high rates of long-term unemployment among older workers in Germany reported in Figure 14.3 is that exit pathways into disability pensions were largely closed in 2001. See also footnote 3 above.

they have cut down inflow rates by respectively 7 and 6 percentage points since the 1990s (OECD 2009, p. 40).

Policy reforms can clearly be linked to such developments. For instance, in Denmark new regulations introduced in 2003 embodied a conceptual shift from dis-ability to work-ability, in that they stipulated that a disability benefit could henceforth only be granted if a person's work capacity was reduced to such an extent that s/he could not even perform a state-subsidized work (a so-called flex-job), not even after participating in rehabilitation programs (OECD 2009). Similarly, the Hartz reforms since 2005 in Germany aimed at activating all workers, but according to Sciubba (2011), they had significant financial consequences especially for older workers. Not only were older workers a large segment of the unemployed, they were mostly long-term unemployed, and Hartz was particularly harsh on the long-term unemployed. Moreover, after Hartz IV, older workers who may have worked and contributed for 20 years were subject to the same regulations and benefit levels as those who had only worked one year. Lastly, the reforms took away early retirement mechanisms. As a result of reforms in the Netherlands, Sweden and Germany, to retire early is more difficult in these countries than it is in Austria. Although (long-term) unemployment rates are lower in Austria than in other countries, early and disability retirement remains one of the main hurdles for social policies.

The case of the Netherlands stands out as the best practice example of how to reduce recipiency rates in a comprehensive and fair way, as it is the only country which recently completed a significant *reassessment of the invalidity status* of almost all of its invalidity benefit recipients (OECD 2009).[85] In the mid-1990s, the Netherlands had the highest population share on invalidity benefits in all of Europe. The subsequent reforms, implemented in the past fifteen years, have included a group of simultaneously planned, integrated measures which were characterised by two major shifts in policy: (1) a shift in social responsibilities, and (2) a move away from a passive system of paying benefits (focusing on incapacity) towards an activation approach (supporting work ability). Although it is difficult to disentangle the effects of the single policy measures, estimations on the impact of measures introduced until 2004 on inflow into the disability scheme show that experience-rating, the gatekeeper protocol and stricter examinations reduced inflow by almost half (van Sonsbeek 2010). All Dutch beneficiaries born after July 1954 have been reassessed in an operation that started in 1987 with claimants aged between 18 and 35. After this first assessment, no less than 50% of recipients saw their invalidity benefit taken away or reduced over a period of two years (Van Oorschot 2010). The second reassessment was initiated in 1993 when all those below the age of 50 were reassessed and according to an interim evaluation it resulted in the withdrawal or reduction of the full invalidity benefit in 28% of the reassessed cases. Thus, in the majority of reassessed cases the degree of invalidity remained the same. In 2004, the third reassessment started covering all those below the age of 55, but now based on new, stricter assessment criteria and including medical and vocational assessment. By 2009, altogether 345,000 persons were reassessed. In 62% of the cases there was no change in the level of invalidity (and the benefit). For 20%, the invalidity benefit was withdrawn, and the level of invalidity was lowered in 12% of the reassessed cases. For the remaining 6%, mainly older people, the degree of invalidity was increased (Van der Burgh and Prins 2010). This major reassessment of invalidity pension recipients from 2004 to 2009 has had a considerable immediate effect on outflow (van Sonsbeek 2010). While outflow rates remained more or less stable between 1999 and 2003 (with a slight decline in 2004), from the 1st quarter of 2005 – shortly after the re-examination process started – there was a significant and sharp increase in outflow rates. However, from 2006 onwards outflow rates started to drop.

Pension design can thus clearly be altered in an effort to increase the participation rates of older workers. A notorious best practice case here is *part-time pensions* in Sweden.[86] The relatively high proportion of employed in the age group 55-64 in Sweden seen in Figure Figure 14.1 can in part be

[85] We thank Eszter Zolyomi for collaboration on the Dutch case.

[86] We thank Eszter Zolyomi for collaboration on the Swedish and Finnish cases.

linked to the Swedish pension design which has been thoroughly reshaped during the 1990s. The reformed system incorporated the need for longer working life. In addition, the Swedish labour market, as a whole, is also characterised by employers´ good practices to encourage continued employment of older workers. Post-reform, the Swedish pension system was characterised by great flexibility, in that it enabled workers older than 61 - and beyond the age of 67 - to reduce their working hours by as much as 50% and to draw 25%, 50%, 75% or 100% of the full old age pension (OECD 2011). Increasing flexibility in the timing of retirement, and between work and retirement, is generally seen as an opportunity to keep older workers longer in the labour market. Although a number of European countries, including Finland and Germany in our sample, have introduced elements of flexible/partial retirement in their pension schemes, Sweden was among the first countries to introduce a part-time pension that allowed employees to work part-time while also receiving an old age pension. It was intended to provide for a gradual transition from work to retirement and to ensure better working conditions during the last years of work. Interestingly, this measure was popular with both the employees and employers in Sweden. However, the economic crisis that hit Sweden during the 1990s forced the government to cut general social spending, and as a result the part-time pension was made less generous. The scheme was eventually abolished in 2001 on the grounds that it contradicted the general principle of the new Swedish old age pension system. Moreover, it was considered to be too costly in a system, which, by then, offered great flexibility regarding options for combining work and retirement (Wadensjö, 2006). Yet this Swedish case indicates the importance of pension incentives for older worker labour market participation.

The higher propensity to be employed in older ages also points to the context in which bonus/malus incentives in the public pension system to delay retirement are high. The 2005 Finnish pension reform, for instance, introduced a "window" of flexible retirement (between ages 63 and 68) within which incentives for later retirement were given by higher accrual rates.[87] Finland had also introduced a part-time pension was in the private sector (in 1987) and in the public sector (in 1989), which could be granted to persons aged between 60 and 67 who had been in full-time employment in the past year.[88] The change from full-time to part-time work and retiring on a part-time pension has to be agreed on with the employer, though changing employers or becoming part-time self-employed is allowed. The reduction in working hours corresponded to the decrease in earnings, which had to be 35-70% of the earlier full-time earnings. The amount of the part-time pension was 50% of the difference between the full-time and part-time earnings. Take-up of the Finnish part-time pension was very low in the few years following its introduction: between 1987 and 1993 around 3,500 persons started receiving the pension. The number gradually increased from 1994 onwards when the lower age limit was reduced from 60 to 58 years, and then to 56 years in 1998. In 2002, before the age-limit was increased again back to 58 years, the number of persons retiring on a part-time pension was the highest (more than 14,000). Since 2003, volume has been decreasing and inflow in 2009 was down to below the 1999 level.[89]

Older workers often tend to be more *job-protected* than younger workers in their jobs, while at the same time less employable than young workers once they lose their jobs. This is evident also in surveys, which find that wide across fifteen selected OECD countries, worker age is negatively correlated with job insecurity and positively correlated with labour market (reemployment)

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[87] See Finnish Centre for Pensions: http://www.etk.fi/en/service/earnings-related_pensions/1434/earnings-related_pensions

[88] The lower age limit was 58 years for those born before 1953. See http://www.tyoelake.fi/

[89] See Finnish Centre for Pensions Database. Apart from its relatively low take-up, the OECD has also criticized the Finnish part-time pension system for reducing the effective labour supply based on the findings of a study proving that about 50% of part-time pensioners would have continued in a full-time work in the absence of a part-time pension scheme (OECD, 2006). Previous survey results which indicated that those on part-time pension were not planning to retire any later than those working full-time have also been also confirmed by a new study using administrative data (Salonen and Takala, 2011).

insecurity (Anderson and Pontusson 2007).[90] Activity rates across these 15 OECD countries correlate negatively with the strictness of employment protection (R=-0,54 for women, R=-0,49 for men; own calculations based on OECD 2006). Therefore, strict employment protection schemes may provide a certain level of security for labour market insiders, but they simultaneously seem to prevent companies from hiring older workers and to force many older workers to go into involuntary (forced) as opposed to voluntary (e.g. leisure driven) early retirement. Indeed, in a study of early retirement motivations and determinants in 19 OECD countries, Dorn and Souza-Posa (2010) find that, together with increases in unemployment levels (economic shocks), higher levels of employment protection are systematically one of the main drivers of *involuntary* early retirement specifically.[91] Schmähl (2003) similarly argues that German firms often tend to push older workers into early retirement schemes in order to circumvent comparatively high levels of employment protection legislation. Thus, we might expect that the reduction of unemployment protection levels (e.g. in the public sector) would increase the labour market participation level of older workers. A note of caution is in place here, however, as seemingly sensible policy measures in this field have not always had the desired effects in reality. A clear example is the notorious LIFO (last in-first out) principle in Sweden.

Legislated in the 1982 Employment Protection Act, the LIFO principle has long been considered as one of the foundational policies to protect the employment of older insiders in the Swedish labour market model. At the same time, it has also often been suggested to be a main hindrance for the employability of older outsiders.

Box 14.1: LIFO (last in – first out) principle in Sweden

This principle implies that the worker who was employed last has to go first when a firm downsizes. Opponents highlight that introduces a cost to the employer since the employer can not necessarily keep the most valuable workers.

A new law from January 2001 stipulates that only for firms with *ten* employees or less, the LIFO principle would no longer have to apply in the case of *two* designated workers. In other words, small firms could exempt up to two recently hired workers from being fired first in case of work shortage.

Source: Below and Thoursie 2010.

Yet the best evidence to date suggests that LIFO may have *little or no impact on the employment behaviour of firms towards older workers*. Von Below and Thoursie (2010) use a recent and limited relaxation in the Swedish LIFO principle to test its effects in a quasi-ideal natural experiment setting. Specifically, using a database with altogether 70,000 firms, the authors compare small firms with ten employees (who fell under the new LIFO relaxation law) and small firms with 11 employees (who did not), and find no differences in either hires of older workers or fires/quits of older workers between these two similar types of firms. In other words, contrary to the expectation of policymakers and the predictions of economic theory, firms did not react at all to the new and seemingly significant relaxation in the LIFO law. In sum, the authors not find any statistically significant effects of the new law on net employment levels and employers' behaviour.

Wage subsidies for older workers is another example of possibly counterproductive labour market measures. Economic theory stipulates that because older workers are by definition likely to remain a

[90] The Anderson and Pontusson (2005) individual-level data were drawn from the International Social Survey Program (ISSP) and they covered the following 15 OECD countries: Canada, Denmark, France, Germany, Great Britain, Italy, Japan, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland and the United States.

[91] Dorn and Souza-Posa (2010) furthermore show that Germany ranks third highest (after Hungary and Portugal respectively) within the 19-country sample in terms of levels of involuntary early exit, with 50 per cent of all early retirees indicating they retired involuntarily. The lowest levels of were recorded in Denmark (8.8 per cent) and the USA (9.4 per cent).

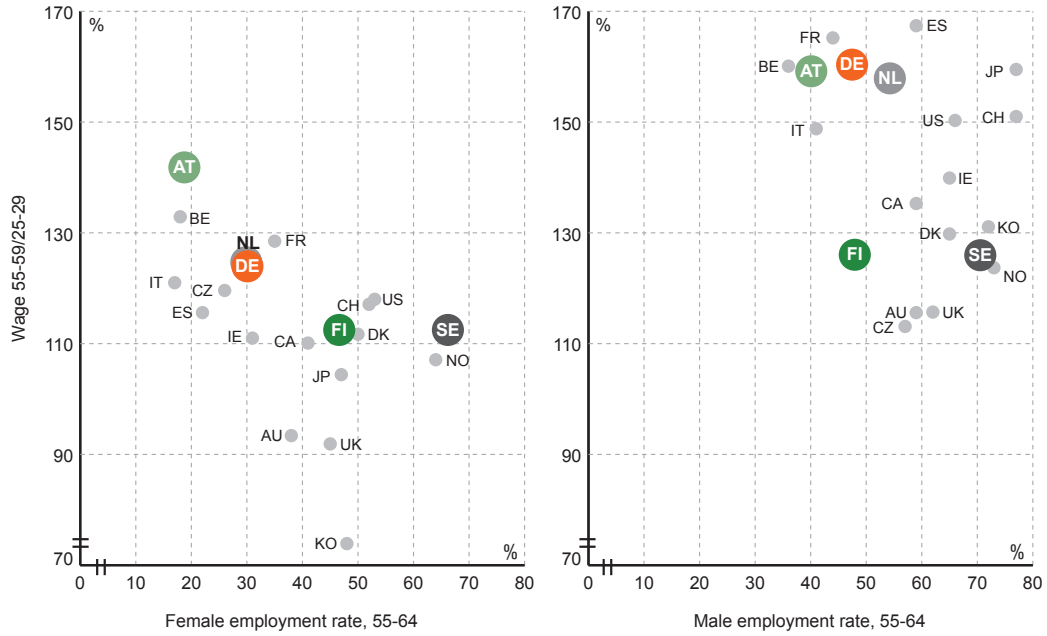
shorter period in new jobs, they will be less likely than younger workers to be hired in jobs that involve high hiring costs or training costs (Saint-Paul 2009). In other words, with a uniform hiring cost, firms are less likely to hire an older employee as there will be a shorter duration of the job over which the company can recoup the costs. This is called the ‚endgame effect'. It is often extremely expensive (thus probably socially inefficient) for the state to pay or subsidize high hiring costs for older workers. In Saint-Paul's (2009) view, this consideration 'should rule out policies that subsidize the hiring of older workers; if older workers have to change jobs, it must be in activities where hiring costs are not too high.' On the positive side, the endgame effect implies that another measure – *raising official retirement ages* – is likely to be highly effective in activating older workers. The mere fact of raising the retirement age will increase the job finding rate for workers in a given age category, as the endgame effect will be weaker for those workers (Saint-Paul 2009).

The seniority rule in wage profiles: from Finnish flatlands to the Austrian Alps

The labour market chances of elderly men and women are clearly determined in great part by the material incentives they face for being active (or inactive). Steep age-wage profiles, which are often prevalent in European labour markets, can be a major incentive for older workers to stay in the labour market, as well as a disincentive for employers to hire older workers. The reason why wage profiles go up with age often relates to the need for employers to provide incentives for workers in hard-to-monitor (often high-value added) jobs. Workers are then being paid less than their marginal product in early phases of their career then more than their marginal product in later stages of their career, which provides powerful incentives to stay with the same firm (Lazear 1981; 1990). In other words, older workers who lose their job also lose a rent that goes above and beyond their own productivity. This explains why steep age-wage profiles affect work mobility between jobs among older workers, as mobility is more costly and therefore more deterred. Moreover, given the short expected tenure in any new position that older workers will find, there is little room for engaging in deferred compensation. This means that older workers are more likely to end up in badly paying (since low value added) jobs where incentive problems are less important, also because it is more difficult to use pay to elicit incentives for workers with short expected tenure (Saint-Paul 2009). Empirically, steep age-wage profiles seem to be a major disincentive especially in the case of women (see Figure 14.5), as higher wages for 55-64-year olds relative to 25-29-year olds are negatively correlated with activity rates at the age of 55-64, at least in the case of women.[92]

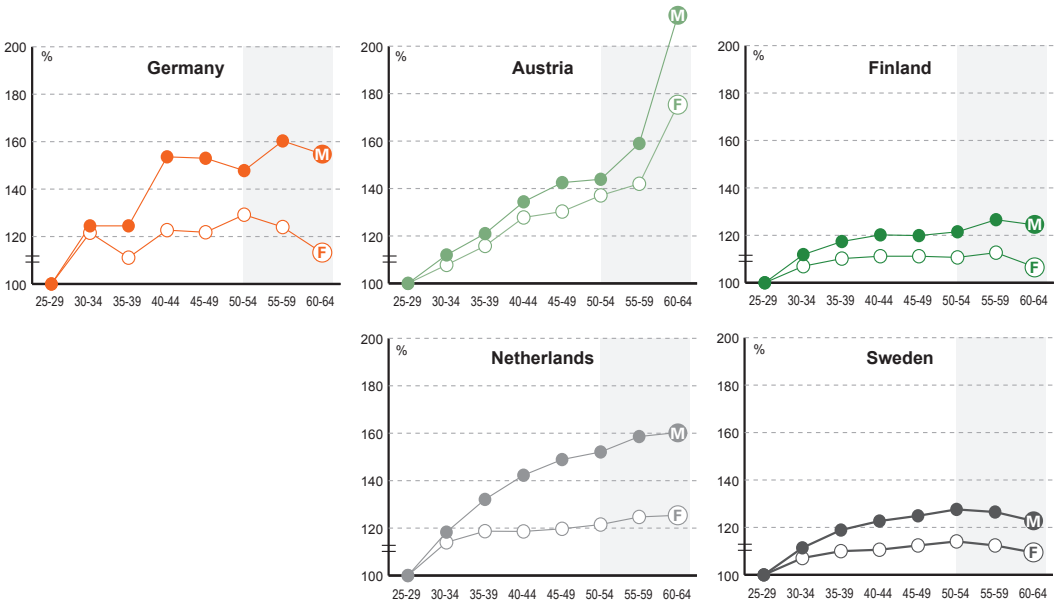
[92] Note however that policy reforms since 2002 (latest year for which data are available on age-wage ratios) may have changed the relationship between age-wage ratios and employment patterns subsequently. However, when we compare age-wage ratios of 2002 with employment rates data of 2009, we do also find moderately high age-wage gaps for women and high age-wage gaps for men, Germany clusters together with the Netherlands, whereas Finland and Sweden seem to cluster in a distinct Nordic cluster characterized by relatively modest age-wage gaps for women and moderately high gaps for men. Specifically, the R values for the correlation between wages for 55-64-year olds relative to 25-29-year olds and activity rates at the age of 55-64 are -0.36 for men and -0.43 for women (own computations from OECD 2006).

Figure 14.5: Employment rate (55-64), 2002 and ratio of wage of persons aged 55-59 compared to persons aged 25-29, 2002*



Source: OECD (2006: 66).
Note: wage of full-time workers. * year differs from country to country, 1998-2003.

Figure 14.6: Age-wage profiles by gender, 2002* (Index: age 25-929 = 100)



Source: OECD (2006: 66).
Note: wage of full-time workers, calculations are based on cross sectional data.
* year: 1998 for Germany, 1999 for Sweden, 2000 for Finland, 2001 for Austria.

This is particularly relevant when one takes the view of the (potential) *employers* of older workers. Older workers tend to become increasingly expensive relative to younger workers as they near the end of the career cycle in countries such as Austria and Germany. Note also that the variation between different countries in our sample is very high when it comes to age-wage profiles (Figure 14.6). In the Nordic cases we can speak of Finnish flatlands and Swedish molehills. That is, Finland is characterized by very flat age-wage profiles for men and women after 35. Sweden is similarly

characterized by flat age-wage profiles for men and women, wages (relative to the age group 25-29) even decline after 55. In the Dutch case, one can speak of female polders versus male hills: the Netherlands are characterized by steeply rising age-wage profiles for men, but flat profiles for women after 40. Germany, in turn, tells a tale of zigzag races between men and women: here we see women intermittently almost catching up with men, only to fall back later on in the career cycle. Germany is characterized rising age-wage profiles for men after 40, but flat profiles for women after 45, and even declining profiles after 50. As a result, in the age category 60-64, gender gaps are relatively wide in Germany – the widest in our sample, closely followed by the Netherlands and Austria. The outstanding case in our sample in terms of age-wage profiles, however, is Austria, which can be characterized by true Alpine peaks. Austria has by far the steepest age-wage profiles for both men and women: already steeply rising slopes in people's thirties and forties further accelerate after 55 and again after 60. To be sure, these steep age-wage profiles are a strong incentive for those (insider) workers who can hold on to their jobs to stay in the labour market as long as they can. But they simultaneously represent strong hurdles for the employability of older workers when viewed from the point of view of employers. This makes older workers prohibitively costly compared to younger workers (who often also have more updated skills). This goes some way towards explaining the particularly low levels of older worker activation particularly in a country such as Austria (Figure 2.1). In sum, it is likely that seniority wages such as those in force in the wage-setting practices of countries such as Austria and to a lesser extent men in Germany and the Netherlands (but also Belgium, France, and Spain, see OECD 2006) represent a likely barrier to the employment of older workers. If increasing labour market participation chances of older workers were the main goal of policy, the reduction of the steepness in age wages profiles where possible (e.g. in the public sector), especially in the very last years before official retirement age, would be likely to be an effective policy measure.

Conclusions

In sum, it is clear that the labour market participation chances of Germany have very markedly improved since 2004 and the 2005 Hartz reforms after decade-long standstill. Activity rates reached 61 percent in 2009, a level which recently established Germany as the second highest achiever in our five-country sample, second only to Sweden (at 74 percent) and just above Finland (59 percent). Together with the Netherlands, Germany reached the 2001 EU Stockholm target to increase the employment rate of persons aged 55 to 64 up to 50 per cent in 2007, ahead of Austria but after Sweden (2001) and Finland (2004). One strong qualifier to this comparative success rate is that Germany stands out as a high-risk labour market for unemployed older workers over the past decade, with both the highest unemployment rate (at 8 percent) and, more worryingly, the highest long-term unemployment rate (at above 5 percent) in the sample. Thus, there is a need for policies which provide a better access to labour market participation for older unemployed workers.

In terms of age-wage profiles, unlike Finland and Sweden (flat profiles over the career cycle) Germany tells a tale of a zigzag gender race: women intermittently almost catch up with men, only to fall back later on in the career cycle. As a result, in the age category 60-64, gender gaps are relatively wide in Germany – the widest in our sample, far closely followed by the Netherlands and Austria, which has by far the steepest age-wage profiles for both men *and* women. While such steep age-wage profiles are a strong incentive for workers to hold on to their current jobs, they represent strong hurdles for the employability of older workers. From a policy viewpoint, it follows that reducing steep age-wage profiles for older workers in the public sector would be desirable if activating older workers is a policy priority.

Similarly, there is evidence that high levels of employment protection regulation prevent companies from hiring older workers and force many older workers to go into *in*voluntary early retirement (e.g. Dorn and Souza-Posa 2010). From a policy viewpoint, reducing of employment protection levels

where possible (e.g. in the public sector) would thus be likely to lead to higher labour market activation levels among older workers, especially if combined with stronger disincentives for early retirement.

All in all, negative incentives, such as closing down pathways into early retirement and disability retirement, as has happened in Germany, Sweden and Finland in recent years, appear to be most effective in increasing labor market participation of older workers, albeit sometimes at the cost of higher levels of long-term unemployment.

In addition, dynamic labour markets with cooperative relations between employers (and their organizations) and employees (and their organizations) can be a major help. A standout recent example here is the 'German employment miracle' during and after the late 2000s, which was in all likelihood more due to employer prudence and flexibility rather than state measures. As Burda and Hunt (2011) point out, Germany experienced an even deeper fall in GDP in this recession than the United States, yet it experienced little employment loss. Burda and Hunt argue that employers' reticence to hire in the preceding expansion, which was itself in no small part due to a belief the expansion would not last, was the main cause for the outstanding German employment record during the recession. In addition, wage moderation on the part of employees and the widespread adoption of working time accounts, which allow employers to avoid overtime pay if hours per worker average to standard hours over a window of time, were also significant factors. Working time accounts, for instance, provided disincentives for employers to lay off workers in the downturn. As a result, whereas overall cuts in hours per worker were severe during the recession, reduction of working time account balances substituted for traditional government-sponsored short-time work.

References

Adams, N., A. Barton, et al., Eds. (2011). Households Below Average Income. An analysis of the income distribution 1994/95 – 2009/10. London, Department for Work and Pensions.

Anderson, C., Pontusson, J. (2007), 'Workers, Worries and Welfare States: Social Protection and Job Insecurity in 15 OECD Countries,' European Journal of Political Research 46: 211-235.

Andrews, F. M. and S. B. Witney (1976). Social indicators of well-being: Americans' perceptions of life quality. New York, Plenum Press.

Argyle, M. (1999), Causes and correlates of happiness. Well-Being. The Foundations of Hedonic Psychology. D. Kahneman, E. Diener and N. Schwarz. New York. Russell Sage Foundation: 353-373.

Armingeon, K. (2007), 'Active Labour Market Policy, International Organizations, and Domestic Politics,' Journal of European Public Policy, 14(6): 905-932.

Arnold, D.H., Doctoroff, G.L. (2003), 'The Early Education of Socio-Economically Disadvantaged Children,' *Annual Review of Psychology*, Vol. 54, pp. 517-545.

Atkinson, A. B. (2007): Measuring Top Incomes: Methodological Issues. In: Atkinson A. B. and Piketty, T. (Eds.): Top Incomes over the Twentieth Century: A Contrast between Continental European and English-Speaking Countries. Oxford and New York, Oxford University Press: 18-42.

Atkinson, A. B., Piketty, T., Saez, E. (2011): Top Incomes in the Long Run of History. Journal of Economic Literature 49(1): 3-71.

Barnett, W.S. (1995), 'Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes,' *The Future of Children*, Vol. 5, No. 3, pp. 25-50.

Barnett, W.S. (1998), 'Long-term cognitive and academic effects of early childhood education on children in poverty, ' *Preventive Medicine*, 27 (2): 204-207.

Barnett, W.S. (2001), 'Preschool Education for Economically Disadvantaged Children: Effects on Reading Achievements and Related Outcomes,' in Neuman, S.B. and Dickinson, D.K., eds., *Handbook of Early Literacy Education*, New York: Guilford Press, pp. 421-443.

Barnett, W.S. (2002), 'Early Childhood Education,' in Molnar, Alex, ed, *School Reform Proposals: The Research Evidence*, Greenwich, Con: Information Age Publishing.

Beaverstock, J. V., Hubbard, P., Short, J. (2004): Getting away with it? Exposing the geographies of the super-rich. Geoforum 35: 401-407.

Behaghel, Luc, Bruno Crépon and Béatrice Sédillot (2008), "The perverse effects of partial employment protection reform: The case of French older workers", Journal of Public Economics 92, 696-721

Bergesen, Albert J., Bata, Michelle (2002): Global and national inequality: are they connected? Journal of World System Research 8(1): 130-144.

Blau, David and Hagy, Alison P. (1998), 'The Demand for Quality in Child Care,' *Journal of Political Economy*, 106, 1, pp. 104-146.

Blau, David and Robins, Philip (1989), 'Fertility, Employment, and Child Care Costs,' *Demography*, 26, 287-299.

Blau, Francine and Grossberg, Adam (1992), 'Maternal Labor Supply and Children's Cognitive Development,' *Review of Economics and Statistics*, 74, 3, 474-481.

Blond, P. (2011) 'England's Riotous Values,' *The New York Times*, August 24th 2011.

Bogenschneider, K. (1997), 'Parental Involvement in Adolescent Schooling: A Proximal Process with Transcontextual Validity,' *Journal of Marriage and the Family*, 59: 718-733.

Bonke, J, Esping-Andersen, G. (2011), 'Family Investments in Children – Productivities, Preferences, and Parental Child Care,' *European Sociological Review* 27(1): 43-55.

Bonoli, G. (2010), 'The Political Economy of Active Labour-Market Policy,' Politics & Society, 38(4): 435-457.

Bonoli, G., Reber, F. (2010), 'The Political Economy of Childcare in OECD Countries: Explaining Crossnational Variation in Spending and Coverage Rates, European Journal of Political Research 49(2): 97-118.

Bourdieu, Pierre (1982): Die feinen Unterschiede. Kritik der gesellschaftlichen Urteilskraft. Frankfurt/Main, Suhrkamp.

Bowles, Samuel, Herbert Gintis and Melissa Osborne Groves. 2005. *Unequal Chances*. New Jersey: Princeton University Press.

Bracey, Gerald W. and Stellar, Arthur (2003), 'Long-term Studies of Preschool: Lasting Benefits far Outweigh Costs,' *Phi Delta Kappan* 84.10, p 780.

Bradburn, N. M. (1969). The structure of psychological well-being.

Bumpass, Larry L. (2004), 'Social Change and the American Family,' *Annals of the New York Academy of Sciences*, Volume 1038, No. 1, pp. 213-219.

Burchardt, T., Hills, J., J. Le Grand and D. Piachaud, Eds. (2002). *Understanding Social Exclusion*. Oxford, Oxford University Press.

Burchinal, M. R. (1999), 'Child Care Experiences and Developmental Outcomes,' *Annals of the American Academy of Political and Social Sciences*, 563, pp. 73-97.

Burda, M. Hunt, J. (2011), 'What Explains the German Labor Market Miracle in the Great Recession?' NBER working paper No 17187.

Campbell, A., P. E. Converse, et al. (1976). The Quality of American Life. Perceptions, Evaluations, and Satisfaction. New York, Russel Sage Foundation.

Campbell, F.A. et al. (2002), 'Early Childhood Education: Young Adult Outcomes for the Abecedarian Project,' *Applied Developmental Science*, Vol. 6, pp. 42-57.

Cantril, H. (1965). The Pattern of Human Concerns. New Brunswick, N.J., Rutgers University Press.

Carneiro, P. & J. Heckman (2003), 'Human Capital Policy,' in J. Heckman & A. Krueger, Eds, *Inequality in America: What Role for Human Capital Policy*. MIT Press. Cambridge, MA.

Chapple, S. (ed) (2011) *Subjective Wellbeing and Social Policy.* Brussels: European Commission.

Christakis, N. and J. Fowler (2009). Connected: The Amazing Power of Social Networks and How They Shape Our Lives. New York, Little, Brown and Company.

Clark, A. E., P. Frijters, et al. (2008). "Relative income, happiness and utility: an explanation for the Easterlin paradox and other puzzles." Journal of Economic Literature 46(1): 95-144.

Coleman, J. C. (1990), Foundations of Social Theory. Cambridge, Massachusetts. The Belknap Press of Harvard University Press.

Connelly R, Kimmel J (2003a) 'Marital status and full-time/part-time work status in child care choices,' *Applied Economics*, 35 (7): 761-777.

Connelly R, Kimmel J (2003b), 'The effect of child care costs on the employment and welfare recipiency of single mothers,' *Southern Economic Journal*, 69 (3): 498-519.

Cryer, D. (1999), 'Defining and Assessing Early Childhood Program Quality,' *Annals of the American Academy of Political and Social Sciences*, 563, pp. 39-55.

Davies, James B., Sandström, Susanna, Shorrocks, Anthony and Wolff, Edward N. (2007): Estimating the Level and Distribution of Global Household Wealth. UNU World Insitute of Development Economics Research, Research Paper 77.

Davies, James B., Sandström, Susanna, Shorrocks, Anthony and Wolff, Edward N. (2008): The World Distribution of Household Wealth. UNU World Insitute of Development Economics Research, Discussion Paper 2008/03.

Department for Environment, Food and Rural Affairs (2010). Measuring progress: Sustainable development indicators 2010. London. Downloadable: http://sd.defra.gov.uk/progress/national/annual-review/. Access date: 28 April 2011.

Diener, E. and M. E. P. Seligman (2004). "Beyond money: Toward an economy of well-being." Psychological Science in the Public Interest **5**(1): 1-31.

Diener, E., E. M. Suh, et al. (1999). "Subjective well-being: three decades of progress." Psychological Bulletin 125(2): 276-303.

Dorn, D. Sousa-Poza, A. (2010), ''Voluntary' and 'Involuntary' Early retirement: An International Analysis,' Applied Economics 42(4): 427-438.

Ebbinghaus, B. (2006) Reforming Early Retirement in Europe, Japan and the USA, Oxford: Oxford University Press.

Erikson, R. and Goldthorpe, J. (1992*), The Constant Flux: A Study of Class Mobility in Industrial Societies*. Oxford: Oxford University Press.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*. Cambridge: Polity Press.

Esping-Andersen, G. (1999) *New Foundations of Postindustrial Economies*. Oxford Polity Press.

Esping-Andersen, G. (2002a), 'Towards the Good Society, Once Again?,' in Esping-Andersen, G., with Gallie, D., Hemerijck,, A., Myles, J., *Why We Need a New Welfare State*. Oxford: Oxford University Press.

Esping-Andersen, G. (2002b) A Child-Centered Social Investment Strategy,' in Esping-Andersen, G., with Gallie, D., Hemerijck,, A., Myles, J., *Why We Need a New Welfare State*. Oxford: Oxford University Press, pp. 26-67.

Esping-Andersen, G. (2002c), 'A New Gender Contract,' in Esping-Andersen, G., with Gallie, D., Hemerijck, A., Myles, J., *Why We Need a New Welfare State*. Oxford: Oxford University Press.

Esping-Andersen, G. (2008), 'Childhood Investments and Skill Formation,' *International tax and Public Finance* 15: 19-44.

Esping-Andersen, G. (2009) *The Unfinished Revolution*. Polity Press.

Eurofound (2007) *Combining Family and Full-Time Work*. Dublin: European Foundation for the Improvement of Living and Working Conditions.

Eurofound (2007), Employment and Labour Market Policies for an Ageing Workforce and Initiatives at the Workplace: National Overview Report Sweden. Dublin: European Foundation for the Improvement of Living and Working Conditions.

EuroHealthNet (2005), Health and Social Inclusion in the EU: the value of transnational exchange, Brussels, EuroHealthNet.

EuroHealthNet, Costongs, C. and Stegeman, I. (2003), Health, Poverty and Social Inclusion in Europe: Health analysis of national plans on social inclusion, Brussels, EuroHealthNet.

EuroHealthNet, Stegeman, I ., and Costongs, C. (2003), Health, Poverty and Social Inclusion in Europe: Literature review on concepts, relations and solutions, Brussels, EuroHealthNet.

EuroHealthNet, Stegeman, I ., and Costongs, C. (2004), Promoting Social Inclusion and Tackling Health Inequalities in Europe: an overview of good practices from the health field, Brussels, EuroHealthNet.

European Commission (2010), Combating poverty and social exclusion – A statistical portrait of the European Union 2010, Luxembourg, Publications Office of the European Union.

European Commission (2011a), EUROSTAT , [online], available at http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database [accessed April-July 2011]

European Commission (2011b), [online], available at http://ec.europa.eu/social/main.jsp?catId=754&langId=en [accessed May 2011]

European Council (2010). *European Council 17 June 2010: Conclusions*, Brussels, European Council.

European Foundation for the Improvement of Living and Working Conditions (2010) Absence from work, Eurofound: Dublin.

Eurostat (2006) Average exit age from the labour force – total, Statistical Office of the European Communities.

Fonseca, R. and Zheng, Y. (2011), The Effect of Education on Health: Cross-Country Evidence. RAND Working Paper No. WR-864.

Frank, Robert (2007): Richi$tan. A Journey through the 21 st Century Wealth Boom and the Lives of the New Rich. Piatkus, New York.

Frede, E.C. (1995), 'The Role of Program Quality in Producing Early Childhood Program Benefits,' *The Future of Children*, 5, 3, 115-132. '

Frey, B. S. and A. Stutzer (2002). "What can economists learn from happiness research?" Journal of Economic Literature XL(2): 402-435.

Gallie, D. and Paugam, S., eds. (2000) Welfare Regimes and the Experience of Unemployment in Europe, Oxford: Oxford University Press.

Gallie, D., Paugam, S., Jacobs, S. (2003), 'Unemployment, Poverty and Social Isolation - Is there a vicious circle of social exclusion? European Societies 5(1): 1-32.

Garces E., Thomas, , Currie J. (2002), 'Longer-Term Effects of Head Start,' *American Economic Review*, 92 (4): 999-1012.

German Federal Government (2010), Third Report on Poverty and Wealth, Berlin, German Federal Government.

Goodman, A., Sianesi, B. (2006) 'Early Education and Children's Cognitive Outcomes: How Long Do the Impacts Last?,' *Fiscal Studies*, 26, 4, 513-548.

Gormley, W. (1999), 'Regulating Child Care Quality,' *Annals of the American Academy of Political and Social Sciences*, 563, pp. 116-129.

Grabka, Markus M. and Frick, Joachim R. (2007): Vermögen in Deutschland wesentlich ungleicher verteilt als Einkommen. In: DIW-Wochenbericht 74(45): 665-672.

Grabka, Markus M. and Frick, Joachim R. (2008): Schrumpfende Mittelschicht in Deutschland - Anzeichen einer dauerhaften Polarisierung der verfügbaren Einkommen? In: DIW-Wochenbericht 75(10): 101-108.

Granovetter, M. S. (1973). "The Strength of Weak Ties." American Journal of Sociology 78(6): 1360-80.

Granovetter, M. S. (1983). "The Strength of the Weak Tie: Revisited." Sociological Theory 1: 201-33

Grootaert, C. and T. v. Bastelaer (2001). Understanding and Measuring Social Capital: A Synthesis of Findings and Recommendation from the Social Capital Initiative. Social Capital Initiative Working Paper Series No. 24., Washington, D.C., The World Bank.

Gurin, G., J. Veroff, et al. (1960). Americans view their mental health: a nationwide interview survey. New York,, Basic Books.

Hanushek, E.A. (2003), 'The Failure of Input-Based Schooling Policies,' *Economic Journal*, 113, 485, 64-98.

Hartmann, Michael (2009): Reichtum und Eliten im europäischen Vergleich. In: Druyen, Thomas, Lauterbach, Wolfgang, Grundmann, Matthias (Eds.): Reichtum und Vermögen. Wiesbaden, VS Verlag für Sozialwissenschaften: 231-241.

Haux, T. (2011), 'Review Article: Balancing Work and Family Life – the Next Big Challenge for Policy-Makers,' Journal of European Social Policy 21(3): 274-277.

Haveman, R. and Wolfe, B. (1995), 'The Determinants of Children's Attainments,' *Journal of Economic Literature*, 33, 1829-1878.

Heckman, J, D.V. Masterov (2007). "The Productivity Argument for Investing in Young Children," *Review of Agricultural Economics,* **29**(3): 446–493.

Heckman, J.J. (2000), 'Policies to Foster Human Capital,' *Research in Economics*, 54, 3-56.

Heckman, J.J. (2004), 'Lessons from the Technology of Skill Formation,' *Annals of the New York Academy of Sciences*, Vol. 1038, No. 1, pp. 179-200.

Helliwell, J. F. (2006), "Well-Being, Social Capital and Public Policy: What's New?" The Economic Journal 116(510): C34-C45

Hering, M. (2012), ‚Live Longer, Work Longer?' Intergenerational Fairness in Retirement Age Reforms in Germany and the UK,' in Pieter Vanhuysse and Achim Goerres (eds), Aging Populations in Postindustrial Democracies: Comparative Studies of Policies and Politics. Abingdon: Routledge/ECPR European Political Science Series.

Herzog, R. James S., House, J.S., and Morgan, J. (1991), 'Relation of Work and Retirement to Health and Well-Being in Older Age,' Psychology and Aging 6(2): 202-211.

Huber, M., et al. (2008), Quality in and Equality of Access to Healthcare Services, Brussels, European Commission.

Hurst, E., Guryan, J., Kearney, M. (2008) 'Parental Education and Parental Time Use,' NBER working paper WP13993.

Imbusch, Peter (2009): Unglaubliche Vermögen – Elitärer Reichtum. In: Druyen, Thomas, Lauterbach, Wolfgang, Grundmann, Matthias (Eds.): Reichtum und Vermögen. Wiesbaden, VS Verlag für Sozialwissenschaften: 212-230.

ISER (2011), 'Research Shows Stark Inequalities for Pre-School Kids,' Colchester: Essex University Institute for Social and Economic Research Newsletter, Summer.

Jacobi, L. and Kluve, J. (2006) 'Before and After the Hartz Reforms: The Performance of Active Labour Market Policy in Germany', Discussion Paper Series, Bonn: Institute for the Study of Labour.

Jensen, C. (2009), 'Institutions and the Politics of Childcare Services,' *Journal of European Social Policy* 19, 1-18.

Judge, K., Platt, S., Costongs, C. and Jurczak, K. (2006), Health Inequalities: a Challenge for Europe, Brussels, An independent expert report commissioned by the UK Presidency of the EU.

Jürges, H., (2007), True Health vs. Response Styles: Exploring Cross-country Differences in self-reported health, Health Economics, 16: 163-178.

Kahneman, D. and A. B. Krueger (2006). "Developments in the measurement of subjective well-being " The Journal of Economic Perspectives 20(1): 3-24.

Kahneman, D., J. L. Knetsch, et al. (1991). "Anomalies - the endowment effect, loss aversion, and status quo bias." Journal of Economic Perspectives 5(1): 193-206.

Kamerman, S.B. (2000), 'Early Childhood Education and Care: An Overview of Developments in the OECD Countries,' *International Journal of Educational Research*, 33, 7-29.

Kamerman, S.B., Moss, P. (2009), *The Politics of Parental Leave Policies: Children, Parenting and the Labour Market*. Policy Press.

Kemmerling, A. and Bruttel, O. (2006) ''New Politics' in German Labour Market Policy? The Implications of the Recent Hartz Reforms for the German Welfare State', West European Politics, 29(1): 90-112.

Knudsen, Eric L., James J Heckman, Judy L. Cameron, and Jack P. Schonkoff. (2007). Economic, Neurobiological and Behavioral Perspectives on Building America's Future Workforce. *Proceedings of the National Academy of Sciences* 103(27):10155-10162.

Kotlikoff, L. and J. Gokhale (1992), "Estimating The Age-Productivity Profle Using the Present Value of Lifetime Earnings", Quarterly Journal of Economics.

Kotowska, I., Matysiak, A., Styrc, M., Pailhé, A. Solaz, A., Vignoli, D. (2010), *Second European Quality of Life Survey: Family Life and Work,* Dublin 2010: European Foundation for the Improvement of Living and Working Conditions. 85 pp.

Krueger, A. and Schkade, D. (2008). "The Reliability of Subjective Well-Being Measures". *Journal of Public Economics,* **92**, 1833-45.

Kuznets, Simon (1953): Shares of Upper Income Groups in Income and Savings. Cambridge/Mass., National Bureau of Economic Research.

Lamb, M. (1997), 'Nonparental Child Care: Context, Quality, Correlates,' in Damon, W., Siegel, I.E., Renninger, K.A., eds., *Handbook of Child Psychology*, Vol. 4, 5th edition, New York: John Wiley.

Larner, M., Behrman, R., Young, M. and Reich, K. (2001), 'Caring for Infants and Toddlers: Analysis and Recommendations,' *The Future of Children*, Vol. 11, No. 1, pp. 7-20.

Lazear, E. (1981), 'Agency, Earnings Profiles, Productivity, and Hours Restrictions,' American Economic Review 71, 4: 606-620.

Lazear, E. (1990), Job Security Provisions and Employment, Quarterly Journal of Economics 105:3, 699-726.

Leitner, S (2010), 'Germany outpaces Austria in childcare policy: the historical contingencies of 'conservative' childcare policy,' *Journal of European Social Policy* 2010 20: 456-467.

Lelkes, O. (2007). Happiness over the Life-Cycle. Exploring Age-specific Preferences. Mainstreaming Ageing. Indicators to Monitor Sustainable Policies. B. Marin and A. Zaidi. Aldershot, Ashgate: 359-391.

Lelkes, O. (2010). Social participation and social isolation. Income and living conditions in Europe. Eurostat Statistical books. A. B. Atkinson and E. Marlier. Luxembourg, Publications Office of the European Union: 217-240.

Lietzmann, T. (2009), 'Warum Alleinerziehende es besonders Schwer Haben,' IAB Kurzbericht 12/2009.

Lyubomirsky, S. (2008). The how of happiness: A scientific approach to getting the life you want. New York, Penguin Press.

Mackenbach, J.P. (2003), Widening socioeconomic inequalities in mortality in six Western European countries, International Journal of Epidemiology, 32, 830-7.

Mackenbach, J.P., Meerding, W.J. and Kunst, A.E. (2011), Economic costs of health inequalities in the European Union, J. Epidemiological Community Health, 65: 412-419.

Masse, L.N., Barnett, WS. (2006), *A Benefit Cost Analysis of the Abecedarian Early Childhood Intervention*, New Jersey: National Institute for Early Education Research.

MISSOC (2011), update January 2011, Mutual Information System on Social Protection database of the European Commission, [online], available at http://ec.europa.eu/employment_social/missoc/db/public/comparetables.do?lang=en [accessed May 2011]

New Economics Foundation (2009), National Accounts of Well-being: bringing real wealth onto the balance sheet. London, New Economics Foundation.

New Economics Foundation (2011). Measuring our progress. The power of well-being. London, New Economics Foundation.

Noll, H.-H. and S. Weick (2010). Subjective Well-Being in Germany: Evolutions, Determinants and Policy Implications. Happiness and Social Policy in Europe. B. Greve. Cheltenham, Edward Elgar

OECD (2000), Employment Outlook. June 2000. Paris: OECD

OECD (2003) Ageing and Employment Policies: Sweden. Paris: OECD.

OECD (2003) OECD Employment Outlook. Towards more and better jobs. OECD: Paris.

OECD (2004), Ageing and Employment Policies: Finland, OECD, Paris.

OECD (2005), Reviews of Health Systems: Finland, Paris, OECD.

OECD (2006), Live Longer, Work Longer. Paris: OECD.

OECD (2007), Regions at a Glance 2007, Paris, OECD.

OECD (2009), Sickness, Disability and Work: Keeping on Track in the Economic Downturn. Paris: OECD.

OECD (2011) The OECD Family Database (data accessed on August 16, 2011) (www.oecd.org/document/4/0,3746,en_2649_34819_37836996_1_1_1_1,00.html).

OECD (2011), Pensions at a Glance. Paris: OECD.

Pong, S.-L. (1997) Family structure, school context, and eighth grade math and reading achievement, *Journal of Marriage and the Family*, 59: 734-746.

Pong, S.L., Dronkers, J., Hampden-Thompson, G. (2003), 'Family Policies and Children's School Achievement in Single- versus Two-Parent Families,' Journal of Marriage and the Family, 65, 3, 681-699.

Powell, W. W. and Snellman, K. (2004), 'The Knowledge Economy,' *Annual Review of Sociology*, 30, 199-220.

Putnam, R. D. (2000), Bowling Alone: The Collapse and Revival of American Community. New York, Simon & Schuster.

Putnam, R., with R. Leonardi, and R. Nanetti (1993), Making Democracy Work: Civic Traditions in Modern Italy. Princeton: Princeton University Press.

Rabin, M. (1998). "Psychology and economics." Journal of Economic Literature 26(March): 11-46.

Ramey, C., Ramey, S. (2000), 'Early Childhood Experiences and Developmental Competence,' in Danziger, S., Waldfogel, J., eds., *Securing the Future*. New York: Russell Sage Foundation.

Riesberg, A., Wörz, M. (2008), Quality in and Equality of Access to Healthcare Service – Country Report for Germany, Brussels, European Commission.

Roemer, J. E. (1998). *Equality of Opportunity*, New York, Harvard University Press.

Rohwedder, S. Willig, R.J. (2010), 'Mental Retirement,' Journal of Economic Perspectives 24(1): 119-138.

Ruhm, C. (1998), 'The Economic Consequences of Parental Leave Policies: Evidence from Europe,' *Quarterly Journal of Economics*, 113, 285-318.

Saint-Paul, G. (1998), 'A Framework for Analyzing the Political Support for Active Labour Market Policy,' Journal of Public Economics 67(2): 151-165.

Saint-Paul, G. (2002), 'The Political Economy of Employment Protection,' Journal of Political Economy, 110(3), 672-704

Saint-Paul, G. (2004), 'Why Are European Countries Diverging in their Unemployment Experience?' Journal of Economic Perspectives, 18(4), 49-68.

Saint-Paul, G. (2009), 'Does the Welfare State Make Older Workers Unemployable?' Bonn IZA Discussion paper no 4440.

Saint-Paul. G. (2000) The Political Economy of Labour Market Institutions, Oxford University Press.

Salonen, J. and Takala, M. (2011) ,Working career and income of part-time pensioners in Finland' *Finnish Centre for Pensions Working Paper Nr* 2011:2.

Sandvik, E., E. Diener, et al. (1993). "Subjective well-being - the convergence and stability of self-report and non-self-report measures." Journal of Personality 61(3): 317-342.

Schmähl, W. (2003), 'Ageing Workforce: Firm Strategies and Public Policy in Germany,' Geneva Papers on Risk and Insurance 28(4): 575-595.

Sciubba, J. (2012), ,Rhetoric and Action on Aging in the World's ,Oldest' Democracies: Party Platforms and Labour Policies in Germany, Italy and Japan,' in Pieter Vanhuysse and Achim Goerres (eds), Aging Populations in Postindustrial Democracies: Comparative Studies of Policies and Politics. Abingdon: Routledge/ECPR European Political Science Series.

Seeleib-Kaiser, M., van Dyke, S. Roggenkamp, M. (2009), *Party Politics and Social Welfare. Comparing Christian and Social Democracy in Austria, Germany and the Netherlands*. Northampton: Edward Elgar.

Sen, A. K. (1992). *Inequality Reexamined*, Oxford, Clarendon Press.

Shavit, Y., Blossfeld, H.P. (1992), *Persistent Inequalities*. Boulder, CO: Westview Press.

Siegrist, J., Wahrendorf, M., von dem Knesebeck, O., Jürges, H. and Börsch-Supan, A. (2006), Quality of Work, Well-being, and Intended Early Retirement of Older Employees—Baseline Results from the SHARE Study, European Journal of Public Health, Vol. 17 (1), pp. 62–68.

Skirbekk, V. (2008) 'Age and Productivity Capacity: Descriptions, Causes, and Policy' Ageing Horizons 8, pp. 4-12.

Stiglitz, J. E., A. Sen and J.-P. Fitoussi (2009), Report by the Commission on the Measurement of Economic Performance and Social Progress. Downloadable: www.stiglitz-sen-fitoussi.fr.

Stiglitz, J. E., A. Sen and J.-P. Fitoussi (2009). Report by the Commission on the Measurement of Economic Performance and Social Progress. Downloadable at: www.stiglitz-sen-fitoussi.fr.

Stiller, S. (2010), Ideational Leadership in German Welfare State Reform. Amsterdam: Amsterdam University Press.

Stipek, J.D., Ryan, R.H. (1997), 'Economically Disadvantaged Preschoolers: Ready to Learn but Further to Go,' *Developmental Psychology*, 33, pp. 711-732.

Tepe, M & Vanhuysse, P (2010), 'Elderly Bias, New Social Risks, and Social Spending: Change and Timing in Eight Programs across Four Worlds of Welfare, 1980-2003', *Journal of European Social Policy* Vol. 20, No. 3, pp. 218-234.

Tepe, M. and Vanhuysse, P. (2011) 'Political, Institutional and Temporal Determinants of Active Labour Market Spending: An Analysis of Welfare State Expansion in Times of Retrenchment,' Paper prepared for the ECPR Joint Sessions, Sankt Gallen 2011.

The World Bank (1998), The Initiative on Defining. Monitoring and Measuring Social Capital: Overview and Program Description. Social Capital Initiative Working Paper Series No. 1., Washington, D.C., The World Bank

UNDP (1991). *Human Development Report,* Oxford, Oxford University Press

UNDP (2010). *Human Development Report,* New York, Palgrave Macmillan.

Van der Burg, C. and Prins, R. (2010), "Employment instead of benefit receipt? Process and outcomes of reassessment of Dutch disability benefit recipients" *European Journal of Social Security*, Vol. 12, No. 2, pp. 144-155.

Van Oorschot, W. (2010) "Disability benefit reforms in the Netherlands 1980-2006, Retrenchment and reconstruction" In M. Kautto and J. Bach-Othman (eds.) *Disability and employment– lessons from reforms*, Finnish Centre for Pensions, Reports 2010:4

Van Praag, B. M. S. and A. Ferrer-i-Carbonell (2004). Happiness Quantified. A Satisfaction Calculus Approach. Oxford, Oxford University Press.

Van Sonsbeek, J.M., Gradus, R.H.J.M. (2006) "A Microsimulation Analysis of the 2006 Regime Change in the Dutch Disability Scheme", *Economic Modelling*, Vol. 23, pp. 427-456.

Verry, D. (2000), 'Some Economic Aspects of Early Childhood Education and Care,' *International Journal of Educational Research*, 33, 7-29.

Von Below, D. and Thoursie P.S. (2010), ,Last-in, First Out? Estimating the Effect of Seniority Rules in Sweden,' Labour Economics 17(6): 987-997.

Wadensjö, E: (2006) 'Part-Time Pensions and Part-Time Work in Sweden,' *IZA Discussion Paper Series* No. 2273.

Waginger, U. (2009), Early Retirement and Well-being in Europe. King's College London: MSc thesis.

Waldfogel, J. (2001), 'International Policies toward Parental Leave and Child Care,' *The Future of Children*, Vol. 11, No. 1, pp. 99-111.

Warr, P, Butcher, V., Robertson, I., Callinan, M. (2004), ,Older People's well-being as a Functiom of Employment, Retirement, Environmental Characteristics and Role Preference,' British Journal of Psychology 95: 297-324.

Weishaupt, T. (2011), From the Manpower Revolution to the Activation Paradigm: Explaining Institutional Continuity and Change in an Integrating Europe. Amsterdam: Amsterdam University Press.

Wolff, Edward N. (1996): Top Heavy? A Study of Increasing Inequality of Wealth in America. New York, New Press.

World Health Organisation (European Observatory n Health Systems and Policies) (2009), Health in the European Union, Trends and analysis, Observatory Studies Series No. 19, Copenhagen, WHO Regional Office for Europe.

World Health Organisation (Secretariat of the Commission on Social Determinants of Health) (2005), Action on the Social Determinants of Health: learning from previous experiences, Geneva, WHO.

Annex

Table A.1: Risk of poverty in EU Member States by household composition, 2008 income year

	One person household	2 adults, both below 65 years	2 adults, at least one adult 65+	Other households without children	Single parent, one or more children	2 adults, one dependent child	2 adults, two dependent children	2 adults, three or more children	Other households with children	Total
BE	21.9	9.5	20.9	5.2	36.9	8.4	8.0	15.8	11.7	14.6
BG	58.4	13.3	35.4	9.3	30.9	12.9	15.5	67.9	22.0	21.7
CZ	19.5	4.9	2.2	2.2	40.3	4.6	7.2	23.1	6.5	8.6
DK	26.5	5.5	14.7	2.1	20.3	5.6	5.2	14.5	7.7	13.2
DE	29.3	14.0	10.7	6.8	37.5	9.8	7.7	13.6	10.0	15.5
EE	48.9	9.5	11.6	7.6	38.7	12.2	14.0	28.6	11.8	19.7
IE	30.5	10.7	10.3	7.9	40.4	6.8	10.5	18.0	9.4	15.0
EL	26.5	17.2	21.0	12.7	32.1	22.3	22.4	28.6	18.6	19.7
ES	30.8	12.6	25.2	11.6	36.7	18.1	21.6	41.8	19.7	19.5
FR	16.3	6.9	7.6	7.2	29.4	5.6	10.6	20.9	24.9	12.7
IT	25.8	10.0	15.7	9.4	35.3	14.6	20.6	39.4	21.0	18.4
CY	37.7	14.0	50.0	9.0	37.1	12.5	7.2	22.2	7.4	16.2
LV	58.6	18.6	40.8	14.8	39.0	15.0	22.1	44.8	16.5	25.7
LT	46.9	16.4	9.8	8.8	44.3	14.1	18.0	31.3	14.9	20.6
LU	16.1	6.8	3.1	6.7	52.3	11.7	14.9	29.5	23.5	14.9
HU	13.9	8.1	2.5	3.9	25.7	10.2	15.5	31.1	13.7	12.4
MT	20.2	16.0	22.2	4.8	53.6	10.2	18.1	33.1	10.4	15.1
NL	17.5	4.7	7.7	3.1	33.0	4.3	8.7	20.7	10.1	11.1
AT	20.4	11.8	12.0	3.6	29.2	9.1	6.9	19.2	8.6	12.0
PL	22.2	12.3	10.9	9.8	34.8	12.3	19.5	37.8	17.6	17.2
PT	28.0	16.4	18.7	8.7	37.0	13.4	19.4	36.1	20.1	17.8
RO	29.1	13.1	14.5	13.1	35.3	14.9	24.3	56.3	25.2	22.4
SI	43.4	10.5	13.4	4.1	28.1	9.4	7.9	15.7	4.8	11.3
SK	23.0	4.2	3.5	3.9	23.0	10.5	9.9	27.9	12.2	11.0
FI	33.6	6.7	8.4	3.9	24.3	6.8	7.4	15.5	5.3	13.8
SE	29.0	6.6	5.9	4.5	28.9	7.1	5.1	14.5	12.8	13.3
UK	26.4	10.0	18.2	10.1	34.5	11.6	13.8	28.1	13.4	17.3
EU27	**25.6**	**10.5**	**13.8**	**9.1**	**33.9**	**11.4**	**14.5**	**25.9**	**17.5**	**16.3**

Source: Own calculations based on EU-SILC 2009 - version 1 of March 2011

Table A.2: Life Expectancy at birth and at age 65 in Europe, 2009

	Life expectancy at birth			Life expectancy at age 65		
	Women	Men	Total	Women	Men	Total
AT	83,2	77,6	80,5	21,2	17,7	19,6
BE	82,8	77,3	80,1	21,1	17,5	19,5
BG	77,4	70,1	73,7	17,0	13,8	15,5
CH	84,6	79,9	82,3	22,2	19,0	20,8
CY	83,6	78,6	81,1	20,9	18,1	19,5
CZ	80,5	74,2	77,4	18,8	15,2	17,2
DE	82,8	77,8	80,3	20,8	17,6	19,3
DK	81,1	76,9	79,0	19,5	16,8	18,2
EE	80,2	69,8	75,2	19,2	14,0	17,1
ES	84,9	78,6	81,8	22,4	18,3	20,5
FI	83,5	76,6	80,1	21,5	17,3	19,6
FR	85,0	78,0	81,6	23,2	18,7	21,2
GR	82,7	77,8	80,2	20,2	18,1	19,2
HU	78,4	70,3	74,4	18,2	14,0	16,4
IE	82,5	77,4	79,9	20,6	17,2	19,0
IT	84,5	79,1	81,9	22	18,2	20,2
LT	78,7	67,5	73,2	18,4	13,4	16,4
LU	83,3	78,1	80,8	21,4	17,6	19,7
LV	78,0	68,1	73,3	18,2	13,4	16,3
MT	82,7	77,8	80,3	20,6	16,8	18,8
NL	82,9	78,7	80,9	21,0	17,6	19,4
NO	83,2	78,7	81,0	21,1	18,0	19,6
PL	80,1	71,5	75,9	19,2	14,8	17,3
PT	82,6	76,5	79,6	20,5	17,1	18,9
RO	77,4	69,8	73,5	17,2	14,0	15,8
SE	83,5	79,4	81,5	21,2	18,2	19,8
SI	82,7	75,9	79,4	20,5	16,4	18,8
SK	79,1	71,4	75,3	18,0	14,1	16,3
UK	82,5	78,3	80,4	20,8	18,1	19,6
EU27	**82,4**	**76,4**	**79,4**	**20,7**	**17,2**	**19,1**

Source: EU-SILC 2009 (demo_mlexpex), version from 4 May 2011; accessed 22 July 2011 (Data for Italy and EU27 from 2008).

Table A.3: Healthy life expectancy at birth and at age 65 in Europe, 2009

	Healthy life years in absolute value at birth		Healthy life years in absolute value at age 65	
	Women	Men	Women	Men
AT	60,6	59,2	8,0	8,1
BE	63,5	63,7	10,1	10,5
BG	65,6	61,9	9,1	8,4
CY	65,8	65,1	8,5	9,9
CZ	62,5	60,9	8,4	8,0
DE	57,7	56,7	6,5	6,4
DK	60,4	61,8	12,0	11,2
EE	59,0	54,8	5,3	5,5
ES	61,9	62,6	8,4	9,2
EU27	62,0	60,9	8,4	8,2
FI	58,4	58,1	8,9	8,1
FR	63,2	62,5	9,2	8,8
GR	60,9	60,2	6,6	7,2
HU	58,0	55,7	5,6	5,7
IE	65,2	63,7	10,5	10,2
IT	61,2	62,4	6,8	7,3
LT	60,9	57,0	6,7	5,9
LU	65,7	65,1	11,4	10,8
LV	55,8	52,6	5,7	4,7
MT	70,6	69,1	11,2	11,0
NL	59,8	61,4	10,3	9,4
PL	62,1	58,1	7,4	6,8
PT	55,9	58,0	5,4	6,6
RO	61,4	59,5	7,0	7,2
SE	69,5	70,5	14,6	13,6
SI	61,5	60,6	9,9	9,3
SK	52,3	52,1	2,8	3,4
UK	66,3	65,0	11,8	10,7

Source: EU-SILC 2009 (hlth_hlye), version from 14 March 2011; accessed 23 July 2011 (Data for Italy, UK and EU27 from 2008).

Table A.4: Self-perceived health by age and income, EU-27, 2009 (% respondents)

Income Group	Grade/	18-44	45 - 54	55 - 64	65 - 74	75 +	Total
First quintile 0-20%	Very good	30,5	11,4	7,7	5,8	4,8	17,9
	Good	49,1	40,5	33,2	27,6	21,4	39,2
	Fair	15,3	32,1	37,6	43,6	40,8	27,9
	Bad	4,1	13,1	17,4	18,4	25,0	11,8
	Very bad	1,0	2,9	4,1	4,5	7,9	3,1
Second quintile 20-40%	Very good	32,0	14,0	7,8	5,6	4,1	18,3
	Good	51,4	48,7	37,3	30,4	21,9	42,0
	Fair	13,1	27,5	37,3	43,7	42,2	27,1
	Bad	2,9	8,0	14,1	16,4	24,2	10,0
	Very bad	0,6	1,8	3,6	3,9	7,7	2,6
Third quintile 40-60%	Very good	34,8	16,6	10,3	6,5	4,3	21,7
	Good	51,8	52,6	40,2	35,2	22,2	45,5
	Fair	11,1	23,6	36,3	40,0	41,5	23,3
	Bad	2,0	6,0	11,1	14,7	23,6	7,5
	Very bad	0,4	1,3	2,1	3,7	8,4	1,9
Fourth quintile 60-80%	Very good	37,3	18,6	12,4	8,1	4,2	24,7
	Good	52,2	53,6	44,7	38,4	22,9	48,1
	Fair	8,7	22,5	32,4	38,2	42,1	20,2
	Bad	1,4	4,5	9,1	12,1	23,3	5,7
	Very bad	0,4	0,7	1,4	3,2	7,6	1,3
Fifth quintile 80-100%	Very good	41,9	22,7	17,0	10,9	4,9	28,7
	Good	50,1	56,1	52,5	45,1	30,9	50,5
	Fair	6,7	17,8	25,1	34,0	40,6	16,5
	Bad	1,1	2,8	4,6	7,9	17,7	3,5
	Very bad	0,2	0,5	0,8	2,2	5,9	0,8
Total	Very good	35,4	17,3	11,5	7,0	4,4	22,3
	Good	50,9	51,0	42,5	34,2	22,9	45,1
	Fair	10,9	24,0	33,1	40,6	41,5	23,0
	Bad	2,3	6,4	10,7	14,6	23,5	7,7
	Very bad	0,5	1,3	2,2	3,6	7,7	1,9

Source: EU-SILC 2009 (hlth_silc_10) - version from 22 February 2011; accessed 25 July 2011.

Table A.5: Self-perceived general health by income, Germany, 2009 (% respondents in bad or very bad health)

	18-44	45-54	55-64	65-74	75+	Total
First quintile of equivalised income	6,4	20,8	25,3	16,8	34,3	15,4
Second quintile of equivalised income	3,3	6,1	15,6	13,0	22,2	9,3
Third quintile of equivalised income	2,1	5,9	11,7	10,6	18,8	6,9
Fourth quintile of equivalised income	2,2	5,0	10,0	7,7	19,5	5,7
Fifth quintile of equivalised income	1,1	3,3	4,5	6,6	13,4	3,2
Total	2,9	7,4	13,3	11,7	22,6	8,1

Source: EU-SILC 2009 (hlth_silc_10) - version from 22 February 2011; accessed 28 July 2011.

Table A.6: Unmet medical needs due to waiting times by income quintile, EU-27 countries and Norway, 2009 (% respondents)

	First quintile of equivalised income	Second quintile of equivalised income	Third quintile of equivalised income	Fourth quintile of equivalised income	Fifth quintile of equivalised income	Total
BE	0,1	:	:	:	:	:
CZ	0,1	0,1	0,1	0,1	0,1	0,1
MT	0,1	0,4	0,1	0,2	0,1	0,2
RO	0,1	0,2	0,3	0,3	0,3	0,3
ES	0,2	0,2	0,3	0,3	0,0	0,2
NL	0,2	0,6	:	0,2	0,1	0,2
AT	0,2	0,1	0,1	0,2	0,1	0,1
SI	0,2	0,2	0,0	0,0	:	0,1
CY	0,3	:	:	:	0,1	0,1
HU	0,3	0,3	0,3	0,4	0,3	0,3
FR	0,4	0,3	0,3	0,3	0,2	0,3
LU	0,4	:	0,0	0,1	0,5	0,2
NO	0,4	:	:	0,1	0,4	0,2
PT	0,5	0,3	0,6	0,2	0,2	0,4
SK	0,5	0,6	0,6	0,6	0,9	0,6
DE	1,0	1,0	0,4	0,5	0,4	0,6
EU	1,1	1,1	0,9	0,9	0,8	1,0
LV	1,3	1,3	1,3	1,5	1,2	1,3
UK	1,3	1,1	1,2	1,2	0,7	1,1
DK	1,5	1,3	1,3	0,8	1,3	1,2
GR	1,6	0,9	1,1	0,5	1,1	1,0
IE	1,7	0,9	0,8	0,9	0,3	0,9
IT	1,8	1,5	1,4	1,2	0,9	1,4
SE	1,9	1,7	1,5	1,2	1,2	1,5
EE	2,3	2,7	3,3	3,4	3,2	3,0
LT	2,5	2,1	3,1	2,2	1,3	2,2
BG	2,7	1,4	1,8	1,9	2,4	2,0
PL	3,5	4,6	4,2	4,3	4,4	4,2
FI	4,3	5,0	3,5	2,4	2,2	3,5

Source: EU-SILC 2009 (hlth_silc_08) - version from 30 May 2011; accessed 24 July 2011.

Table A.7: Unmet dental needs due to waiting times by income quintile, EU-27 countries and Norway, 2009 (% respondents)

	First quintile of equivalised income	Second quintile of equivalised income	Third quintile of equivalised income	Fourth quintile of equivalised income	Fifth quintile of equivalised income	Total
BE	0,0	0,1	:	0,1	:	0,0
ES	0,0	0,0	0,0	0,1	0,0	0,0
LU	0,0	:	:	0,1	:	0,0
RO	0,0	0,2	0,2	0,1	0,2	0,1
DK	0,1	0,1	0,1	0,4	0,2	0,2
DE	0,1	0,2	:	0,1	0,0	0,1
EE	0,1	0,3	0,4	0,1	0,5	0,3
CY	0,1	0,0	:	0,2	:	0,1
MT	0,1	:	:	:	0,1	0,0
AT	0,1	0,2	0,2	0,1	0,0	0,1
FR	0,2	0,1	0,2	0,2	0,1	0,1
LV	0,2	0,4	0,5	0,4	0,3	0,4
HU	0,2	0,1	0,1	0,1	0,1	0,1
SK	0,2	0,5	0,5	0,8	0,8	0,5
CZ	0,3	0,3	0,5	0,5	0,4	0,4
NL	0,3	0,1	:	:	0,1	0,0
SI	0,3	0,1	0,1	0,4	0,2	0,2
SE	0,3	0,1	0,2	0,1	0,3	0,2
BG	0,5	0,5	0,9	1,1	0,6	0,7
GR	0,5	0,4	0,3	0,1	0,3	0,3
PT	0,6	0,3	0,5	0,1	:	0,3
EU	0,7	0,5	0,6	0,4	0,5	0,5
IE	0,8	0,0	0,2	0,3	0,1	0,3
IT	0,8	0,8	0,6	0,5	0,6	0,7
LT	1,0	1,4	1,4	1,5	0,4	1,1
NO	1,2	0,6	1,4	1,8	1,3	1,3
PL	1,4	0,9	1,2	0,8	0,9	1,0
UK	3,1	1,5	2,8	1,2	1,8	2,1
FI	5,7	5,4	5,0	5,1	4,6	5,2

Source: EU-SILC 2009 (hlth_silc_09) - version from 30 May 2011; accessed 24 July 2011.

Table A.8: Unmet medical needs due to distance to services by income quintile, EU-27 countries, Switzerland and Norway, 2009 (% respondents)

	First quintile of equivalised income	Second quintile of equivalised income	Third quintile of equivalised income	Fourth quintile of equivalised income	Fifth quintile of equivalised income	Total
Belgium	:	:	:	:	:	:
Bulgaria	2,4	1,1	0,5	0,3	0,2	0,9
Czech Republic	0,4	0,2	0,3	0,1	0,0	0,2
Denmark	0,1	0,4	0,1	0,2	:	0,2
Germany	0,3	0,3	0,1	:	0,0	0,1
Estonia	1,3	1,0	0,5	0,3	0,2	0,6
Ireland	0,1	0,0	:	:	:	0,0
Greece	1,3	0,4	0,2	0,3	0,0	0,5
Spain	0,1	0,0	0,0	:	0,0	0,1
France	0,0	0,1	0,0	0,0	0,0	0,0
Italy	0,1	0,1	0,1	0,1	0,0	0,1
Cyprus	0,0	0,1	0,0	:	:	0,0
Latvia	1,4	0,4	0,3	0,2	0,4	0,5
Lithuania	0,3	0,2	0,1	0,0	0,1	0,2
Luxembourg	:	0,0	:	:	:	0,0
Hungary	0,6	0,4	0,3	0,2	0,1	0,3
Malta	0,0	:	:	:	:	0,0
Netherlands	:	:	0,1	:	:	0,0
Austria	0,1	:	0,0	:	0,1	0,1
Poland	1,5	1,0	0,6	0,4	0,2	0,7
Portugal	0,3	0,0	0,0	:	:	0,1
Romania	0,7	0,8	0,6	0,2	0,3	0,5
Slovenia	:	:	0,0	:	:	0,0
Slovakia	1,0	0,6	0,3	0,4	0,1	0,5
Finland	0,0	:	:	:	:	0,0
Sweden	0,1	0,1	:	0,1	0,1	0,1
United Kingdom	0,3	0,1	:	0,1	:	0,1
Iceland	0,8	0,3	:	0,2	0,4	0,3
Norway	1,1	1,0	0,9	0,8	0,6	0,9
Switzerland	0,1	0,0	:	:	0,1	0,0
European Union	0,4	0,2	0,1	0,1	0,1	0,2

Source: EU-SILC 2009 (hlth_silc_08) - version from 30 May 2011; accessed 26 July 2011.

Table A.9: Distance to services as main reason why medical needs were unmet across Europe, by gender, 2009 (% respondents)

	Women	Men	Total
Belgium	:	:	:
Bulgaria	1,0	0,8	0,9
Czech Republic	0,2	0,2	0,2
Denmark	0,3	0,0	0,2
Germany	0,2	0,1	0,1
Estonia	0,8	0,4	0,6
Ireland	0,0	0,0	0,0
Greece	0,4	0,5	0,5
Spain	0,1	0,0	0,1
France	0,1	:	0,0
Italy	0,1	0,1	0,1
Cyprus	0,1	:	0,0
Latvia	0,7	0,4	0,5
Lithuania	0,2	0,1	0,2
Luxembourg	0,0	:	0,0
Hungary	0,4	0,2	0,3
Malta	0,0	:	0,0
Netherlands	0,0	0,0	0,0
Austria	0,1	0,0	0,1
Poland	0,9	0,5	0,7
Portugal	0,1	0,1	0,1
Romania	0,6	0,5	0,5
Slovenia	0,0	:	0,0
Slovakia	0,5	0,4	0,5
Finland	0,0	:	0,0
Sweden	0,2	:	0,1
United Kingdom	0,1	0,1	0,1
Iceland	0,4	0,2	0,3
Norway	1,0	0,8	0,9
Switzerland	:	0,1	0,0
EU-27	0,2	0,1	0,2

Source: EU-SILC 2009 (hlth_silc_08) - version from 30 May 2011; accessed 29 July 2011.

Table A.10: Distance to services as main reason why medical needs were unmet: total population by age group, Germany, 2004-2009 (% respondents)

	Total	18-44	45-54	55-64	65-74	75+
2004	0,2	0,1	0,1	0,0	0,2	0,7
2005	0,2	0,1	0,1	0,0	0,2	0,7
2006	0,1	0,1	0,1	0,1	0,1	0,1
2007	0,1	0,1	0,0	0,2	0,2	0,2
2008	0,1	0,0	0,1	0,2	0,1	0,1
2009	0,1	0,0	0,2	0,2	0,2	0,3

Source: EU-SILC 2009 (hlth_silc_08) - version from 30 May 2011; accessed 29 September 2011.

Table A.11: Tenure status across EU, 2009

	Owner	Tenant or subtenant paying rent at prevailing or market rate	Rented at a reduced rate	Provided free	Total in Mio.
BE	72.7	18.5	7.3	1.6	10.6
BG	86.8	2.1	2.1	9.1	7.6
CZ	76.6	5.4	15.3	2.6	10.3
DK	66.3	33.7	0.0	0.0	5.5
DE	53.5	38.9	4.9	2.7	81.0
EE	87.1	2.5	2.0	8.4	1.3
IE	73.7	11.3	14.3	0.7	4.5
EL	76.4	17.9	0.5	5.1	10.9
ES	83.2	8.2	2.7	5.9	45.6
FR	63.0	19.7	14.1	3.2	60.5
IT	72.5	13.3	5.5	8.7	60.1
CY	73.8	10.3	0.7	15.2	0.8
LV	87.1	6.3	4.1	2.5	2.2
LT	91.0	2.1	1.8	5.2	3.3
LU	70.4	22.3	4.3	2.9	0.5
HU	89.8	2.2	3.4	4.6	9.9
NL	68.4	31.1	0.0	0.5	16.4
MT	79.2	1.4	15.6	3.8	0.4
AT	57.5	27.7	9.3	5.6	8.3
PL	68.7	2.2	1.2	28.0	36.2
PT	74.6	10.9	6.2	8.3	10.6
RO	96.3	0.8	1.2	1.6	21.1
SI	81.3	4.1	1.9	12.6	2.0
SK	89.5	8.8	0.5	1.2	5.4
FI	74.1	10.4	14.8	0.7	5.2
SE	69.7	29.8	0.5	0.0	9.0
UK	69.9	12.5	16.6	1.0	60.7
NO	85.4	10.7	3.9	0.0	4.7
EU27	**70.4**	**17.1**	**6.9**	**5.6**	**489.8**

Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Total refers to weighted results.

Table A.12: Tenure status across social groups in Germany, 2009

	Owner	Tenant or subtenant paying rent at prevailing or market rate	Rented at a reduced rate or provided for free	Total in Mio.
Families with 3+ children	83.2	13.6	3.2	4.3
Rural area, all	65.1	27.8	7.1	12.1
3+ adults & children	70.4	22.0	7.6	5.2
Women	52.1	40.0	7.9	41.2
Young adults (18-29)	41.7	49.5	8.8	11.5
Migrants (outside EU)	45.6	43.3	11.1	6.7
Jobless young adults	21.6	67.0	11.4	0.8
Rural area, elderly	62.8	25.8	11.4	2.0
Single elderly (65+)	38.6	49.7	11.7	5.0
At-risk-of poverty	24.8	61.0	14.2	12.6
Single parents	23.1	60.0	17.0	4.2
Germany – total	53.5	38.9	7.6	**489.8**

Source: Own calculations based on EU-SILC 2009 – version 1 of March 2011.
Note: Total refers to weighted results. Categories "Rented at reduced rate" and "Provided for free" are sumed up due to small sample numbers.

Table A.13: Distribution of self-reported happiness and life satisfaction scores across the total sample and for Germany

	Total sample		Germany	
	happy	satisfied	happy	satisfied
extremely unhappy/dissatisfied	0,6	1,7	0,6	1,5
1	0,6	1,2	0,7	0,8
2	1,3	2,5	1,3	2,3
3	2,6	4,4	2,7	4,5
4	3,1	4,8	2,6	4,5
5	10,0	11,3	10,2	10,8
6	9,0	9,0	7,9	7,7
7	19,4	17,7	19,4	17,5
8	28,6	25,8	29,7	27,1
9	15,3	12,8	16,0	13,8
extremely happy/satisfied	9,6	9,0	9,0	9,6
Median	8	7	8	7
Number of obervations (N)	45617	45634	2713	2720

Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Notes: Survey questions: "All things considered, how satisfied are you with your life as a whole nowadays"? "Taking all things together, how happy would you say you are?"
The questions are answered on a scale of 0 to 10, where 0 means extremely dissatisfied (unhappy) and 10 means extremely satisfied (happy).

Table A. 14: Size of the specific social groups, 2008 (%)

	DE	FR	UK	SE	Total sample
Politically active	24,2	22,2	13,8	29,2	15,7
Intense social connections	37,8	50,9	46,1	54,8	43,4
Top income quintile	23,9	22,2	21,3	24,1	22,1
Bottom income quintile	13,7	19,2	17,6	19,4	18,3
Inactive	35,1	32,7	34,1	26,3	34,5
Unemployed	4,7	5,5	4,3	3,0	5,0
Tertiary education	28,2	30,2	44,2	26,5	26,4
Low education	2,4	16,2	23,5	12,2	13,7
Disabled	5,6	6,2	8,0	5,5	5,9
Ethnic minority	4,6	4,0	7,9	3,1	5,5
Elderly, 65+	22,1	17,3	18,4	22,5	19,0
Young adults, 18-29	14,5	16,6	17,9	16,6	17,6

Source: Own calculations, based on the European Social Survey, ESS4-2008 Edition 4.0
Total sample refers to 24 European countries.
Politically active: Political participation in 2 or more activities (out of 6) during the past 12 months, including "contacted politician or government official", "worked in political party or action group", "worked in another organisation or association", "worn or displayed campaign badge/sticker", "taken part in lawful public demonstration", or "boycotted certain products".
Intense social connections: meeting socially friends, relatives or colleagues every day or several times a week. Inactive: includes those in retirement, doing housework or those who are long term sick or disabled, and excludes those who are in full-time education.
Low education: less than lower secondary education (isced 0-1), for Germany: "Grundschule nicht beendet" or "Schule beendet ohne Abschluss einer weiterführenden Schule"
Disabled: those who say that they are hampered "a lot" in their daily activities by a longstanding illness, or disability, infirmity or mental health problem.
Ethnic minority: respondents saying that they belong to a minority ethnic group in the country.
Top and bottom income quintile: the shares differ from 20%, because the original sample variable for the different countries deviates to varying degrees from the expected decile distribution.

Table A.15: Prevalence of long-standing illness by educational attainment and gender, EU-27, 2009 (% respondents)

	Women	Men	Total
Pre-primary	59,1	52,1	56,6
Primary	51,4	44,2	48,3
Lower secondary	36,1	27,6	32,2
Upper secondary	29,3	27,1	28,2
Post-secondary	26,4	28,7	27,5
First stage of tertiary	23,4	25,2	24,3
Second stage of tertiary	21,6	25,1	23,7
Total (ISCED 1997)	33,3	29,0	31,2

Source: EU-SILC – version from 22 February 2011; accessed 30 July 2011.

Table A.16: Prevalence of severe limitations in daily activities by educational attainment and gender, EU-27, 2009 (% respondents)

	Women	Men	Total
Pre-primary	27,9	24,0	26,5
Primary	17,4	15,3	16,5
Lower secondary	11,0	8,2	9,7
Upper secondary	6,1	6,5	6,3
Post-secondary	5,0	6,3	5,6
First stage of tertiary	3,4	4,0	3,7
Second stage of tertiary	2,4	4,8	3,9
Total (ISCED 1997)	8,7	7,5	8,1

Source: EU-SILC – version from 22 February 2011; accessed 30 July 2011.

Table A.17: Prevalence of long-standing illness by income and gender, EU-27, 2009 (% respondents)

	Women	Men	Total
First quintile of equivalised income	39,5	34,9	37,5
Second quintile of equivalised income	38,7	34,5	36,7
Third quintile of equivalised income	34,4	30,0	32,3
Fourth quintile of equivalised income	30,2	26,6	28,4
Fifth quintile of equivalised income	25,7	23,3	24,5
Total	33,9	29,6	31,8

Source: EU-SILC – version from 22 February 2011; accessed 30 July 2011.

Table A.18: Prevalence of severe limitations in daily activities by income and gender, EU-27, 2009 (% respondents)

	Women	Men	Total
First quintile of equivalised income	12,4	12,0	12,2
Second quintile of equivalised income	11,5	10,2	10,9
Third quintile of equivalised income	9,0	7,6	8,3
Fourth quintile of equivalised income	6,7	5,6	6,2
Fifth quintile of equivalised income	4,5	3,8	4,2
Total	8,9	7,7	8,3

Source: EU-SILC – version from 22 February 2011; accessed 30 July 2011.

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