行政院及所屬各機關出國報告

(出國類別：實習)

參加歐盟執委會就業、社會融合與保障總署2017年「國家專家專業訓練(NEPTs)」報告

服務機關：衛生福利部中央健康保險署

姓名職稱：李健誠專員

派赴國家：比利時

出國期間：106年10月16日至107年1月15日

報告日期：107年3月8日

摘要

本報告為職參與歐盟執委會 2017 年 10 月至 2018 年 1 月之「國家專家專業訓練計畫(NEPTs)」經驗分享，為期三個月的實習期間，於就業、社會融合與保障總署的社會保障現代化處(Unit C2. Modernisation of social protection)學習。

實習工作內容大致上為：

(1) 協助完成 28 個會員國之醫療體系國家分析報告(JAFH Country report)，並就各會員國之回饋與意見修正報告。

(2) 盤點 JAFH 報告中之指標，共計有 6 大面向，共 93 個評估指標，瞭解各國家最新數據表現與過去 3 年發展趨勢，並進行跨國比較描述。

(3) 參與指標工作小組會議(Indicators Sub-group meeting)，瞭解歐盟執委會下社會保障事務之運作流程，並聽取歐洲官員對於討論事情之邏輯思維。

身處多重語言與多元文化的工作環境之中，觀察歐盟官員推動與執行政策之思維，並能尊重與包容不同國家與族群之意見與聲音，對於職之想法與思考方式拓展，實在收穫良多，也期許自身持續在我國政府部門中努力，扮演好自己的角色，讓臺灣更好！

目錄

圖目錄

壹、目的

一、瞭解歐盟執委會(EU commission)行政實務運作與政策推動情形，體驗歐洲公務人員於規劃與執行政策之思考邏輯與工作文化，以作為我國政府運作之參考。

二、促進臺灣與歐盟間衛生或社會事務專業領域交流，建立雙方合作關係與溝通人脈。

三、身處多重語言與多元文化環境，學習以新思維與新觀念看待工作與人生，藉此與歐洲各國公務人員進行交流。

四、協助外交部就國際外交情勢進行我國情勢宣傳，讓歐洲國家人員更瞭解亞洲或臺灣。

五、學習歐盟執委會就業總署(DG EMPL)進行社會事務推展，以及歐洲因應人口老化議題之經驗。

貳、國家專家專業訓練(NEPTs)簡介與申請說明

一、國家專家專業訓練

歐盟執委會「國家專家專業訓練計畫」(National Experts in Professional Training，簡稱 NEPTs)，為各國政府派員至歐盟相關總署短期實習工作，使參訓官員瞭解歐盟執委會之政策及運作方式，獲取實務工作經驗，同時運用自身專業知識及工作經驗，與實習單位進行交流。

本計畫 1 年有 2 梯次實習申請(3 月及 10 月)，非歐盟成員國家之受訓時間為 3 個月(歐盟成員國人員可實習 4 或 5 個月)。本案出國費用由派員單位自行負擔，按「赴國外進修、研究、實習人員補助項目及數額表標準」計算。

如申請人員獲得歐盟同意實習，受訓人員需自行處理在歐盟實習期間之生活，如食宿及交通等事項，及辦理歐盟實習單位交代之事務。

二、申請說明

(一)申請文件

需填寫英文計畫報名表，內容包含個人簡歷、語言能力、文書或統計應用軟體等能力。

(二)徵選流程

繳交申請文件予外交部彙整後，該部將送請歐盟進行徵選流程，分成兩個階段：

1. 第一階段：

於申請文件上申請人將可填寫三個欲實習的單位，歐盟方會先將個人簡歷依志願順序送此三個單位，若其中有單位認為申請人符合該單位工作需求，則會給予錄取完成申請流程。若第一階段未媒合成功，則將進行第二階段徵選。

以職為例，填寫的三個單位分別為：

健康暨消費者保護總署(Directorate-General Health and Food Safety，DG SANTE)；消費者健康、農業與食物執行局(Consumers, Health, Agriculture and Food Executive Agency)；以及歐盟統計處(Eurostat)。

歐盟執委會旗下政務及事務總署查詢：

https://ec.europa.eu/info/departments_en

2. 第二階段：

若第一階段未錄取，歐盟方會將申請履歷轉交其餘單位進行媒合，若有符合需要的單位則會給予錄取實習機會。

(三)錄取通知：歐盟方將於實習前兩個月以電子郵件通知核錄人員，並正式通知外交部轉知。

三、本計畫對歐盟與臺灣之益處

(一)歐盟：

1.補充臨時人力：

歐盟的預算其實也不斷縮減，但業務量不減反增，因此行政人力也有不足的情形，因此藉由本計畫補充 3 至 5 個月之行政人力，期望業務順利推行。

2.促進歐盟與會員國、觀察國或其他國家之交流：

歐盟也透過本計畫讓歐盟旗下會員國公務員至歐盟實習，瞭解行政作業和政策推動的細節,促進雙方的瞭解與構通，也會讓觀察國，例如土耳其等，或是非歐洲國家，例如臺灣，進行交流與學習，減少彼此間的鴻溝與不熟悉。

(二)臺灣：

1.促進歐盟臺灣關係：

臺灣與歐盟於 2016 年雙邊貨品貿易額達 457 億歐元(約 1.6 兆新台幣)，創歷史新高，臺灣為歐盟在全球第 19 大貿易夥伴，因此歐盟與臺灣也藉此機會更瞭解彼此關係。

2.突破外交處境：

臺灣無法參加正式國際組織，因此透過本計畫派員至歐盟學習交流，試圖在外交處境上有所突破、提升知名度。

參、歐洲聯盟及實習部門簡介

一、歐洲聯盟(European Union)

歐盟(European Union 簡稱 EU)目前共有 28 個會員國，官方語言共計 24 種，總部設於比利時布魯塞爾，人口數約 5 億人，人數僅次於中國大陸與印度，其中有 19 個會員國採用歐元為共同貨幣。歐盟主要組織分別有：

(一)歐盟理事會(European Council)：

由各會員國最高行政首長(總理、首相或總統)組成，每年開會 4 次(稱為歐盟高峰會)，為歐盟之發展訂定方向。

(二)歐盟執委會(European Commission)：

主要執行機構，類似臺灣的行政院，負責執行各項政策。其下有 31 個政務總署(Directorate-General)與 16 個事務總署(Service)，前者負責專責推動相關政策，後者則提供行政服務或臨時編列任務。https://ec.europa.eu/info/departments_en

(三)部長理事會(Council of the European Union)：

由各會員國部長組成，類似上議院。修法必須由歐盟執委會提出，並經歐洲議會及部長理事會同意才算通過。

(四)歐洲議會(European Parliament)：

由各國直選之議員組成，類似下議院。

二、公共衛生相關總署

(一)健康與食物安全總署(DG SANTE)

健康與食物安全總署(Health and Food Safety，以下簡稱健康總署),該總署負責歐盟在食物安全和健康層面之監控與相關法規之執行。過去我國衛生福利部曾於 99 年與 106 年派員至健康總署實習，業務為菸害防治政策之推動。

(二)消費者健康、農業與食物執行局(CHAFEA)

消費者健康、農業與食物執行局英文全名為 Consumers, Health, Agriculture and Food Executive Agency，業務為制定消費者在健康、農業與食物方面之權利。

三、就業、社會融合與保障總署(DG EMPL)

就業、社會融合與保障總署(以下簡稱就業總署)，英文全名為 Directorate-General of Employment, Social Affairs and Inclusion (DG EMPL)，該總署主要負責歐盟的就業、社會事務、技能、勞力流動，以及歐盟相關的基金計畫。

就業總署所轄業務範圍非常廣泛，106 年員工數目約 800 多名，屬於相當大的單位，總署下設有 7 個司，其在比利時布魯塞爾與盧森堡辦公，DG EMPL 組織架構圖詳圖 1。

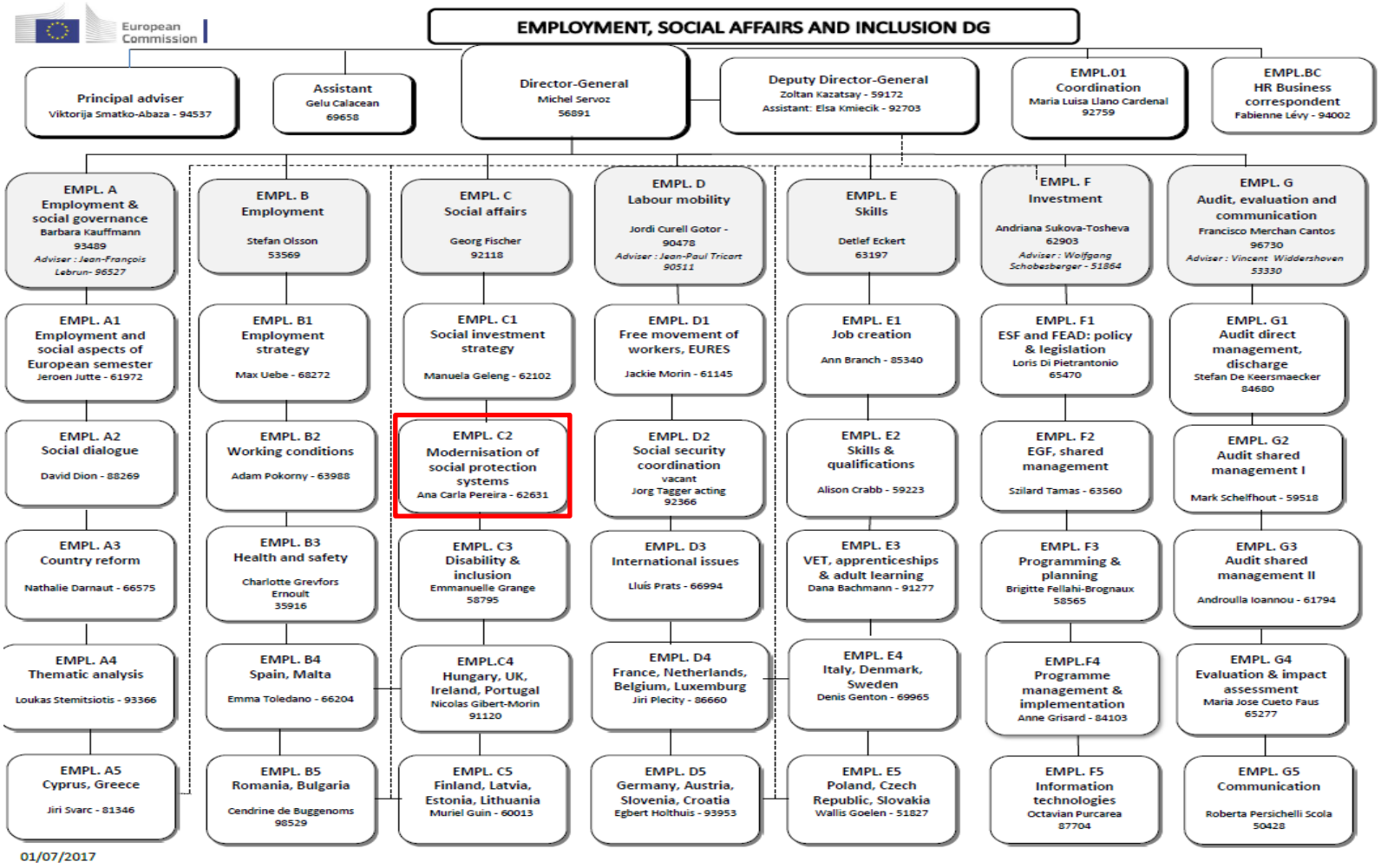


圖 1 就業、社會融合與保障總署組織架構圖

四、實習單位說明

(一)Europe 2020

歐盟針對就業部分有訂定 10 年計畫，預計於 2020 年要達到五大目標：

1.就業率：年齡在 20-64 歲的就業人口比率達 75%。

2.研究發展：GDP 的 3%要投資在研究發展上。

3.氣候變化與能源：20%的能源利用要使用再生能源。

4.教育：30-34 歲的人至少有 40%的比例完成高等教育。

5.貧窮與弱勢：至少減少 2 千萬貧窮與弱勢人口。

參考網址：

https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/european-semester/framework/europe-2020-strategy_en

(二)社會保障委員會(Social Protection Committee，簡稱 SPC)

為歐盟執委會下負責社會保障事務之委員會，其主委類似我國的政務委員，該委員會負責監控各歐盟會員國在社會保障事務上的推動，並負責協調與各會員國之間的溝通討論。

參考網址：

http://ec.europa.eu/social/main.jsp?catId=758&langId=en

(三)社會保障現代化處(Unit C2. Modernisation of social protection)

職於就業總署的社會保障現代化處進行實習，該處位於社會事務司(Directorate Social affairs)下，主管為 Ana Carla Pereira 處長(head)，其下有 12 名員工，主要負責年金 Pension、健康照護體系 healthcare、長期照顧 long-term care 和健康老化 active aging 等業務。

負責指導職業務的輔導員為 Virginia Maestri 女士，職稱為 Policy officer，公務上 Virginia 幫助職很多，包含瞭解歐盟整體政策運作情形，以及各項會議進程，業務內容討論等，在實習期間一同完成歐盟 28 個國家的 Healthcare 分析報告、參加 SPC 指標訂定小組會議，以及完成各項指標盤點工作，此部分將於下個章節「訓練過程與內容」詳細說明。

肆、訓練過程與內容

一、聯合架構兩階段健康體系報告(JAF Health First and Second step analysis)

(一)JAFH 說明

Joint Assessment Framework 簡稱 JAF 為歐盟執委會旗下之社會保障委員會，為了監控並追蹤歐盟各會員國在達成 Europe 2020 目標，而建置的一套系統化架構。主要可分成兩階段分別為質性(Qualitative)與量性(Quantitative)評估工作，用以定義歐盟各會員國在社會保障上所面對的挑戰，並發展出各面向之監控指標與統計工具，以公平、有效率地比較各會員國在發展社會事務上的差異，以提升整體歐盟社會社務之水平，並作為實證基礎的決策分析參考。

參考網址：

http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=972&furtherNews=yes

(二)JAFH 國家報告說明

1. 國家報告說明

職所參與的實習業務，即為 JAF 在健康照護體系領域的分析(Joint Assessment Framework in the area of Health，簡稱 JAFH)，其架構示意圖詳見圖 2，在 JAFH 下可分為六大面向：

(1) 整體健康結果 Overall Health Outcomes

(2) 醫療可近性 Access

(3) 醫療品質 Quality

(4) 非醫療決定因素 Non-Health determinants (Life style)

(5) 醫療資源 Resources

(6) 社會經濟情形 Socio-Economic Situation

其具體作法為利用這六大面向之指標監控，撰寫歐盟 28 個會員國在健康照護體系之情形，前述提及兩階段評估，即為第一階段的質性(Qualitative)與第二階段的量性(Quantitative)評估，實務上，該分析報告的第一階段由「經濟合作暨發展組織(OECD)」所提供，內容包含社會經濟情形(例如 GDP、貧窮率等)、醫療資源(例如醫療照護體系架構、醫師與護理人力等)，以及政策發展，例如過去 3-4 年該國在健康照體系之改革，以及未來 2-3 年將改善之問題與對策發展等。

第二階段則由就業總署負責，內容包含整體健康結果(例如平均餘命、嬰幼兒死亡率等)、醫療可近性(因為金錢、等候時間或距離而無法獲得足夠的醫療照護、健康保險覆蓋率等)、醫療品質(癌症存活率、住院後死亡率等)與生活型態，例如吸菸率、肥胖、蔬菜水果攝取量等等。

最後，綜整兩階段之內容總結該國家 JAFH 的結論，完成分析評估報告，送交社會保障委員會進行評估與年度報告總會整。

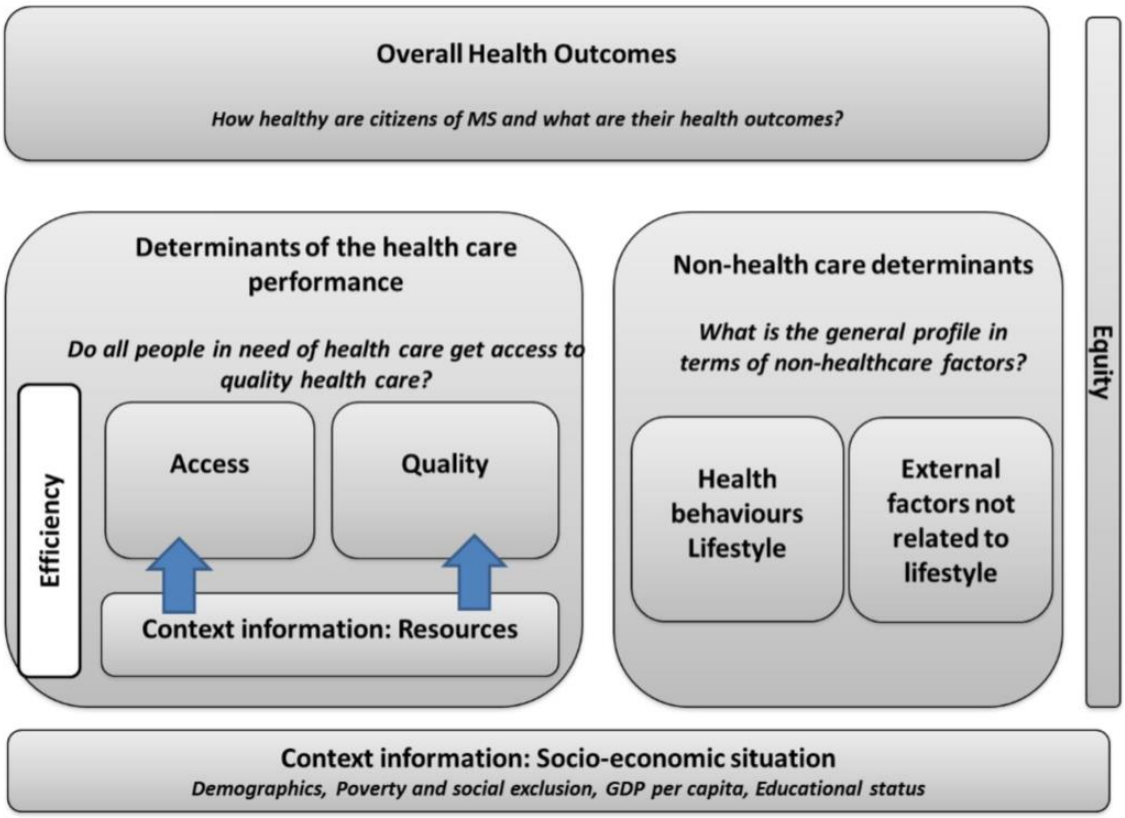


圖 2 JAFH 架構示意圖

2. 社會福利相關政府部門組織圖

於說明健康照護體系資源時，分析報告均會提及各個國家在社會保障或醫療體系之政府組織架構，歐盟提供以下網址可以查詢各歐洲國家不同年度之組織架構供參。(職以比利時組織架構圖為例，請見圖 3)

http://www.missoc.org/MISSOC/INFORMATIONBASE/informationBase.jsp

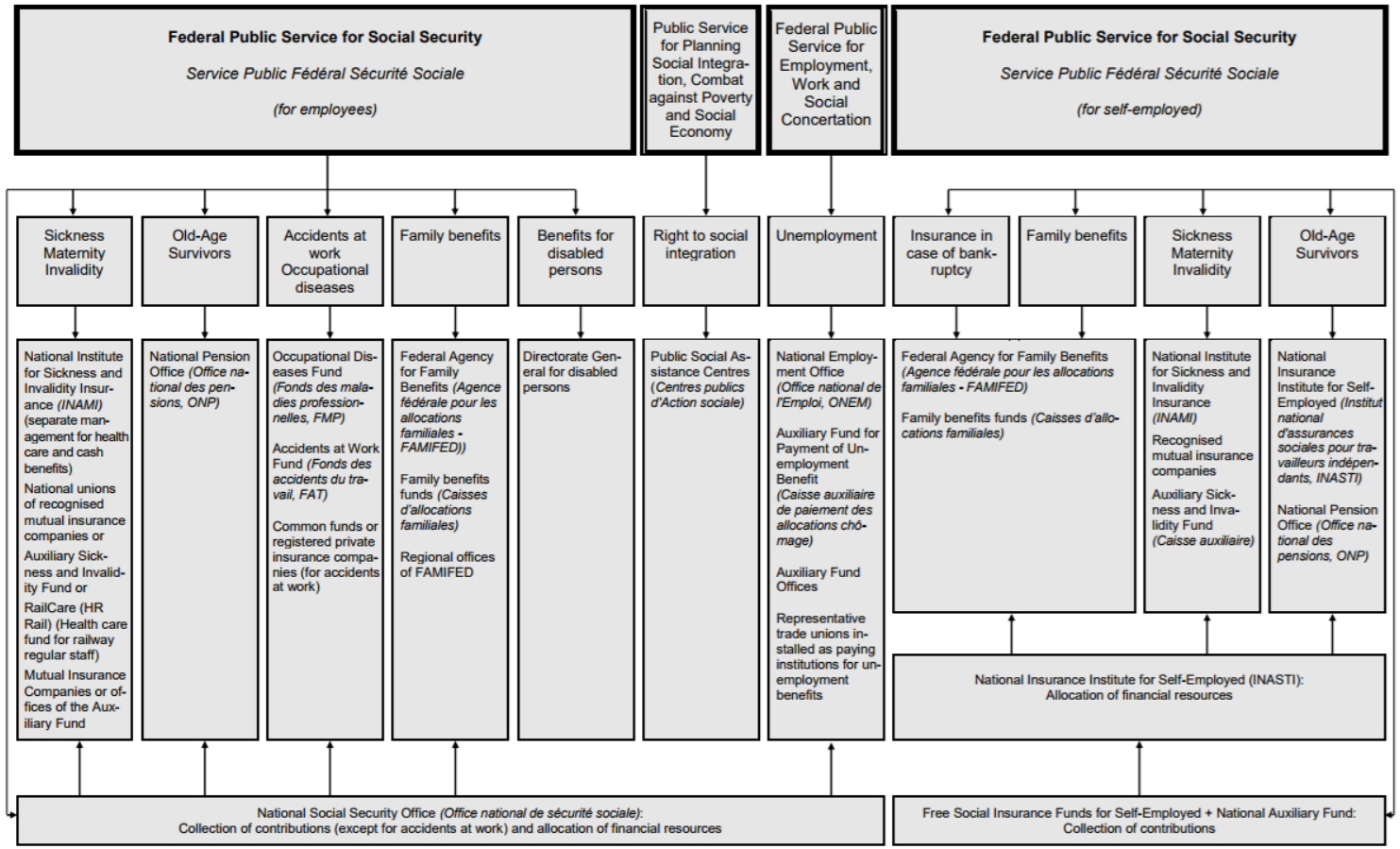


圖 3 歐洲國家社會保障政府組織圖(以比利時為例)

3. 指標標準化與視覺化

歐盟有 28 個會員國，而 JAFH 的指標多達 93 項，因此要能比較各國之間在社會保障事務上推動的情形，必須先把各項指標標準化後進行評估，標準化分數即為減去平均值後除以標準差得之，其公式如下：

Standardised score indicator x =
[(value of indicator x – EU average of x)/standard deviation across EU MS of x] * 10

除了觀察該國最新年度數據(levels)的表現情形外，歐盟也會觀察過去三年的發展情形(changes)跟歐盟平均變化情形作比較評估，以定義該會員國之指標是否需要建議改善或更進一步的長期觀察。

為了更加方便觀察各項指標，JAFH 分析報告中會將指標的好壞情形給予顏色視覺化：

(1) 若標準化分數介於-7 至+7 之間，則定義該指標接近歐盟平均水準，顏色以「白色(0)」表示。

(2) 若標準化分數介於-7 至-13 之間，則定義該指標較歐盟平均水準為差，顏色以「橘色(-)」表示。

(3) 若標準化分數介於+7 至+13 之間，則定義該指標較歐盟平均水準為佳，顏色以「黃色(+)」表示。

(4) 若標準化分數小於-13，則定義該指標較歐盟平均水準**顯著為差**，顏色以「紅色(--)」表示。

(5) 若標準化分數大於+13，則定義該指標較歐盟平均水準**顯著為佳**，顏色以「綠色(++)」表示。

示意圖如圖 4。

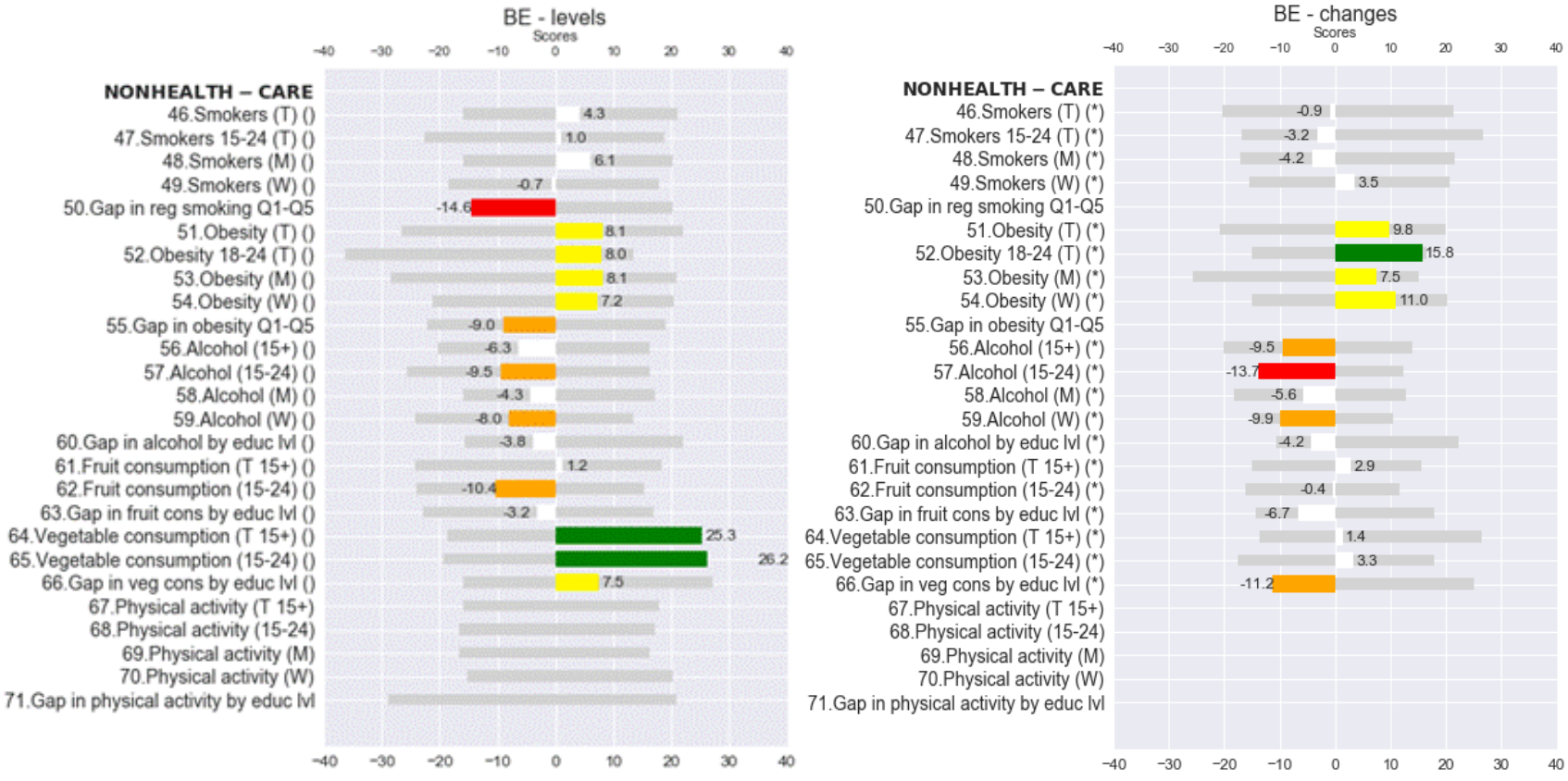
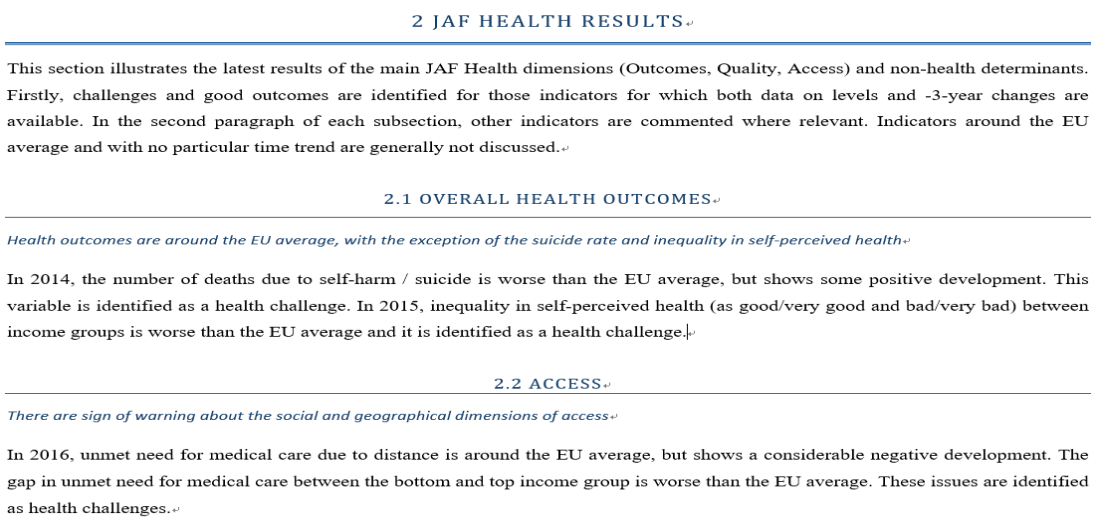


圖 4 JAFH 標準化與視覺化指標評估圖(以比利時為例)

*註：左圖為最新年度數據指標，右圖為過去三年發展趨勢，灰色表示極值

(三)JAFH 國家分析報告內容簡述

上述已提及 JAFH 分析報告分為兩個階段撰寫，而每個面向下則會給予一個標題文句，描述該面向的重點表現情形，而內文通常會以表現較差的指標優先說明，因此依各會員國的社會保障指標優劣而有不同的內容，加上結論、資料來源與圖表數據，平均每個國家之報告頁數在 18 至 22 頁不等。其內容如下圖 5。



2 JAF HEALTH RESULTS

This section illustrates the latest results of the main JAF Health dimensions (Outcomes, Quality, Access) and non-health determinants. Firstly, challenges and good outcomes are identified for those indicators for which both data on levels and -3-year changes are available. In the second paragraph of each subsection, other indicators are commented where relevant. Indicators around the EU average and with no particular time trend are generally not discussed.

2.1 OVERALL HEALTH OUTCOMES

Health outcomes are around the EU average, with the exception of the suicide rate and inequality in self-perceived health

In 2014, the number of deaths due to self-harm / suicide is worse than the EU average, but shows some positive development. This variable is identified as a health challenge. In 2015, inequality in self-perceived health (as good/very good and bad/very bad) between income groups is worse than the EU average and it is identified as a health challenge.

2.2 ACCESS

There are sign of warning about the social and geographical dimensions of access

In 2016, unmet need for medical care due to distance is around the EU average, but shows a considerable negative development. The gap in unmet need for medical care between the bottom and top income group is worse than the EU average. These issues are identified as health challenges.

圖 5 JAFH 分析報告內容(以比利時為例)

(四)會員國報告內容回饋

上述分析報告完成後，歐盟方會將報告初稿寄至各會員國窗口，請該會員國於兩週內提供意見或進一步說明，歐盟則會依照其提出之意見與回饋評估修正報告內容。

二、健康體系指標(JAF Health indicators)盤點

JAFH 指標共有六大面向，合計 93 個指標，因此職於歐盟實習期間即協助盤點各指標的定義、資料來源、更新頻率等資料進行整理，詳細資料摘要可見附件表格，茲就各欄位簡單說明如下：

(一)定義(Definition)：

為歐盟統計局(Eurostat)對該指標蒐集之定義，用以向外界或各歐盟會員國進行說明，以加強各國家間指標之可比較性與正確性。

(二)資料來源(Source)：

JAFH 指標大多可從歐盟統計局(Eurostat)取得，但仍有部分數據來自 OECD 或 WHO 等國際性組織。資料來源大致上有：

1. Eurostat
2. Causes of death (COD) statistics
3. Demographic statistics
4. EHIS(European Health Interview Survey)
5. EU_LFS(Labour Force Survey)
6. EU_SILC(Statistics on Income and Living condition)
7. EUROCARE - 5 database
8. Joint questionnaire OECD/Eurostat/WHO
9. OECD
10. SHA 2011 (The System of Healthcare Accounts)

11. WHO/UNICEF Global Dataset

*歐盟統計局網址：http://ec.europa.eu/eurostat

(三)數據更新頻率(Frequency)：

大多指標為每年更新，但有部分問卷調查如抽菸、酗酒、肥胖情形之國民健康調查則是每 4 年更新一次。

(四)評估面向(JAF domain)：

即前述的六大面向：整體健康結果 Overall Health Outcomes、醫療可近性 Access、醫療品質 Quality、非醫療決定因素 Non-Health determinants (Life style)、醫療資源 Resources、社會經濟情形 Socio-Economic Situation

三、指標工作小組會議(Indicators Sub-group meeting)

在社會保障委員會(SPC)下設立有指標工作小組，任務為：

(一)發展和定義歐盟社會事務相關監控指標，以監督歐盟各會員國在社會保障事務上的發展與協調是否能達到歐盟整體的目標。

(二)發展分析方法與工具以協助社會保障委員會之決策參考。

(三)改善歐盟層級的社會指標統計，尤其是歐盟在收入和生活情形調查(Income and Living Conditions，簡稱 EU-SILC)發展。

職於三個月實習期間有參與 2 次會議，觀察該指標小組會議有以下特點：

(一)會議由歐盟 DG EMPL 主辦，平均每月召開一次，通常為接近月底時召開，但 12 月因適逢聖誕節與新年假期並無召開。

(二)該會議依討論主題與議程安排，為密集 2-3 天召開，討論各項社會保障事務(醫療體系、年金、長期照顧、住宅等)，職參與的 Healthcare 討論大約都在 80-90 分鐘討論結束。

(三)基本上會邀請歐盟 28 個會員國參加，但不一定每個國家代表均會到場，未到場的代表即無法於會上表達意見，但各個議題若有疑問或回饋，仍可利用電子郵件與歐盟的窗口代表聯繫告知。

(四)會議上發言以「英文」為主，但也配有即時翻譯，職參與的場次均有英文、法文、德文、義大利文、西班牙文與葡萄牙文的專人翻譯，透過會場上的耳機調整頻道即可即時收聽。

(五)每個議題均會由歐盟政策文官(policy officer)負責先進行15-20 分鐘的簡報，進行工作進度報告、與會員國協調情形，以及未來請各會員國需要配合或討論之事項。

(六)因為歐盟仍處於恐攻的警戒時刻，故參加會議入場前均會進行各項安檢與身分確認，可見歐盟各單位仍應提高警覺。

四、德國人口老化與低生育率對策

除了歐盟實習業務外，職也趁此段期間結識其他國家之公務員，期望從歐洲國家學習人口老化之處理與對策。

歐盟老年族群(超過 65 歲以上長者)比例約為 19.2%，其中以義大利、希臘和德國為前三名老化之國家，相較臺灣目前約 14%的比例，確實可以歐洲國家因應人口老化之策略作為參考。

從德國經驗來看，思考點為生活與醫療水平不斷提升，人口老化的趨勢是不可擋的，因此德國政府過去幾年均把重心放在「如何提高生育率？」，德國的聯邦家庭事務、老年、婦女及青年部(federal ministry for family affairs, senior citizens, women and youth)極力推動以下策略，期望提高長年低迷之生育率：

(一)育嬰津貼

自 2007 年起，若父母其中一人每週工作時數降至 30 小時，則每月給予小孩出生前 1 年淨薪水的 67%，最多為 1,800 歐元(約 64,800 新臺幣)。

如果是低薪或失業者，則會收到 100%的給付或每月至少 300 歐元(約 10,800 新臺幣)補助。

(二)育嬰假

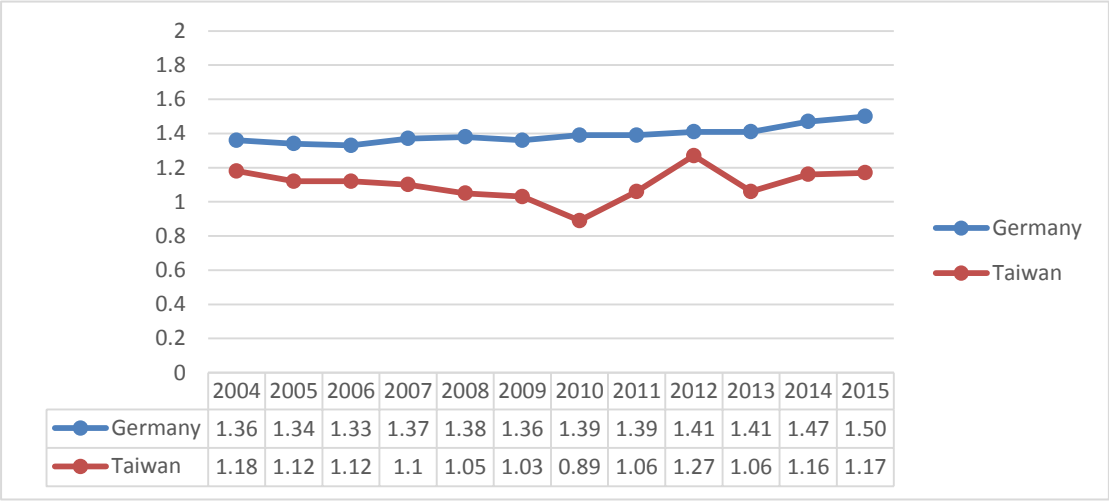
孩子出生後，除了母親外，父親會有兩個月的育嬰假陪伴太

太與孩子。後續的育嬰假為 36 個月，不需要雇主的同意，而父母也可以選擇將其中的 24 個月用於孩子 3 至 8 歲請假，較為彈性。

(三)幼兒照顧

2013 年起，德國法律規定超過 1 歲的兒童，都能夠被日間照護機構(daycare facility)收留。

而近年的改革也收到了些許成效，在 2015 年，德國的生育率提升至 1.5/每位母親，為 33 年之新高(新聞連結：https://tinyurl.com/jpwqdx8)。而臺灣之生育率在過去 10 年均低於 1.2 之水準，實有提早因應未來人口結構失衡之必要。德國與臺灣之生育率請見下圖 6。



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Germany	1.36	1.34	1.33	1.37	1.38	1.36	1.39	1.39	1.41	1.41	1.47	1.50
Taiwan	1.18	1.12	1.12	1.1	1.05	1.03	0.89	1.06	1.27	1.06	1.16	1.17

圖 6 德國與我國生育率趨勢圖

五、其他

(一)外交部與駐歐盟兼駐比利時代表處(Taipei Representative Office in the EU and Belgium)

此次實習機會多虧外交部的努力，才能讓臺灣與歐盟在不同領域間有更多的交流與瞭解，從出發前外交部即有安排行前說明，邀請前輩進行經驗分享。

而到了比利時當地，也由駐歐盟兼駐比利時代表處長官安排至住宿處，讓初次到異鄉出差的職安心不少，而這次出國實習除了認識歐盟與歐洲國家公務員外，也對外交部的運作有了更多認識，體認到臺灣在國際上的情勢，以及外交人員對國家的奉獻，期望未來臺灣在國際上的處境能更加順利。

(二)年金改革業務(Pension)

職所實習的單位「C2.社會保障現代化處」，其中最大宗的業務為年金或退休金改革(Pension)，因此職有私下跟 Valdis 科長(leader)交談，大致瞭解歐盟在退休金制度上的運作。

基本上，退休金議題在歐盟算是各個國家的內政事務，屬於國家層級(national level)，相較歐盟層級 EU level，國家層級的事務對於歐盟來說並無法干涉太多，只能給予建議或部分資金協助，各個國家的退休金制度差距很大，要統整起來有

其難度，例如國家已破產的希臘，其退休制度即過於優渥導致國家財政失衡，而歐盟國家退休後的所得替代率大約是40-50%，而歐盟也透過前述的社會保障委員會與指標工作小組進行指標監控，期望能平衡歐盟各國家的退休金制度與水平。

而歐盟也發展出一些連動性的參考指標，像是退休年齡與預期壽命的關係，歐盟建議若是該國的預期壽命增加 3 歲，則退休年齡則可適度延後 1 年，例如一個國家目前的平均預期壽命為 80 歲，平均退休年齡為 65 歲，當該國平均預期壽命成長至 83 歲，則建議平均退休年齡應延後至 66 歲，以因應未來人口老化與少子女化趨勢，國家的財政能永續經營。

(三)健康老化(Active Ageing)

歐洲國家的人口老化情形比臺灣還嚴重，而職實習的單位有一小塊業務為推廣各會員國採行社區化的健康老化，這項業務是由職的同事 Ettore 先生負責，職也是私下跟他交談，在歐盟對老化也是期望去機構化，因為機構式的長期照顧實在是太昂貴，政府也無法負擔。但是 Ettore 也一再強調，歐盟實質上無法規定各個會員國如何推動老年族群照顧，畢竟這

也算是各個國家自己的內政，所以歐盟也只能給予建議，而 Ettore 也提到歐盟也會跟一些國際組織合作去推動健康老化政策。

而從職的觀察發現，歐洲的老年人在街上都還算健康，比較少發現跟臺灣一樣，會需要由別人推著輪椅出門的情形，但路上的指標會有注意老人的標誌，顯示歐洲老年族群比例還是高，能受到地方政府的重視，但究竟健康老化或人口老化的在各個歐洲國家的對策如何，仍需要更進一步的研究和交流才能得知，尤其歐盟各會員國的經濟水平、家庭觀念或人口結構也許都有些微差異，很難以一個國家以偏概全。歐洲國家在健康老化的政策上仍可作為臺灣的參考。

伍、心得與建議

一、歐盟工作文化

歐洲人做事的風格與工作文化與我國或是整個亞洲是完全不同的，茲就以下幾點說明職所觀察到的現象。

(一) 自律辦公環境

在歐盟工作，上班時間彈性不用打卡，每週工作總額 40 小時自行調控，但核心工作時間要出現在辦公室(9:30-12:00、15:00-16:30)，因此許多歐洲人可能星期一至星期四每日會工作達 9 小時，但是週五就只上半天班即放假。

職所在的單位每個人都有各自的獨立辦公室，與同事聊天，有同事表示無法在開放空間辦公，覺得自身隱私相當沒有保障，這跟亞洲或臺灣的工作觀念也相當大的差異。而中午午餐時間也相當彈性，通常愈北方國家的作息會比較早，如丹麥、瑞典等，比較早到辦公室，中午可能 12 點就會用餐，而愈南邊的國家，例如義大利，則作息較晚，可能下午 2 點才會離開辦公室去用餐，其工時之彈性為職先前在臺灣無法想像。

(二) 遠端工作制度(teleworking)

在歐盟，員工有權利在自家進行辦公，當日工作公務信件會傳送至個人信箱、公務電話接聽至個人手機，當然需單位主管同意，一週最多有 50%的時間可以進行遠端工作。當日進行遠端工作的員工一早就會寄信跟所有主管與同事告知當天為遠端辦公日，並留下聯絡方式，能讓主管或同事輕易找到，可以討論公事和協助辦公等。此制度的目的在於照顧員工能兼顧自身家庭生活與工作的平衡，雖然臺灣要做到此點可能還有點遙遠，但是隨著勞工意識權益逐漸抬頭，愈來愈多工作事實上是可以逐步簡化，以及數位科技的進步，也許某日我國也可以嘗試此類工作模式，以評估其員工生產效率與效能是否會增加，或是成效較差，都是相當值得討論與探討的。

(三) 家庭與生活為重

相較亞洲國家，如臺灣或日本，加班文化似乎很平常，但在歐洲，加班情形很少見，除非是隔日有重要會議或活動才有可能加班，當然歐盟的主管如職實習單位的處

長相較其下屬工時也是較長，還滿常看到處長晚間 9 點發送公務信件，但相對員工，不論是公務單位或私人企業，工時都是相當合理，且歐洲人以自身的生活或家庭為重，下班後絕對不會在討論公務，而讓職印象最深刻的是，就算是長官找的聚餐，可能是晚上在某間餐廳用餐，歐洲人也都是習慣先把自己的私事處理完才會去赴約，像是要上課或修車，都是結束後才會參加長官邀約或同事的聚會，相當特別。

二、政策學習與人事組織參考

歐盟共有 28 個會員國，各個事務的推廣都需要多次的溝通與協調，因此在歐盟職發現如何設定政策推行的優先順序與有效溝通即相當重要。例如職實習的單位就有以業務命名的處室，以及以國家為命名的處室，通常具有共通性質的事物就會以前者命名，像是社會保障處、就業協調處，而後者則是依照不同國家而有特別的事務推動，像是西班牙暨馬爾他處，即負責兩國之社會保障特別事務，其組織架構有其特殊性，通常歐盟在與會員國成員召開會議前，都會邀集不同總署之政策文官，像是職所在的就業總署，就會與健康總署、經濟總署等人員，先進行會前會議，討論社會事務發展之重點，以及歐盟共識的方向與關心議題，之後在跟歐盟會員國成員討論時，才能盡速達成共識並順利推展業務，也許未來我國在參與國際性組織時可以作為參考。

在歐洲對於電子檔案或數位辦公的接受度也比我國為高，像是各項工作證明或居留登記，都是可以透過網路就可執行，無須本人親自到場，而歐洲許多國家也積極推動無紙化，諸如使用電子票券、信用卡支付，而非現金交易或卡片使用都漸漸退場。而職在實習工作期間，也很習慣於使用電子郵件

跟同事討論公務事務，當然職有機會也會多多跟歐洲同事交談，以磨練英文口說、聽力與表達之能力，但是使用電子郵件交辦事務與回覆在歐洲是非常平常與頻繁的。

在人事方面，歐盟也規定其主管，像是處長、科長等，在同個單位服務分別不超過 5 年和 3 年，透過經常性輪調可以加深主管階層對工作業務的廣度，也能增強不同單位間的溝通性，而歐盟也很重視組織改造，常常詢問員工對於組織的意見與看法，並試圖執行組織重組再造。在歐盟，職也經常收到不同單位之新聞、推動事務，單位的秘書也會整理重要新聞與國際情勢，定期發送給各個員工，職認為此作法可以打破本位主義，讓彼此瞭解不同單位所作的努力與成就，

以上都是我國可以參考學習之處。

三、實習計畫心得

感謝外交部向歐盟爭取到此寶貴實習機會，本計畫在臺灣自 2006 年開始，每年均會送 1 至 2 名臺灣公務員至歐盟執委會實習，而這次有 4 名實習生一同前往歐盟學習，可見歐盟對臺灣實習生的肯定，以及臺灣歐盟之間的關係日趨重要。

事實上，在前往歐洲前，職對歐洲以及歐盟是非常陌生的，

因此透過本計畫親自體驗歐盟的行事風格與辦事效率，實讓職大開眼界。除此之外，職於實習期間也結交歐洲各國之公務員，有德國、丹麥、奧地利、義大利、葡萄牙、荷蘭、比利時等，彼此留下聯絡方式，未來若有需要各國實務經驗學習，都是相當難得的人脈資產，也期待歐洲先進國家的各項政策推廣與經驗，能讓我國師法學習，讓臺灣有朝一日能和歐洲先進國家並駕齊驅。

而這個計畫也讓職改變對人生的態度與想法，世界真的很廣大，尤其在歐洲多重語言、多元文化的環境下，更能感受到歐洲人對於不同文化、族群與國家的尊重，當然也讓職能體會到臺灣優勢與劣勢的地方，期許自身能繼續增廣見聞，為國家盡一份心力。

職也真心推薦各個部會能多選送優秀公務員至歐盟學習，讓我國優點持續發揚光大，不足的地方則能因應世界潮流與時精進。

陸、生活須知與建議

一、餐飲

歐盟部分總署附有員工餐廳，但不接受 Master Card 或 VISA 信用卡，故以歐元現金消費為主，中餐消費一個套餐(麵、飯或馬鈴薯之類)配上一碗熱湯，價格約在 6-8 歐元可以解決。早餐和晚餐則依個人喜好，可至餐廳或超市購買。

二、衣物

職於 10 月至 1 月實習，布魯塞爾天氣常下雨、風勢強，冬季溫度平均約 3-7 度，因此保暖需做足，但歐洲室內均有暖氣，故建議可採洋蔥式穿法。職上班平日以襯衫配西裝褲為主，若有參加會議場合，則以正式西裝為主。

三、租屋

實習期間住宿須自行安排尋找，因實習單位位於布魯塞爾市中心，加上冬季有下雪情形，建議租屋可尋找離辦公地點步行 10-15 分鐘可到為宜。

(一)租屋資訊網：

1. Bed & Breakfast

   www.bnb-brussels.be/en/index.html

2. accommodation for up to 6 months
   www.brusselsdestination.be/en/index.html
3. finding accommodation
   www.blbe.be
4. Airbnb
5. Facebook 社團

(二)治安不佳區(租屋可盡量避免租賃之區域)：

1. 北區的 Schaarbeek (斯哈爾貝克)
2. St.Josse 區 (聖若斯，土耳其人聚集區)
3. 西區的 Molenbeek (莫倫貝克)和 Anderlecht(安德萊赫特)
4. 南區的 Bruxelles-Midi-Zuid(布魯塞爾南站)區域

四、交通

布魯塞爾市區大眾交通便捷，包含捷運 Metro、輕軌和公車，可以購買 Mobib 卡(類似臺灣悠遊卡)，利用各捷運站內之機器可以儲值，一次購買 10 行程(jump)為 14 歐元，搭乘時於 60 分鐘內均可無限轉車、來回，並不看起迄站計算。

五、通訊

職手機通話與網路通訊購買比利時當地電信 BASE(類似臺灣中

華電信)之預付卡 pre-paid card，每次儲值依價格不同可以使用期限為一個月，BASE 也有 App 可以查詢價目表及通訊使用量。

六、其他

(一)安全：

歐洲仍然為恐怖攻擊的黃色警戒區域，職於實習期間布魯塞爾路上仍有許多武裝人員巡邏，各總署也都有安檢措施，建議在歐洲仍要有警覺心。另外歐洲扒手猖獗，建議個人錢包、手機等務必收好，有陌生人攀談也須警覺。

(二)語言：

比利時官方語言為法語、荷蘭語和德語，而布魯塞爾為法語區，故若會一點法語在生活上會較便利。

(三)醫療：

職於實習期間並無就醫經驗，但詢問當地比利時人，若有保險情況下至診所就診要先支付 25 歐元，之後可核銷 70%的費用回來，但人生地不熟就醫較麻煩，建議可多備一些常備藥，並注意身體保暖，盡量不感冒為原則。

柒、附件

一、歐盟實習結業證書

EUROPEAN COMMISSION
DIRECTORATE-GENERAL
HUMAN RESOURCES AND SECURITY
Directorate HR.DDG.B : Talent Management & Diversity
Career Management & Mobility

Brussels, 23/01/2018
HR.DDG.B.4/MHP

CERTIFICATE

Issued to Mr LEE Chien-Cheng

who was seconded to the European Commission

as an unpaid National Expert in Professional Training

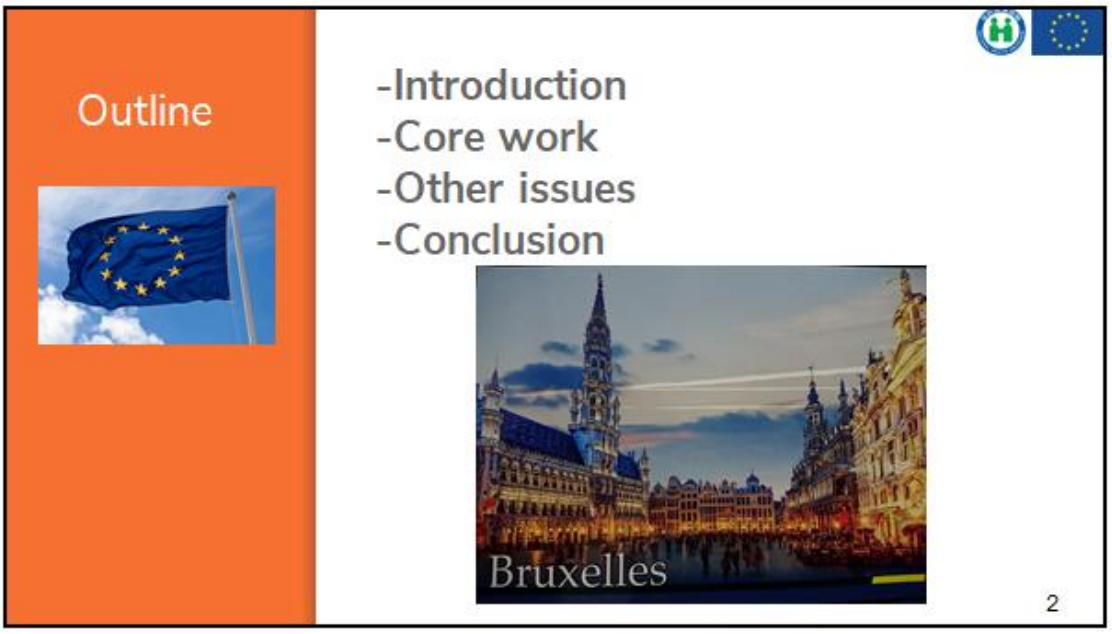
during the period from 16/10/2017 to 15/01/2018.

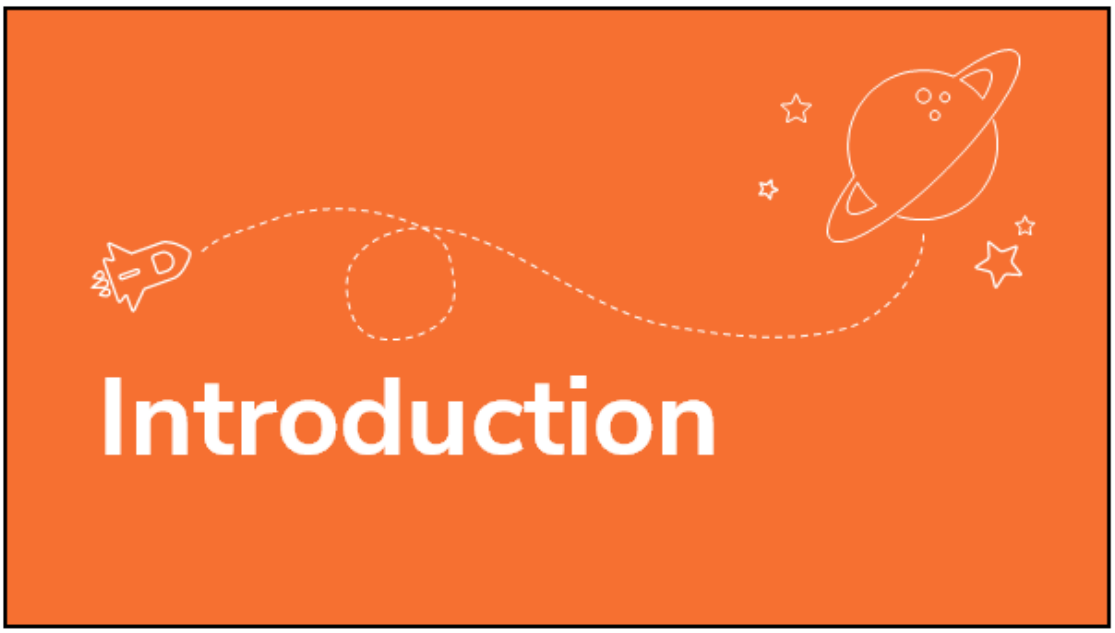
Marie-Hélène PRADINES
Head of Unit

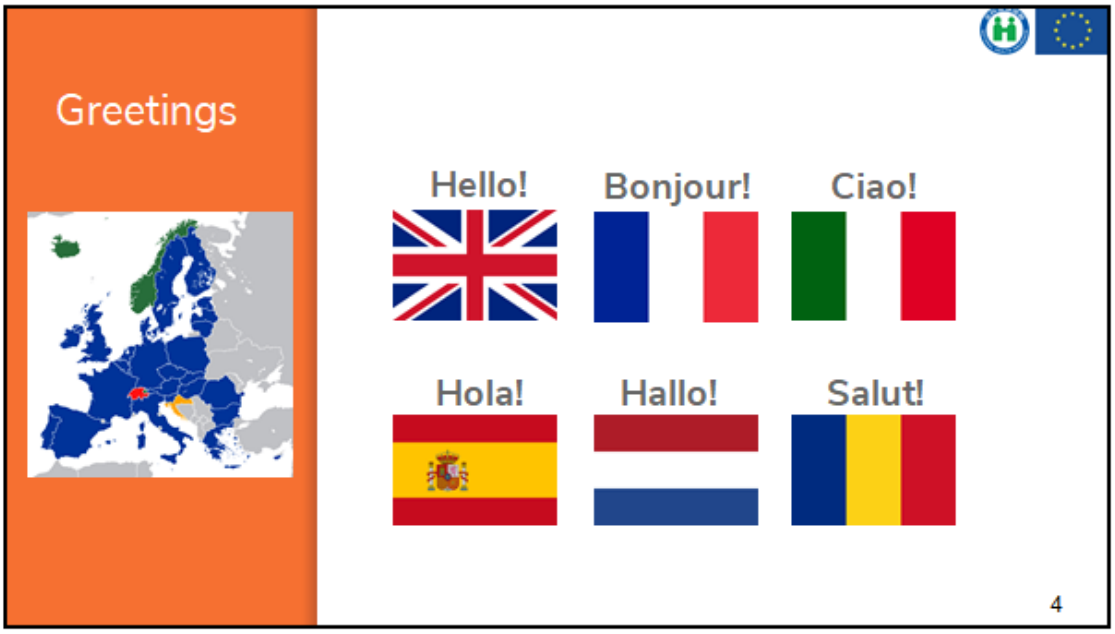
COMMISSION EUROPÉENNE

EUROPEAN COMMISSION, B-1049 Brussels - Belgium
Telephone: switchboard 299.11.11, Email : HR-ENFP@ec.europa.eu

二、單位(衛生福利部中央健康保險署)出國經驗分享簡報




Introduction


Greetings
Hello!
Bonjour!
Ciao!
Hola!
Hallo!
Salut!
4

European Union (EU)

28 Member states. 24 official languages. 510million pop.

Austria	Belgium	Bulgaria	Croatia	Cyprus
Czech Republic	Denmark	Estonia	Finland	France
Germany	Greece	Hungary	Iceland	Ireland
Italy	Latvia	Liechtenstein	Lithuania	Luxembourg
Malta	The Netherlands	Norway	Poland	Portugal
Romania	Slovakia	Slovenia	Spain	Sweden
Switzerland	UK ⇨ **Brexit in 2019.**			

*European Economic Area (EEA，歐洲經濟區) :
Iceland, Liechtenstein and Norway

*Neutral : Switzerland

5

Where is EU?

6

Why can I work in EU?

- 「國家專家專業訓練計畫」
- National Experts in Professional Training Programme，簡稱「NEPTs」
- There are 2 waves each year :
  One is from Mar. - Jun. Another is from Oct. – Jan.
- Only civil servants can join the program.
- Every year, over 100 NEPTs work in EU, including Switzerland, Norway, Turkey and Taiwan.

7

Taiwanese NEPTs

Taiwan is the only country from Asia in the program.

勞動部

國發會

衛福部
健保署

法務部

8

EU framework

European Court of Justice (歐洲法院)

European Council (歐洲理事會)

European Commission (歐盟執委會) ⇨ ~ Executive Yuan (行政院)

European Parliament (歐洲議會)

Council of the European Union (歐盟部長理事會)

EU Law

9

European Commission (EUCM)

31 Directorate-General (政務總署)：專責推動相關政策
16 Service (事務總署)：提供行政服務或臨時編列任務

10

Directorate-General of Employment, Social Affairs and Inclusion (DG EMPL，就業總署)

Similar to the Ministry of Labor in Taiwan.

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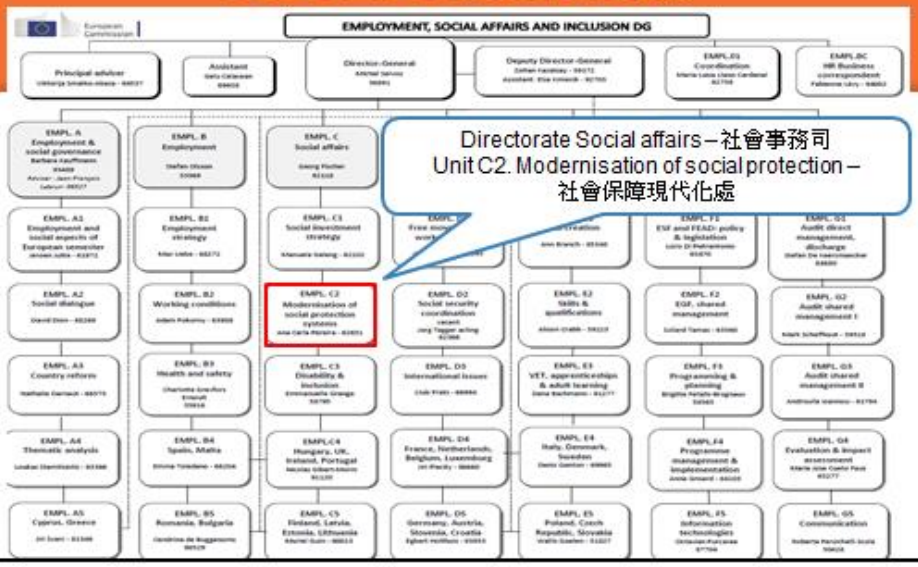
DG EMPL framework



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EMPL. Unit C2

12 members. Pension, healthcare, long-term care, etc.

14

Core work

What is the benefit?

- European Union
  - ✓ Not enough employees due to budget.
  - ✓ Promote the communication between EU level & National level or non-EU countries.
- Taiwan
  - ✓ Ministry of foreign affairs promotes the relationship between Taiwan & EU.
  - ✓ The role in the current international situation.

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Europe 2020 strategy

Targets :

- **Employment**
  -75% of people aged 20–64 to be in work
  68.4% in 2012, 71.1% in 2016
- Research and development (R&D)
  -3% of the EU's GDP to be invested in R&D
- Climate change and energy
  -20% of energy coming from renewables
- Education
  -at least 40% of people aged 30–34 having completed higher education
- **Poverty and social exclusion**
  -at least 20 million fewer people in – or at risk of – poverty/social exclusion
  806 thousand difference from 2008

17

Social Protection Committee (SPC)

An EU advisory policy committee for Employment and Social Affairs.
Mission:

-**Monitors social conditions** in the EU and the development of social protection policies in member countries.

-**Promotes discussion and coordination of policy approaches** among national governments and the Commission.

Commissioner Marianne Thyssen (類似臺灣政務委員)

18

What did I do in EU??

- ✓ Drafting "JAF Health First and Second step analysis" for 22 countries.
- ✓ Managing the JAF Health indicators (93 in total), including definition, data sources, availability, domain.
- ✓ Joining the Social Protection Committee Indicators Sub-group meeting and listening to the discussion about the coordination, indicators and data comparability issues.

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My advisors

Ana Carla Pereira(Head)

Virginia Maestri (Policy officer)

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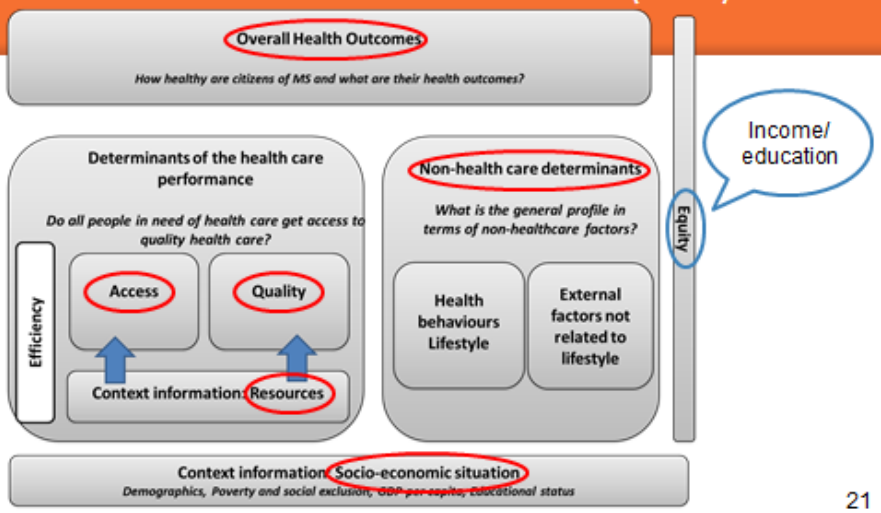
Joint Assessment Framework (JAF)



21

JAF Health First and Second step analysis

Country Report ⇨ For policy makers, not for citizens.

22

JAF Health First and Second step analysis

*First Step (Qualitative information, OECD經濟合作暨發展組織):
-Socio-Economic Situation (e.g. GDP, poverty)
-Resources, Coverage and Organisation of the health system (e.g. physicians, organisation)
-Policy Developments (e.g. reform)

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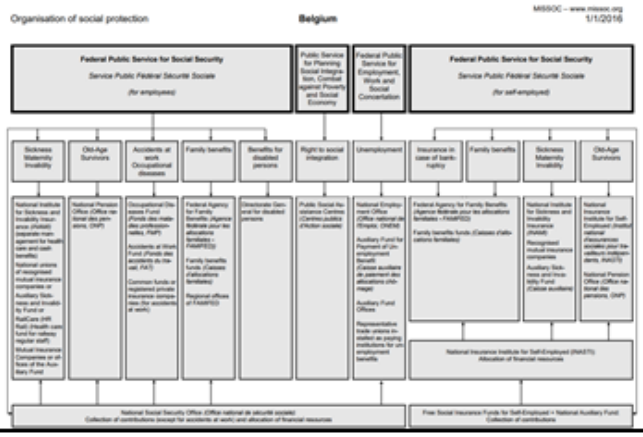
JAF Health First and Second step analysis

http://www.missoc.org/MISSOC/INFORMATIONBASE/informationBase.jsp



比利時社會福利相關政府部門組織圖

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JAF Health First and Second step analysis

*Second Step (Quantitative data, DG EMPL):
-Overall Health Outcomes
-Access
-Quality
-Non-Health determinants (Life style, EHIS)

*Conclusion

25

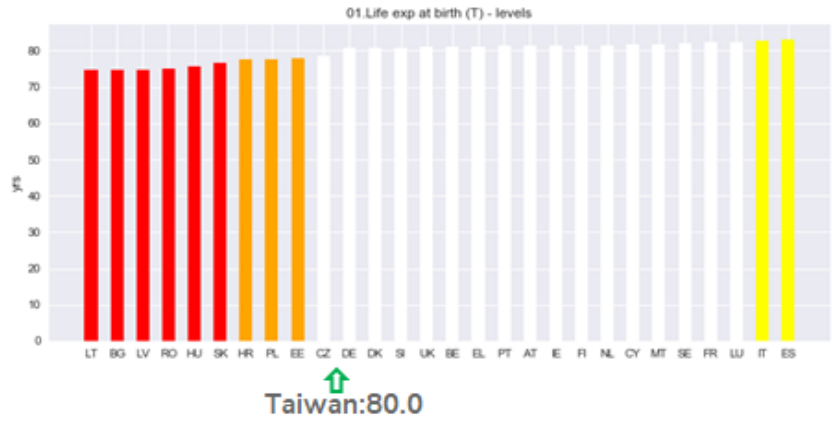
Overall Health Outcomes

-Life expectancy at birth / at 65
-Healthy life years at birth / at 65
-Self perceived general health (good/bad)
-Gap in self-perceived general health (Q1-Q5 income)
-Infant mortality rate
-Child mortality, 1-14
-Potential years of life lost
-Amenable/Preventable mortality
-External causes of death, excl. transp accidents
-Number of deaths due to self-harm/suicide
-Self-reported 12-month depression symptoms

26

Life expectancy

ES	83.0
IT	82.7
LU	82.4
FR	82.4
SE	82.2
MT	81.9
CY	81.8
FI	81.6
NL	81.6
IE	81.5
AT	81.3
PT	81.3
BE	81.1
EL	81.1
UK	81
SI	80.9
DK	80.8
DE	80.7
EU28	80.6
CZ	78.7
EE	78
HR	77.6
PL	77.5
SK	76.7
HU	75.7
RO	75
LV	74.8
BG	74.7
LT	74.6



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Access

-Unmet need med care due to cost
-Unmet need med care due to waiting
-Unmet need med care due to distance
-Gap in unmet need med care Q1-Q5 income
-Health insurance coverage
-Number of doctor's consultations

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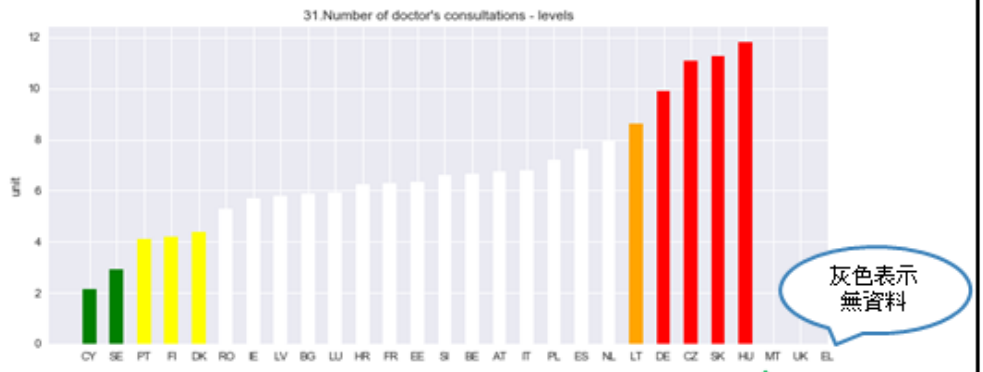
Number of doctor's consultations

HU	11.81
SK	11.28
CZ	11.09
DE	9.9
LT	8.63
NL	8
ES	7.6
PL	7.2
IT	6.8
AT	6.77
BE	6.67
SI	6.6
EE	6.32
FR	6.3
HR	6.26
LU	5.91
BG	5.9
LV	5.8
RO	5.3
DK	4.5
FI	4.2
PT	4.1
SE	2.91
CY	2.16



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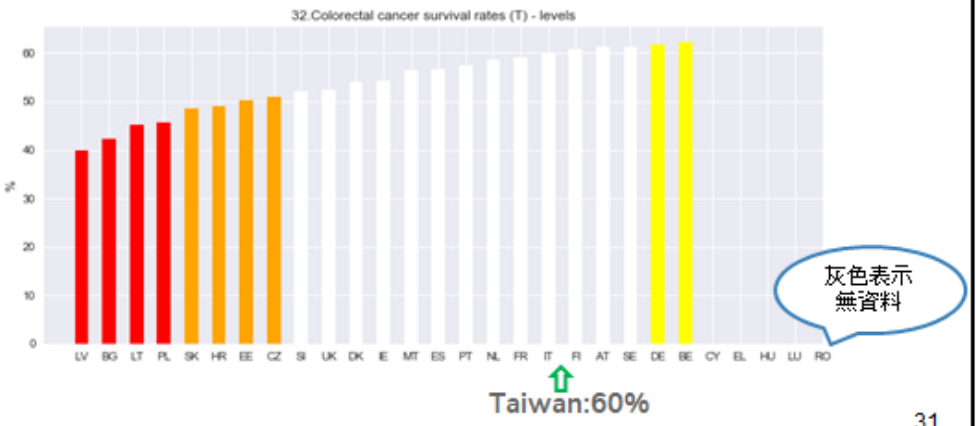
Quality

-Colorectal/Breast/Cervical (結直腸癌/乳癌/子宮頸癌)cancer 5 years survival rates
-Colorectal/Breast/Cervical cancer screening
-Vaccination coverage children - diphtheria, tetanus, pertussis and measles (白喉,破傷風,百日咳,麻疹)
-Influenza vaccination 65+
-Gap influenza vaccination 65+ by educational level
-In-hospital mortality following AMI(心肌梗塞)/stroke

30

Colorectal cancer 5 years survival rates

BE	62.2
DE	61.7
AT	61.3
SE	61.3
FI	60.7
IT	59.9
FR	59
NL	58.7
PT	57.4
ES	56.8
EU28	56.57
MT	56.4
IE	54.3
DK	54.1
UK	52.29
SI	52.1
CZ	50.9
EE	50.3
HR	49
SK	48.57
PL	45.64
LT	45.2
BG	42.3
LV	40



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Life style (from EHIS)

European Commission

- -Regular daily smoking (total/teenager/men/women)
- -Gap in regular daily smoking Q1-Q5 by income
- -Obesity(total/teenager/men/women)
- -Gap in obesity Q1-Q5 by income
- -Risky drinking (adults/teenager/men/women)
- -Gap in risky drinking by educational level
- -Fruit consumption(adults/teenager)
- -Gap in fruit consumption by educational level
- -Vegetable consumption(adults/teenager)
- -Gap in vege consumption by educational level
- -Physical activity > 150 minutes per week (T/Y/M/W)
- -Gap in physical activity by educational level

32

Obesity (BMI >= 30kg/m^2)

MT	25.2
LV	20.8
HU	20.6
UK	19.8
EE	19.7
CZ	18.7
SI	18.6
IE	18.2
HR	18
FI	17.8
EL	16.9
PL	16.7
LT	16.6
DE	16.4
ES	16.2
PT	16.1
SK	15.9
LU	15.1
FR	14.7
BG	14.4
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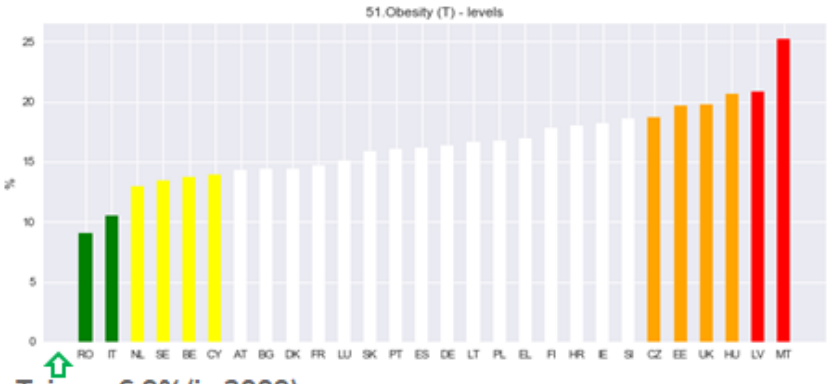
CY	13.9
BE	13.7
SE	13.4
NL	12.9
IT	10.5
RO	9.1



Taiwan:6.9%(in 2009)

Data Sources

-Eurostat
-Causes of death (COD) statistics
-Demographic statistics
-EHIS(European Health Interview Survey)
-EU_LFS(Labour Force Survey)
-EU_SILC(Statistics on Income and Living condition)
-EUROCARE - 5 database
-Joint questionnaire OECD/Eurostat/WHO
-OECD
-SHA 2011 (The System of Healthcare Accounts)
-WHO/UNICEF Global Dataset

JAF Health indicators

JAF Health Database – Indicator definition

定義 來源 取得性 領域 最新年度

JAF code	Name	Definition	Eurostat data	Source	availability (in last available year)	Latest available year in JAFF	Periodicity in JAFH: annual data (otherwise)	Adopted in JAF	JAF domain	EUNAT	Type of indicator	Average used in JAFH for standardised scores
1	Life expectancy at birth (T)	Represents the mean number of years to be lived by a person at birth, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying).	Y	Demographic statistics	28 MS		Y	Y	1.Outcome	EU	Social Portfolio	EU28 weighted average
2	Life expectancy at birth (M)	Represents the mean number of years to be lived by a man at birth, if subjected throughout the rest of his life to the current mortality conditions (age-specific probabilities of dying).	Y	Demographic statistics	28 MS	2015	Y	Y	1.Outcome	EU	Social Portfolio	EU28 weighted average
3	Life expectancy at birth (W)	Represents the mean number of years to be lived by a woman at birth, if subjected throughout the rest of her life to the current mortality conditions (age-specific probabilities of dying).	Y	Demographic statistics	28 MS	2015	Y	Y	1.Outcome	EU	Social Portfolio	EU28 weighted average
4	Life expectancy at 65 (T)	Represents the mean number of years to be lived by a person at age 65, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying).	Y	Demographic statistics	28 MS	2015	Y	Y	1.Outcome	EU	Social Portfolio	EU28 weighted average
5	Life expectancy at 65 (M)	Represents the mean number of years to be lived by a man at age 65, if subjected throughout the rest of his life to the current mortality conditions (age-specific probabilities of dying).	Y	Demographic statistics	28 MS	2015	Y	Y	1.Outcome	EU	Social Portfolio	EU28 weighted average
6	Life expectancy at 65 (W)	Represents the mean number of years to be lived by a woman at age 65, if subjected throughout the rest of her life to the current mortality conditions (age-specific probabilities of dying).	Y	Demographic statistics	28 MS	2015	Y	Y	1.Outcome	EU	Social Portfolio	EU28 weighted average
7	Healthy life years at birth (M)	The mean number of healthy years to be lived by a man at birth, if subjected throughout the rest of his life to the current mortality conditions. A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE).	Y	Demographic statistics & EU-SILC	28 MS	2015	Y	Y	1.Outcome	NAT	Social Portfolio	EU28 weighted average
8	Healthy life years at birth (W)	The mean number of healthy years to be lived by a woman at birth, if subjected throughout the rest of her life to the current mortality conditions. A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE).	Y	Demographic statistics & EU-SILC	28 MS	2015	Y	Y	1.Outcome	NAT	Social Portfolio	EU28 weighted average

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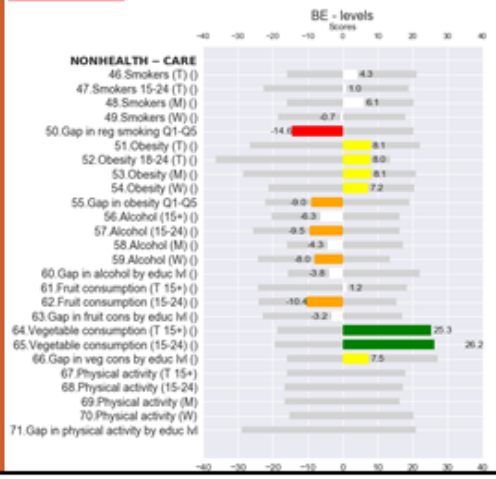
Visualization

Standardised Score (levels / changes):
between -7 and +7 as **around the EU average** (0)
from +-7 to +-13 as better(+)/worse (-) than the EU average
smaller than -13 or bigger than +13 as **considerably** better (++) / worse (--) than the EU average



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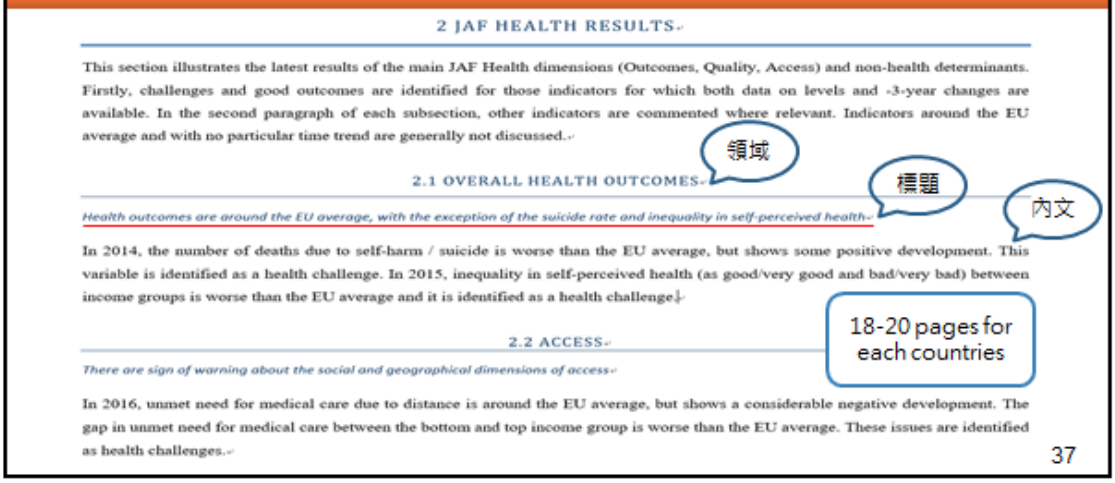
JAF Health report



2 JAF HEALTH RESULTS

This section illustrates the latest results of the main JAF Health dimensions (Outcomes, Quality, Access) and non-health determinants. Firstly, challenges and good outcomes are identified for those indicators for which both data on levels and 3-year changes are available. In the second paragraph of each subsection, other indicators are commented where relevant. Indicators around the EU average and with no particular time trend are generally not discussed.

領域

2.1 OVERALL HEALTH OUTCOMES

標題

Health outcomes are around the EU average, with the exception of the suicide rate and inequality in self-perceived health

內文

In 2014, the number of deaths due to self-harm / suicide is worse than the EU average, but shows some positive development. This variable is identified as a health challenge. In 2015, inequality in self-perceived health (as good/very good and bad/very bad) between income groups is worse than the EU average and it is identified as a health challenge.

18-20 pages for each countries

2.2 ACCESS

There are sign of warning about the social and geographical dimensions of access

In 2016, unmet need for medical care due to distance is around the EU average, but shows a considerable negative development. The gap in unmet need for medical care between the bottom and top income group is worse than the EU average. These issues are identified as health challenges.

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Indicators Sub-group meeting

Under the Social Protection Committee, set up in 2001

- -develop and define EU social indicators to monitor member countries' progress towards the commonly agreed objectives underpinning the Open Method of Coordination for social protection and inclusion.
- -carry out analytical work based on agreed indicators and develop analytical frameworks to support policy reviews conducted by the SPC.
- -contribute to the improvement of social statistics at EU level, particularly through development of the EU Survey on Income and Living Conditions (EU-SILC).

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Indicators Sub-group meeting room

平均1~2個月召開一次會議

密集2~3天開會，討論社會事務相關議題

不一定全部28個國家均到場

發言主要以英文為主

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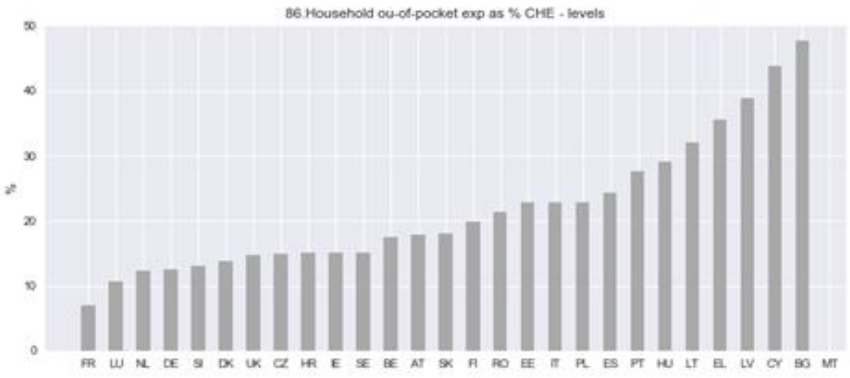
Indicator Discussion

BG	47.67
CY	43.9
LV	38.92
EL	35.48
LT	32.05
HU	29.04
PT	27.65
ES	24.23
PL	22.85
IT	22.83
EE	22.77
RO	21.28
FI	19.89
SK	18.01
AT	17.92
BE	17.57
SE	15.19
HR	15.16
IE	15.16
CZ	14.83
UK	14.79
DK	13.81
SI	13.03
DE	12.53
NL	12.25
LU	10.64
FR	6.99



40

Before I leave...

- ✓ Completing JAF Health First and Second step analysis for 22 countries. (LV, MT, BE, FR, IT and EE not included)
- ✓ Inspecting comments from member states, modifying the analysis reports based on these feedbacks.
- ✓ Managing the JAF Health indicators (93 in total)
- ✓ Joining the Social Protection Committee Indicators Sub-group meeting and listening to the discussion about the coordination, indicators and data comparability issues.
- ✓ Other temporary works: integrating the opinions from member states, power point slides and tables for the presentation.

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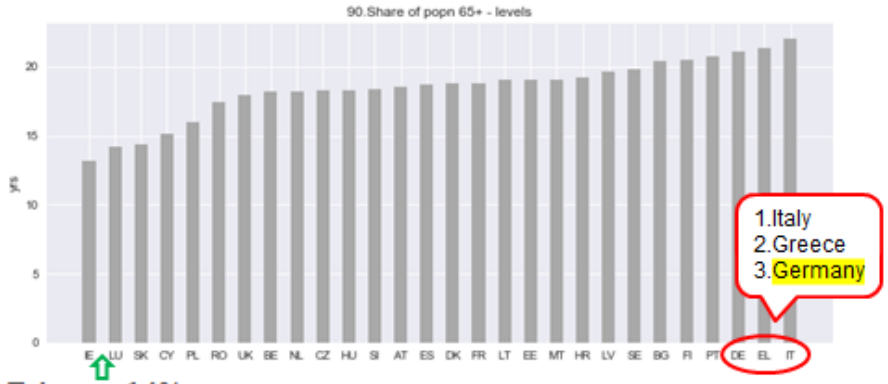
What else?

Ageing population

IT	22
EL	21.3
DE	21.1
PT	20.7
FI	20.5
BG	20.4
SE	19.8
LV	19.6
HR	19.2
EU28	19.2
EE	19
LT	19
MT	19
DK	18.8
FR	18.8
ES	18.7
AT	18.5
SI	18.4
CZ	18.3
HU	18.3
BE	18.2
NL	18.2
UK	17.9
RO	17.4
PL	16
CY	15.1
SK	14.4
LU	14.2
IE	13.2

Population over age 65 in EU average is 19.2%



Taiwan : 14%

43

Experience from Germany

Federal Ministry for Family Affairs, Senior Citizens, Women and Youth

德國聯邦家庭事務、老年、婦女及青年部

Aim: **Promote Fertility rate**

Reform, **family-friendly environment**:

(1)Parental benefit(育嬰津貼):

自2007年起，若父母其中一人每週工作時數降至30小時，則每月給予小孩出生前1年淨薪水的67%，最多為1,800歐元(約64,800新臺幣)。如果是低薪或失業者，則會收到100%的給付或每月至少300歐元(約10,800新臺幣)補助。

(2)Parental leave(育嬰假):

孩子出生後，除了母親外，父親會有兩個月的育嬰假陪伴太太與孩子。後續的育嬰假為36個月，不需要雇主的同意，而父母也可以選擇將其中的24個月用於孩子3至8歲請假，較為彈性。

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Experience from Germany

Federal Ministry for Family Affairs, Senior Citizens, Women and Youth

德國聯邦家庭事務、老年、婦女及青年部

(3)Better child care(幼兒照顧):
2013年起，德國法律規定超過1歲的兒童，都能夠被日間照護機構(daycare facility)收留。

【成效】

The Guardian

News link: https://tinyurl.com/jpwqdx8

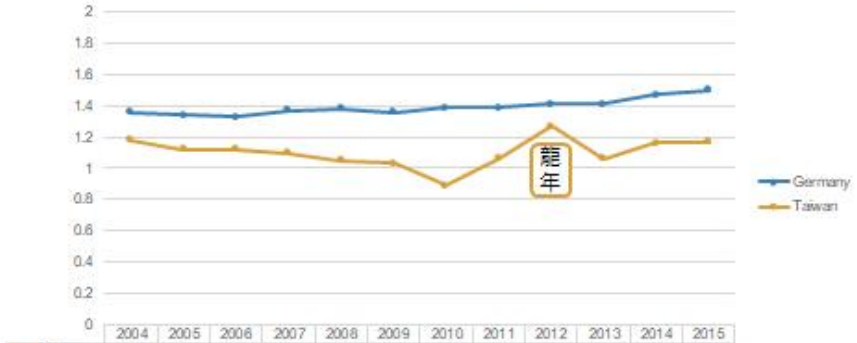
Fertility rate in Germany rises to 33-year high

In 2015 the fertility rate was 1.5 children per woman, in a sign a corner has been turned after years of declining births

45

Fertility rate

Fertility rate in EU average is 1.58



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Germany	1.36	1.34	1.33	1.37	1.38	1.36	1.39	1.39	1.41	1.41	1.47	1.50
Taiwan	1.18	1.12	1.12	1.1	1.05	1.03	0.89	1.06	1.27	1.06	1.16	1.17

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Working Culture in Europe

- 上班時間彈性不打卡，每週工作總額40小時自行調控，但核心工作時間要出現在辦公室(9:30-12:00、15:00-16:30)
- 遠端辦公(teleworking)，公務信傳送至個人信箱、公務電話接聽至個人手機，需主管同意，一週最多50%
- 歐盟事務較繁忙，但歐洲人也很注重生活和家庭，下班後就是私人時間。
- 主管同樣很忙碌，參加許多協調會議，晚上9-10點仍在傳送公務訊息。
- 地方單位公務員的辦事效率慢得可怕！(居留登記經驗)

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Time to say good-bye

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Meet a superior

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Suggestion & Conclusion

Suggestion

- Healthcare related indicators and social affairs policy from EU commission can be a reference on decision-making.
- Ageing population is a complicated problem, we can still learn lessons from European experience to prevent crisis in advance.
- Enjoying more on your own life. Getting along well with family, friends and lover.

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Conclusion

Europe wasn't built in a Day

GDP
29,100 per capita
in 2016

GDP
22,497 per capita
in 2016

*與Slovakia(22,400)、Portugal(22,500)相當

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三、JAFH 指標定義盤點表(摘要)

JAF code	Name	Definition	Source	Frequency	JAF domain
1	Life expectancy at birth (T)	Represents the mean number of years still to be lived by a person who has reached that exact age, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying)	Demographic statistics	1yr	1.Outcome
2	Life expectancy at birth (W)	Represents the mean number of years still to be lived by a person who has reached that exact age, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying)	Demographic statistics	1yr	1.Outcome
3	Life expectancy at birth (M)	Represents the mean number of years still to be lived by a person who has reached that exact age, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying)	Demographic statistics	1yr	1.Outcome
4	Life expectancy at 65 (T)	Represents the mean number of years still to be lived by a person who has reached that exact age, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying)	Demographic statistics	1yr	1.Outcome
5	Life expectancy at 65 (W)	Represents the mean number of years still to be lived by a person who has reached that exact age, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying)	Demographic statistics	1yr	1.Outcome
6	Life expectancy at 65 (M)	Represents the mean number of years still to be lived by a person who has reached that exact age, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying)	Demographic statistics	1yr	1.Outcome
7	Healthy life years at birth (M)	A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE)	Demographic statistics & EU-SILC	1yr	1.Outcome
8	Healthy life years at birth (W)	A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE)	Demographic statistics & EU-SILC	1yr	1.Outcome

JAF code	Name	Definition	Source	Frequency	JAF domain
9	Healthy life years at 65 (M)	A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE)	Demographic statistics & EU-SILC	1yr	1.Outcome
10	Healthy life years at 65 (W)	A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE)	Demographic statistics & EU-SILC	1yr	1.Outcome
11	Well-being: Self-perceived general health (good + very good)	Percentage of people reporting a good health. The concept is operationalized by a question on how a person perceives his/her health in general using one of the answer categories: very good/good/fair/bad/very bad	EU-SILC	1yr	1.Outcome
12	Well-being: Self-perceived general health (good + very good) - income quintile gap (q1-q5)	The difference between the percentage of the people from the bottom (q1) and the top (q5) income quintiles reporting a good health. The total disposable income of a household is calculated by adding together the personal income of all household members plus income received at household level. Missing income information is imputed.Disposable household income includes: -all income from work (employee wages and earnings from self-employment) -private income from investment and property -transfers between households -all social transfers received in cash including old-age pensions	EU-SILC	1yr	1.Outcome
13	Infant mortality rate (total)	Ratio of the number of children's deaths under one year of age to the number of live births in the same year. The value is expressed per 1,000 live births.	Demographic statistics	1yr	1.Outcome
14	Child mortality rate, 1-14 (total)	Death rate of children aged 1-14 years per 100,000 children. Number of deaths of residents dying inside and outside their home country at age 1-14 years divided by the midterm population aged 1-14 years.	Causes of death (COD) statistics	1yr	1.Outcome
15	Potential years of life lost (T)	PYLL is a summary measure of premature mortality which provides an explicit way of weighting deaths occurring at younger ages, which are, a	Demographic statistics & Causes	1yr	1.Outcome

JAF code	Name	Definition	Source	Frequency	JAF domain
		priori, preventable. The calculation for PYLL involves adding up deaths for all causes occurring at each age to 70 years and multiplying this with the number of remaining years to live until a selected age limit.	of death (COD) statistics		
16	Potential years of life lost (M)	PYLL is a summary measure of premature mortality which provides an explicit way of weighting deaths occurring at younger ages, which are, a priori, preventable. The calculation for PYLL involves adding up deaths for all causes occurring at each age to 70 years and multiplying this with the number of remaining years to live until a selected age limit.	Demographic statistics & Causes of death (COD) statistics	1yr	1.Outcome
17	Potential years of life lost (W)	PYLL is a summary measure of premature mortality which provides an explicit way of weighting deaths occurring at younger ages, which are, a priori, preventable. The calculation for PYLL involves adding up deaths for all causes occurring at each age to 70 years and multiplying this with the number of remaining years to live until a selected age limit.	Demographic statistics & Causes of death (COD) statistics	1yr	1.Outcome
18	Amenable mortality, standardised death rate per 100.000 population aged 0-74 years (total)	A dimension of avoidable mortality and is understood as deaths that could be avoided through good quality of healthcare. The list of amenable deaths is calculated according to a list of ICD codes and specific age groups compiled by the Eurostat Task Force on Satellite Lists.	Causes of death (COD) statistics	1yr	1.Outcome
19	Preventable mortality, standardised death rate per 100.000 population aged 0-74 years (total)	Another dimension of avoidable mortality. A death is preventable if, given the understanding of the determinants of health at the time of death, all or most deaths from that cause could be avoided by public health interventions.	Causes of death (COD) statistics	1yr	1.Outcome
20	External causes of death excl. transport accidents (total)	Mortality due to external causes (excluding transport accidents (V01-V99,Y85)). Number of deaths of residents dying inside and outside their home country with a cause of death between W00-Y89 (excluding Y85) at all ages divided by the total midterm population.	Causes of death (COD) statistics	1yr	1.Outcome

JAF code	Name	Definition	Source	Frequency	JAF domain
		*midterm population = (pop. in t0 + pop. in t+1) / 2			
21	Well-being: Self-perceived general health (bad + very bad)	Percentage of people reporting a bad health. The concept is operationalized by a question on how a person perceives his/her health in general using one of the answer categories: very good/good/fair/bad/very bad	EU-SILC	1yr	1.Outcome
22	Well-being: Self-perceived general health (bad + very bad) - income quintile gap (q1-q5)	The difference between the percentage of the people from the bottom (q1) and the top (q5) income quintiles reporting a bad health. The total disposable income of a household is calculated by adding together the personal income of all household members plus income received at household level. Missing income information is imputed.Disposable household income includes: -all income from work (employee wages and earnings from self-employment) -private income from investment and property -transfers between households -all social transfers received in cash including old-age pensions	EU-SILC	1yr	1.Outcome
23	Mental Health: Number of deaths due to intentional self-harm/suicide	The number of deaths per 100,000 inhabitants due to intentional self-harm/suicide.	Causes of death (COD) statistics	1yr	1.Outcome
24	Mental Health: Self-reported 12-month depression symptoms	EHIS contains questions on self-reported depression: Do you have or have you ever had chronic depression? Was this chronic depression in the past 12 months? The self-reported depression prevalence indicator gives the proportion of people reporting to have chronic depression by answering Yes to these EHIS questions. Data is further broken down by gender, age group and educational level.	EU-EHIS	4yrs	1.Outcome
25	Self-reported unmet need for medical care	Percentage of the population aged 16 or over reporting unmet needs in the previous 12 months for medical care together and for any of the following	EU-SILC	1yr	2.Access

JAF code	Name	Definition	Source	Frequency	JAF domain
		three reasons: financial reasons (too expensive), waiting time(long waiting lists), or distance(too ar to travel)			
26	Self-reported unmet need for medical care - due to cost	Percentage of the population aged 16 or over reporting unmet needs in the previous 12 months for medical care together and for any of the following three reasons: financial reasons (too expensive), waiting time(long waiting lists), or distance(too ar to travel)	EU-SILC	1yr	2.Access
27	Self-reported unmet need for medical care - due to waiting time	Percentage of the population aged 16 or over reporting unmet needs in the previous 12 months for medical care together and for any of the following three reasons: financial reasons (too expensive), waiting time(long waiting lists), or distance(too ar to travel)	EU-SILC	1yr	2.Access
28	Self-reported unmet need for medical care - due to distance	Percentage of the population aged 16 or over reporting unmet needs in the previous 12 months for medical care together and for any of the following three reasons: financial reasons (too expensive), waiting time(long waiting lists), or distance(too ar to travel)	EU-SILC	1yr	2.Access
29	Self-reported unmet need for medical care - income quintile gap (q1-q5 by reason: cost, waiting time, distance)	The differecne (gap) between the percentage of the population aged 16 or over from the bottom (q1) and top (q5) income quintile with self-reported total unmet need for medical examination during the previous 12 months for any of the following three reasons: financial barriers, waiting times, too far to travel. The first quintile group represents the 20% of the population with the lowest income, and the fifth quintile group represents the 20% of the population with the highest income.	EU-SILC	1yr	2.Access
30	Share of population covered by health insurance	The percentage of the population covered by public health insurance (which is defined as tax-based public health insurance and income-related payroll taxes including social security contribution schemes) + the percentage of the population covered by private health insurance including: Private mandatory health insurance, Private employment group health insurance, Private	OECD - Health statistics DB	1yr	2.Access

JAF code	Name	Definition	Source	Frequency	JAF domain
		community-rated health insurance, and Private risk-rated health insurance. Coverage for health care is defined as the share of the population receiving a defined set of health care goods and services under public programmes and through private health insurance. It includes those covered in their own name and their dependents. Public coverage refers both to government programmes, generally financed by taxation, and social health insurance, generally financed by payroll taxes. Take-up of private health insurance is often voluntary, although it may be mandatory by law or compulsory for employees as part of their working conditions. Premiums are generally non-income related, although the purchase of private coverage can be subsidised by the government.			
31	Care utilisation (total, by SES): Number of doctors' consultations per year per inhabitant (generalist and specialist in private practice or as outpatient)	The average number of consultations/visits with a physician per person per year includes consultations/visits both to generalist and specialist medical practitioners, consultations/visits at the physician's office, in the patient's home, or in out-patient departments in hospitals and ambulatory health care centres. The indicator excludes telephone and email contacts, visits for prescribed laboratory tests, visits to perform prescribed and scheduled treatment procedures, e.g. injections, physiotherapy etc., visits to dentists, visits to nurses and consultations during an inpatient stay or day care treatment. The data are published in absolute numbers of consultation of a medical doctor (in private practice or as outpatient) per inhabitant.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	2.Access
32	Colorectal cancer survival rates (total)	Age-standardised 5-year relative colorectal survival rate is the observed rate of persons diagnosed with colorectal cancer (C18-C21) surviving five years after diagnosis, divided by expected survival rate in the general population.	Eurocare	1yr	3.Quality
33	Breast cancer survival rates (total)	Age-standardized 5-year relative breast survival rate is the observed rate of women diagnosed with breast cancer (C50) surviving five years after diagnosis, divided by expected survival rate in the general population.	Eurocare	1yr	3.Quality

JAF code	Name	Definition	Source	Frequency	JAF domain
34	Cervical cancer survival rates (total)	Age-standardised 5-year relative cervical survival rate is the observed rate of women diagnosed with cervical cancer (C53) surviving five years after diagnosis, divided by expected survival rate in the general population.	Eurocare	1yr	3.Quality
35	Breast cancer screening (women)	Breast cancer screening rates reflect the proportion of eligible women (aged 50-69) reporting a mammography in the past 2 years.	EU-EHIS	5yrs	3.Quality
36	Cervical cancer screening (women)	Proportion of women (aged 20-69) reporting to have undergone a cervical cancer screening test within the past 3 years.	EU-EHIS	5yrs	3.Quality
37	Colorectal cancer screening (T)	Proportion of persons (aged 50-74) reporting to have undergone a colorectal cancer screening test in the past 2 years.	EU-EHIS	5yrs	3.Quality
38	Colorectal cancer screening (M)	Proportion of persons (aged 50-74) reporting to have undergone a colorectal cancer screening test in the past 2 years.	EU-EHIS	5yrs	3.Quality
39	Colorectal cancer screening (W)	Proportion of persons (aged 50-74) reporting to have undergone a colorectal cancer screening test in the past 2 years.	EU-EHIS	5yrs	3.Quality
40	Vaccination coverage for children: against diphtheria, pertussis, tetanus (DTP)	Percentage of surviving infants (0-11 months old) who received the third dose of combination vaccine containing diphtheria, tetanus and pertussis (DTP3)	UNICEF/WHO Global Dataset - Immunization coverage by antigen	1yr	3.Quality
41	Vaccination coverage for children: against measles	Percentage of children reaching their second birthday who have been fully vaccinated against measles (1st dose)	UNICEF/WHO Global Dataset - Immunization coverage by antigen	1yr	3.Quality
42	Influenza vaccination for 65+	Influenza vaccination rate refers to the number of people aged 65 and older who have received an annual influenza vaccination, divided by the total number of people over 65 years of age.	EU-EHIS	5yrs	3.Quality
43	Influenza vaccination	The gap in influenza vaccination for the elderly is the difference between the	EU-EHIS	5yrs	3.Quality

JAF code	Name	Definition	Source	Frequency	JAF domain
	for 65+ (total, by educational level gap between ISCED 0-2 and 5-6)	percentage of people aged 65+ with lower secondary education (ISCED 2) and people aged 65+ with tertiary education (ISCED 5-6).			
44	In-hospital mortality following AMI	The number of people who die within 30 days of being admitted to hospital with AMI, where death occurs at the same hospital as the initial AMI admission, as a proportion of all hospital admissions for AMI in a specified year, standardised for age and gender to the 2010 OECD population. The admission-based indicator is used and the unit of counting is a hospital admission.	OECD	1yr	3.Quality
45	In-hospital mortality following stroke	The number of people who die within 30 days of being admitted to hospital with ischaemic stroke, where death occurs in the same hospital as the initial stroke admission, as a proportion of all hospital admissions for ischaemic stroke in a specified year, standardised for age and gender to the 2010 OECD population. The admission-based indicator is used and the unit of counting is a hospital admission.	OECD	1yr	3.Quality
46	Regular daily smoking (total population)	Proportion of people reporting to smoke cigarettes daily. Percentage of respondents reporting to smoke cigarettes daily derived from EHIS questions SK.1 and SK.2; SK.1: Do you smoke at all nowadays? 1. Yes, daily; 2. Yes, occasionally; 3. Not at all. SK.2: What tobacco product do you smoke each day? 1. Manufactured cigarettes; 2. Hand-rolled cigarettes; 3. Cigars; 4. Pipefuls of tobacco; 5. Other. For the calculation of this indicator the answering categories “yes, daily” for EHIS question SK.1 should be combined with answering categories “manufactured cigarettes” and/or “hand-rolled cigarettes” for EHIS question SK2. EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
47	Regular daily smoking (15-24)	Proportion of people reporting to smoke cigarettes daily. Percentage of respondents reporting to smoke cigarettes daily derived from EHIS questions SK.1 and SK.2; SK.1: Do you smoke at all nowadays? 1. Yes, daily; 2. Yes, occasionally; 3. Not at all. SK.2: What tobacco product do you smoke each day? 1. Manufactured cigarettes; 2. Hand-rolled cigarettes; 3. Cigars; 4. Pipefuls of tobacco; 5. Other. For the calculation of this indicator the answering categories “yes, daily” for EHIS question SK.1 should be combined with answering categories “manufactured cigarettes” and/or “hand-rolled cigarettes” for EHIS question SK2. EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
48	Regular daily smoking (men)	Proportion of people reporting to smoke cigarettes daily. Percentage of respondents reporting to smoke cigarettes daily derived from EHIS questions SK.1 and SK.2; SK.1: Do you smoke at all nowadays? 1. Yes, daily; 2. Yes, occasionally; 3. Not at all. SK.2: What tobacco product do you smoke each day? 1. Manufactured cigarettes; 2. Hand-rolled cigarettes; 3. Cigars; 4. Pipefuls of tobacco; 5. Other. For the calculation of this indicator the answering categories “yes, daily” for EHIS question SK.1 should be combined with answering categories “manufactured cigarettes” and/or “hand-rolled cigarettes” for EHIS question SK2. EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
49	Regular daily smoking (women)	Proportion of people reporting to smoke cigarettes daily. Percentage of respondents reporting to smoke cigarettes daily derived from EHIS questions SK.1 and SK.2; SK.1: Do you smoke at all nowadays? 1. Yes, daily; 2. Yes, occasionally; 3. Not at all. SK.2: What tobacco product do you smoke each day? 1. Manufactured cigarettes; 2. Hand-rolled cigarettes; 3. Cigars; 4.	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
		Pipefuls of tobacco; 5. Other. For the calculation of this indicator the answering categories “yes, daily” for EHIS question SK.1 should be combined with answering categories “manufactured cigarettes” and/or “hand-rolled cigarettes” for EHIS question SK2. EHIS data will not be age standardized.			
50	Regular daily smoking (income quintile gap q1-q5)	Proportion of people reporting to smoke cigarettes daily. Percentage of respondents reporting to smoke cigarettes daily derived from EHIS questions SK.1 and SK.2; SK.1: Do you smoke at all nowadays? 1. Yes, daily; 2. Yes, occasionally; 3. Not at all. SK.2: What tobacco product do you smoke each day? 1. Manufactured cigarettes; 2. Hand-rolled cigarettes; 3. Cigars; 4. Pipefuls of tobacco; 5. Other. For the calculation of this indicator the answering categories “yes, daily” for EHIS question SK.1 should be combined with answering categories “manufactured cigarettes” and/or “hand-rolled cigarettes” for EHIS question SK2. EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
51	Obesity (total population)	Proportion of people who are obese, i.e. whose body mass index (BMI) is >= 30kg/m2. Body mass index (BMI), or Quetelet index, is defined as the individual’s body weight (in kilograms) divided by the square of their height (in metres). Weight and height are derived from European Health Interview Survey (EHIS) questions BMI01: How tall are you? (cm), and BMI02: How much do you weight without clothes and shoes? (kg). EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
52	Obesity (18-24)	Proportion of people who are obese, i.e. whose body mass index (BMI) is >= 30kg/m2. Body mass index (BMI), or Quetelet index, is defined as the individual’s body weight (in kilograms) divided by the square of their height	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
		(in metres). Weight and height are derived from European Health Interview Survey (EHIS) questions BMI01: How tall are you? (cm), and BMI02: How much do you weight without clothes and shoes? (kg). EHIS data will not be age standardized.			
53	Obesity (men)	Proportion of people who are obese, i.e. whose body mass index (BMI) is >= 30kg/m2. Body mass index (BMI), or Quetelet index, is defined as the individual's body weight (in kilograms) divided by the square of their height (in metres). Weight and height are derived from European Health Interview Survey (EHIS) questions BMI01: How tall are you? (cm), and BMI02: How much do you weight without clothes and shoes? (kg). EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
54	Obesity (women)	Proportion of people who are obese, i.e. whose body mass index (BMI) is >= 30kg/m2. Body mass index (BMI), or Quetelet index, is defined as the individual's body weight (in kilograms) divided by the square of their height (in metres). Weight and height are derived from European Health Interview Survey (EHIS) questions BMI01: How tall are you? (cm), and BMI02: How much do you weight without clothes and shoes? (kg). EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
55	Obesity (income quintile gap q1-q5)	Proportion of people who are obese, i.e. whose body mass index (BMI) is >= 30kg/m2. Body mass index (BMI), or Quetelet index, is defined as the individual's body weight (in kilograms) divided by the square of their height (in metres). Weight and height are derived from European Health Interview Survey (EHIS) questions BMI01: How tall are you? (cm), and BMI02: How much do you weight without clothes and shoes? (kg). EHIS data will not be age standardized.	EU-EHIS	5yrs	4.Non-health care determinants
56	Risky single occasion drinking (total	Percentage of population reporting to ingest more than 60g of pure ethanol on a single occasion in the past 12 months derived from EHIS wave 2 variable	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
	population 15+)	AL6: Question: In the past 12 months, how often have you had [6 or more] drinks containing alcohol on one occasion? For instance, during a party, a meal, an evening out with friends, alone at home, … Answer categories: 1. Every day or almost 2. 5 - 6 days a week 3. 3 - 4 days a week 4. 1 - 2 days a week 5. 2 - 3 days in a month 6. Once a month			
57	Risky single occasion drinking (15-24)	Percentage of population reporting to ingest more than 60g of pure ethanol on a single occasion in the past 12 months derived from EHIS wave 2 variable AL6: Question: In the past 12 months, how often have you had [6 or more] drinks containing alcohol on one occasion? For instance, during a party, a meal, an evening out with friends, alone at home, … Answer categories: 1. Every day or almost 2. 5 - 6 days a week 3. 3 - 4 days a week 4. 1 - 2 days a week 5. 2 - 3 days in a month 6. Once a month	EU-EHIS	5yrs	4.Non-health care determinants
58	Risky single occasion drinking (men)	Percentage of population reporting to ingest more than 60g of pure ethanol on a single occasion in the past 12 months derived from EHIS wave 2 variable AL6: Question: In the past 12 months, how often have you had [6 or more] drinks containing alcohol on one occasion? For instance, during a party, a meal, an evening out with friends, alone at home, …	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
		Answer categories: 1. Every day or almost 2. 5 - 6 days a week 3. 3 - 4 days a week 4. 1 - 2 days a week 5. 2 - 3 days in a month 6. Once a month			
59	Risky single occasion drinking (women)	Percentage of population reporting to ingest more than 60g of pure ethanol on a single occasion in the past 12 months derived from EHIS wave 2 variable AL6: Question: In the past 12 months, how often have you had [6 or more] drinks containing alcohol on one occasion? For instance, during a party, a meal, an evening out with friends, alone at home, … Answer categories: 1. Every day or almost 2. 5 - 6 days a week 3. 3 - 4 days a week 4. 1 - 2 days a week 5. 2 - 3 days in a month 6. Once a month	EU-EHIS	5yrs	4.Non-health care determinants
60	Risky single occasion drinking (educational level gap between ISCED 0-2 and 5-6)	Percentage of population reporting to ingest more than 60g of pure ethanol on a single occasion in the past 12 months derived from EHIS wave 2 variable AL6: Question: In the past 12 months, how often have you had [6 or more] drinks containing alcohol on one occasion? For instance, during a party, a meal, an evening out with friends, alone at home, Answer categories: 1. Every day or almost 2. 5 - 6 days a week	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
		3. 3 - 4 days a week 4. 1 - 2 days a week 5. 2 - 3 days in a month 6. Once a month			
61	Fruit consumption (total population 15+)	Proportion of people reporting to eat fruits (excluding juice) at least once a day. Estimates of daily fruit and vegetable consumption are derived from national and European Health Interview Survey questions, conducted in many EU member states between 2006 and 2010. Typically, respondents were asked "How often do you eat fruit (excluding juice)?" and "How often do you eat vegetables or salad (excluding juice and potatoes)?" Response categories included: Twice or more a day/ Once a day/Less than once a day but at least four times a week/Less than four times a week, but at least once a week/Less than once a week/Never.	EU-EHIS	5yrs	4.Non-health care determinants
62	Fruit consumption (15-24)	Proportion of people reporting to eat fruits (excluding juice) at least once a day. Estimates of daily fruit and vegetable consumption are derived from national and European Health Interview Survey questions, conducted in many EU member states between 2006 and 2010. Typically, respondents were asked "How often do you eat fruit (excluding juice)?" and "How often do you eat vegetables or salad (excluding juice and potatoes)?" Response categories included: Twice or more a day/ Once a day/Less than once a day but at least four times a week/Less than four times a week, but at least once a week/Less than once a week/Never.	EU-EHIS	5yrs	4.Non-health care determinants
63	Fruit consumption (educational level gap between ISCED 0-2 and 5-6)	Proportion of people reporting to eat fruits (excluding juice) at least once a day. Estimates of daily fruit and vegetable consumption are derived from national and European Health Interview Survey questions, conducted in many EU member states between 2006 and 2010. Typically, respondents were asked "How often do you eat fruit (excluding juice)?" and "How often do you eat	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
		vegetables or salad (excluding juice and potatoes)?" Response categories included: Twice or more a day/ Once a day/Less than once a day but at least four times a week/Less than four times a week, but at least once a week/Less than once a week/Never.			
64	Vegetable consumption (total population 15+)	Proportion of people reporting to eat vegetables (excluding potatoes and juice) at least once a day. Estimates of daily fruit and vegetable consumption are derived from national and European Health Interview Survey questions, conducted in many EU member states between 2006 and 2010. Typically, respondents were asked "How often do you eat fruit (excluding juice)?" and "How often do you eat vegetables or salad (excluding juice and potatoes)?" Response categories included: Twice or more a day/ Once a day/Less than once a day but at least four times a week/Less than four times a week, but at least once a week/Less than once a week/Never.	EU-EHIS	5yrs	4.Non-health care determinants
65	Vegetable consumption (15-24)	Proportion of people reporting to eat vegetables (excluding potatoes and juice) at least once a day. Estimates of daily fruit and vegetable consumption are derived from national and European Health Interview Survey questions, conducted in many EU member states between 2006 and 2010. Typically, respondents were asked "How often do you eat fruit (excluding juice)?" and "How often do you eat vegetables or salad (excluding juice and potatoes)?" Response categories included: Twice or more a day/ Once a day/Less than once a day but at least four times a week/Less than four times a week, but at least once a week/Less than once a week/Never.	EU-EHIS	5yrs	4.Non-health care determinants
66	Vegetable consumption (educational level gap between ISCED 0-2 and 5-6)	Proportion of people reporting to eat vegetables (excluding potatoes and juice) at least once a day. Estimates of daily fruit and vegetable consumption are derived from national and European Health Interview Survey questions, conducted in many EU member states between 2006 and 2010. Typically, respondents were asked "How often do you eat fruit (excluding juice)?" and	EU-EHIS	5yrs	4.Non-health care determinants

JAF code	Name	Definition	Source	Frequency	JAF domain
		"How often do you eat vegetables or salad (excluding juice and potatoes)?" Response categories included: Twice or more a day/ Once a day/Less than once a day but at least four times a week/Less than four times a week, but at least once a week/Less than once a week/Never.			
67	Physical activity (total population 15+)	Percentage of a countries' population doing ≥ 150 minutes of at least moderate- intensity aerobic physical activity per week.	EU-EHIS	5yrs	4.Non-health care determinants
68	Physical activity (15-24)	Percentage of a countries' population doing ≥ 150 minutes of at least moderate- intensity aerobic physical activity per week.	EU-EHIS	5yrs	4.Non-health care determinants
69	Physical activity (men)	Percentage of a countries' population doing ≥ 150 minutes of at least moderate- intensity aerobic physical activity per week.	EU-EHIS	5yrs	4.Non-health care determinants
70	Physical activity (women)	Percentage of a countries' population doing ≥ 150 minutes of at least moderate- intensity aerobic physical activity per week.	EU-EHIS	5yrs	4.Non-health care determinants
71	Physical activity (educational level gap between ISCED 0-2 and 5-6)	Percentage of a countries' population doing ≥ 150 minutes of at least moderate- intensity aerobic physical activity per week.	EU-EHIS	5yrs	4.Non-health care determinants
72	Current expenditure on health care per capita (in pps)	'Current expenditure on healthcare' means the final consumption expenditure of resident units on healthcare goods and services, including the healthcare goods and services provided directly to individual persons as well as collective healthcare services.	SHA(System of Health Accounts) 2011	1yr	5.Resources
73	Current expenditure on health care as % of GDP	'Current expenditure on healthcare' means the final consumption expenditure of resident units on healthcare goods and services, including the healthcare goods and services provided directly to individual persons as well as collective healthcare services. Gross domestic product (GDP) = final consumption + gross capital formation + net exports. Final consumption of households includes goods and services used by households or the community to satisfy their individual needs. It	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources

JAF code	Name	Definition	Source	Frequency	JAF domain
		includes final consumption expenditure of households, general government and non-profit institutions serving households.			
74	Total long-term care expenditure as % of GDP	Expenditure on long-term care (health) (category HC.3 in SHA 2011) plus expenditure on long-term care (social) (category HC.R.1 in SHA 2011) as a % of GDP. 'Long-term care (health)' means a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency. 'Long-term care (social)' means lower-level social care services to assist with instrumental activities of daily living (such as home-help, meals on wheels, transport and day centres, etc.) including in-kind long-term social care and long-term social care cash-benefits.	SHA(System of Health Accounts) 2011	1yr	5.Resources
75	Expenditure on curative care as % of current expenditure on health care	Curative care' means the health care services during which the principal intent is to relieve symptoms or to reduce the severity of an illness or injury, or to protect against its exacerbation or complication that could threaten life or normal function.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
76	Expenditure on rehabilitative care as % of current expenditure on health care	Rehabilitative care means the services to stabilise, improve or restore impaired body functions and structures, compensate for the absence or loss of body functions and structures, improve activities and participation and prevent impairments, medical complications and risks.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
77	Expenditure on long-term nursing care as % of current expenditure on health care	Long-term care (health) indicates a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources

JAF code	Name	Definition	Source	Frequency	JAF domain
78	Expenditure on preventive care as a % of current expenditure on health care	Preventive care' means any measure that aims to avoid or reduce the number or the severity of injuries and diseases, their sequelae and complications. It is based on a health promotion strategy that involves a process to enable people to improve their health through the control over some of its immediate determinants. Interventions (both individual and collective) are included when their primary purpose is health promotion and if they occur before the diagnosis has been made.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
79	Administrative Expenditure as share of current health expenditure	Spending on health systems administration is used as defined in category HC7 as "Governance, and health system and financing administration" in the functional classification in the International Classifications of Health Accounts (ICHA HC). This excludes all administrative activities that take place at the level of the health care provider. Current health spending is used as defined in the ICHA HC.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
80	Practicing physicians or doctors per 100K	Total number of practising physicians (medical doctors) per 100 000 inhabitants. The data for most countries refer to practising medical doctors, defined as the number of doctors who are providing care directly to patients. In many countries, the numbers include interns and residents (doctors in training). The numbers are based on head counts.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
81	Practicing and professionally active nurses and midwives per 100K	Total number of professional nurses and midwives per 100,000 inhabitants. The number of nurses includes those employed in public and private settings providing services directly to patients (“practising”) and in some cases also those working as managers, educators or researchers.	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
82	Health personnel in hospital, FTE per 100K	Number of persons employed (head counts), and number of full-time equivalent (FTE) persons employed in general and specialised hospitals. Self-employed are included. Inclusion	Eurostat (Joint quesionnaire with OECD/WHO)	1yr	5.Resources
83	Government exp as	Payment for healthcare goods and services from the government.	Eurostat	1yr	5.Resources

JAF code	Name	Definition	Source	Frequency	JAF domain
	% CHE				
84	Compulsory insurance exp as % CHE	Payment for healthcare goods and services from the compulsory insurance.	Eurostat	1yr	5.Resources
85	Voluntary schemes exp as % CHE	Payment for healthcare goods and services from the voluntary schemes.	Eurostat	1yr	5.Resources
86	Household out-of-pocket exp as % CHE	'Household out-of-pocket payment' means a direct payment for healthcare goods and services from the household primary income or savings, where the payment is made by the user at the time of the purchase of goods or the use of the services either without any reimbursement or as cost-sharing with an organized scheme.	Eurostat	1yr	5.Resources
87	Rest of the world exp as % CHE	Payment for healthcare goods and services from the rest of the world.	Eurostat	1yr	5.Resources
88	Old age dependency ratio	This indicator is the ratio between the total number of elderly persons of an age when they are generally economically inactive (aged 65 and over) and the number of persons of working age (from 15 to 64).	Demographic statistics	1yr	6.Socio-Economic
89	At risk of poverty or social exclusion rate	The share of the total population that is at-risk-of-poverty, or severely materially deprived, or living in households with very low work intensity.The indicator sums up the number of persons who are at risk of poverty, severely materially deprived or living in households with very low work intensity. Persons present in several sub-indicators are counted only once. Persons at risk of poverty have an equivalised disposable income below 60 % of the national median equivalised disposable income after social transfers. Material deprivation covers indicators relating to economic strain and durables. Persons are considered living in households with very low work intensity if they are aged 0-59 and the working age members in the household worked less than 20 % of their potential during the past year.	EU-SILC	1yr	6.Socio-Economic

JAF code	Name	Definition	Source	Frequency	JAF domain
90	Share of population 65+	Share of population aged 65 and above expressed as a percentage of the total population.	Demographic statistics	1yr	6.Socio-Economic
91	Share of population 80+	Share of population aged 80 and above expressed as a percentage of the total population.	Demographic statistics	1yr	6.Socio-Economic
92	Percentage of population 25-64 with low education	Percentage of population (25-64) with low educational attainment (ISCED 0-2). The educational attainment of an individual is the highest International Standard Classification of Education level successfully completed, the successful completion of an education programme being validated by a recognised qualification (or credential), i.e. a qualification officially recognised by the relevant national education authorities. The aggregate 'lower secondary education attainment' refers to levels 0, 1 and 2 of the ISCED 2011 (less than primary, primary and lower secondary education, online code ED0-2). Data up to 2013 refer to ISCED 1997 levels 0, 1 and 2 but also include level 3C short.	EU - LFS	1yr	6.Socio-Economic
93	GDP per capita (pps)	Gross domestic product (GDP) is a measure for the economic activity. It is defined as the value of all goods and services produced less the value of any goods or services used in their creation. Gross domestic product per capita in purchasing power standards (PPS) is the ratio between the level of gross domestic product (GDP), expressed in purchasing power standards, and total population. GDP in PPS is obtained by converting GDP to a fictive currency using special conversion factors. Purchasing power parities reflect the price ratios between the countries and are at the same time expressed in a single currency. They thus eliminate from national gross domestic products both the differences in currency expression and the differences in the prices levels between the countries. The result is GDP comparable across countries.	Eurostat	1yr	6.Socio-Economic