

SOCIAL PROTECTION SYSTEMS IN EUROPE: THE UNITED KINGDOM

*By Graham Garbutt,
Visiting Professor,
University of the West of England*

Introduction

The 'welfare state' in Britain, providing social protection from cradle to grave, has been a source of immense national pride. In a secular and multicultural society, it (and specially the National Health Service) has been described as the nearest thing we have to a national religion. Its genesis in the aftermath of the second world war was nurtured by the political and popular consensus that this was the time to build a better, more equal society. Seventy year later the momentum created has weakened, however, challenged by the forces of demographic change, financial crisis and marketisation. That earlier consensus is replaced by vigorous debate and highly controversial policy changes.

Institutional context

Social protection policy in the UK has evolved in the context of the structure and geography of political administration and devolution more generally. In contrast with much of the rest of Europe, the UK has an informal, unwritten constitution. This can provide useful flexibility and an ability to adapt to changing needs. But it lacks the certainty and guarantees of a more formal structure: in the UK decision making is often devolved unevenly – sometimes experimentally – and can be re-centralised at the whim of central government. Moreover, there is often little consistency across the departments of central government, based in London.

This experimental, or gradualist, approach is reflected in the different arrangements which apply across the 'nations' that make up the UK. Scotland, Wales and Northern Ireland now enjoy a high degree of devolution for domestic policy – though in total account for only 10m people or about 17% of the population. Scotland and, to a lesser degree, Wales are noted for their more 'generous' public services, allowed within the formal devolved powers they enjoy. Northern Ireland also has some formal devolution. Special arrangements also apply to London, in effect a metropolitan region within England, where the Mayor and London Assembly also enjoy significant autonomy for the affairs of a further 7.5m (13%) people.

The remaining 43m in the UK (70% of the population) live in the regions of England, where governance arrangements in recent decades have been inconsistent, uncertain and subject to repeated change. The inevitable consequence is a highly centralised structure of political and administrative power, with a pervading sense of uncertainty and instability at regional and local scales.

English Pragmatism

In many areas of policy it was left to local municipalities, county councils, business partnerships and others to address weaknesses in strategic planning, and in organisational capacity to implement policy.

Tony Blair's Labour government from 1997 to 2010 introduced eight new regions in England, each of roughly 5 million people. This reflected the idea of a 'Europe of Regions', incentivised by substantial European funding programmes managed at regional scale. For each region new administrative bodies were set up: Government Offices, Regional Development Agencies, and indirectly elected Assemblies. (An experiment with direct elections did not succeed, for complex reasons). The new regional agencies were required to improve coordination of government services, including spatial planning, housing, policing, education and health. Existing regional directors of Public Health were brought into the Government Offices to promote integration of proactive health strategies with other main policies and programmes. Numerous special projects and programmes were set up to address challenges of poverty, unemployment, poor educational attainment, ethnic conflict, and other social issues.

National Health Service structures

Within this evolving and uncertain pattern of administration, the National Health Service created 'Strategic Health Authorities' to provide regional oversight of investment and policy implementation. More recently this was accompanied by various measures to introduce 'competition' or 'contestability', together with wider 'choice' for patients and other service users. In essence this represented an attempt to introduce perceived benefits of private sector competition, culture, and investment in return for profit.

A central idea has been the division between agencies that 'commission' or 'purchase' health services, and those defined as 'providers'. The debate moved on to formulate different organisational models incorporating the 'purchaser/provider split'.

The model developed by the Blair (Labour) government, and only recently changed by the (Conservative/ Liberal Democrat) coalition government elected in 2010, included 'Primary Care Trusts' as the main purchasers.

They were created to specify and buy primary care services from general practitioner (GP) doctors, and secondary care services from hospitals. England's NHS Hospital Trusts typically serve about 0.5m people and include emergency services as well as a range of medical and surgical specialties. These are the key 'provider' services.

But, again, even this relatively simple model has not been static. The Primary Care Trusts have developed to include larger populations, enabling reductions in management costs. The Hospital Trusts have themselves evolved, with the aim that each becomes a 'Foundation Trust' with substantial autonomy and local control and accountability. However, the model also included a national agency, 'Monitor', to oversee the Trusts and ensure good levels of service and financial control, and to intervene to deal with failure.

The idea of 'choice' includes the possibility of greater patient involvement in selecting their doctor, but also the idea that 'provider' hospitals should compete with each other, or with the private sector. The scale of private sector involvement remains uncertain, with the last Labour minister envisaging a

maximum level of about 15% of hospital service provision.

These substantial changes under the Blair government were accompanied by significant increases in public funding, intended to place the UK at about the European average for per capita health spending. It was this commitment that was used to justify the organisational changes sought, and also the use of extensive and centrally defined 'targets' for service improvement. These have shown significant improvements but also led to criticism of too much central control and a compromising of clinical judgement by doctors.

The election of 2010 brought the prospect of further, major change, despite commitments having been made not to engage in more 'top-down' reorganisation. The coalition government has introduced reductions in spending across government, intended to reduce the national budget deficit and public debt but also to reduce the size of the public sector and, it is hoped, facilitate private sector led growth in the economy. These 'cuts' are the most ambitious for a generation with government departments typically asked to reduce costs by about 25%. While the government has vowed to protect the health service from cuts, demographic, scientific and other pressures are now threatening service levels evidenced, for example, in increased waiting times for hospital treatment. And, as other government departments have endured increasingly severe financial constraints, pressure from them has grown for health and social security to become targets for greater cuts.

The government has abolished the regional strategic health authorities. The more local primary care trusts responsible for commissioning health services have also been abolished; to be replaced by consortia of general practitioners (GPs) called Clinical Commissioning Groups (CCGs). The aim is that the GPs will create new organisations, at a scale they think suitable, and create the capacity to manage the 'purchaser' function themselves. This could include deciding, for example, not to purchase some services from hospitals but to seek alternative provision, or to deliver the services themselves. At the same time it is planned that all hospitals will become autonomous foundation trusts, with even greater freedoms to compete in the market place as providers but also, potentially, in employment practices. For example, local or regional consortia of hospital trusts are debating how they might reduce staff costs. Established methods include 'outsourcing' of support services from private or voluntary organisations. But current ideas also include transferring staff, including senior doctors and others, onto 'zero hours' contracts where their hours of work can be varied by managers from full time to zero with related impacts on their income.

This new arrangement should, it is intended, provide a framework for greater patient choice in the health market place, with the market itself adapting services better to meet local needs.

The interface with the wider public sector and its structures of democratic accountability will require new adaptation. The intention is that local municipal government will have an enhanced role in integrating preventative health care with other areas of social policy, and in providing democratic scrutiny of health service provision. Precise arrangements are not yet clear, nor indeed is the adequacy of capacity of local government to take on further responsibilities alongside major budget cuts.

Devolved structures

The government has also introduced major changes in sub-national governance. The former regional bodies had been effective in many of their economic and social programmes but, together with over 100 national agencies, were abolished. English regional governance has been largely 'swept away', to be replaced in part by voluntary partnerships between municipalities and the private sector with limited funding and no additional capacity. Early indications show patchy coverage and effectiveness nationally and there is significant concern about the viability of the model. A recent 2012 report by former deputy prime minister Lord Heseltine ('No stone unturned in search of growth') has urged strengthening of this structure and much increased, and integrated, funding. The government has stated its support but has yet to implement the recommendations.

The government also plans a policy of radical 'localisation' with many powers transferred directly to local municipalities. A reduction in their finances of about 25% creates a challenging context for major change. However, the leading cities are engaged in negotiations to control more government programmes directly, albeit while lamenting the prospect of service reductions – or indeed complete closure of some established service provision.

The Prime Minister, David Cameron, has put significant emphasis on the idea of the 'Big Society', involving much higher levels of voluntary work and local activism. It is not clear how or whether this might offset some of the loss of public sector capacity. It is also not clear how the new arrangements will influence the overall balance of central and local control, since some functions currently managed by regions or government agencies are being transferred to the central civil service.

The changes to sub-national governance more generally have yet to become clear. Fundamentally, the continuing absence of a national framework of constitutional subsidiarity means that there are few clear points of reference or signposts. It may be difficult to provide clarity for service users and providers – in health services and beyond - as to exactly how new arrangements will work, who will make decisions and who will be accountable. There is a great deal to do, little apparent enthusiasm, and resources are tightly stretched. At the moment the risks involved seem more evident than the potential benefits.

'Universal Credit'

Benefit payments in the UK are notoriously complex in their range and application. There has been an associated long-term problem of eligible people not taking up their entitlements. Government policy, strongly supported by sections of the media, and among the wider public, responds to the notion that there are large numbers of 'shirkers' who are too lazy to work and prefer to live on state benefits as a 'lifestyle choice'.

In fact the great majority of benefits go to pensioners, followed by people in work but on low pay. Of course that still leaves significant numbers who, for a variety of reasons, are not in paid employment. Thus a great deal of government policy activity is focused on dealing with this issue, in particular the wish to 'make work pay' by ensuring that payments are less than potential wages. The secretary of state for work and pensions, Ian Duncan Smith, has promised: "Universal credit will mean that people will be consistently and transparently better off for each hour they work and every pound they earn." The current system of means-tested out-of-work benefits, tax credits and support for housing will be replaced by a single income-replacement benefit.

This policy is combined with the broader aim of substantially reducing public spending to create major change, with significant reductions in benefit income for the poorest people. The mechanism is 'Universal Credit', through which a number of separate payment processes will be combined into a single process of assessment and payment. It replaces six income-related work-based benefits:

- Working tax credit.
- Child tax credit.
- Housing benefit.
- Income-related employment and support allowance (ESA).
- Income-based jobseeker's allowance (JSA).
- Income support.

But in fact universal credit is less comprehensive than the name suggests, given that it does not embrace all benefits into one simplified system. A large number of benefits remains, including:

- Contribution-based JSA.
- Contributory ESA (limited to 52 weeks for those in the work-related activity group).
- Attendance allowance (AA) and disability living allowance (DLA) for children.
- Carer's allowance.
- Bereavement benefits.
- Industrial injuries disablement benefit and war pensions.
- Maternity allowance; statutory sick/maternity/paternity/adoption pay (these will be treated as earnings for UC assessment).
- Child benefit and guardian's allowance.
- Pension credit (PC) – unlike now, both partners in a couple will need to be over the prescribed age to get PC, which will also include allowances for children and rent, although in the short-term it appears claimants over PC age will be able to claim tax credits and housing benefit.
- Social fund maternity, funeral, winter fuel and cold weather payments.
- "Passported" benefits: additional benefits (such as free school meals or free prescriptions) to which claimants on certain other benefits and/or tax credits are automatically entitled.

Further detail is provided in the government's document: 'universal credit – frequently asked questions' available at www.dwp.gov.uk/docs/universal-credit-faqs.pdf, an explanatory note to the Welfare Reform Act 2012, itself available at: http://www.legislation.gov.uk/ukpga/2012/5/pdfs/ukpga_20120005_en.pdf

However, the financial sums involved in Universal Credit are very large - roughly £500m per day – and require new structures and systems for payment. New computer systems are currently being developed and tested and these will require all applicants to submit application on-line. This itself will create new challenges for many benefit claimants and for the voluntary and other bodies who try to support them.

Public Officials

In the UK Public officials enjoy access to the same Social Security benefits as others in the wider society. But there is also a strong tradition of pension, sickness, maternity and other benefits being provided through specific public sector schemes. As private sector pension systems have been significantly worsened in recent years, there is a strong sense that public employees enjoy clear – perhaps 'unfair'

- advantages. In particular, their access to "final salary" pensions, where payments are based on a formula that includes years worked and final salary, is regarded as the "gold standard" among UK pensions. In this system, a public employee may typically retire on about half of the final salary plus a capital sum.

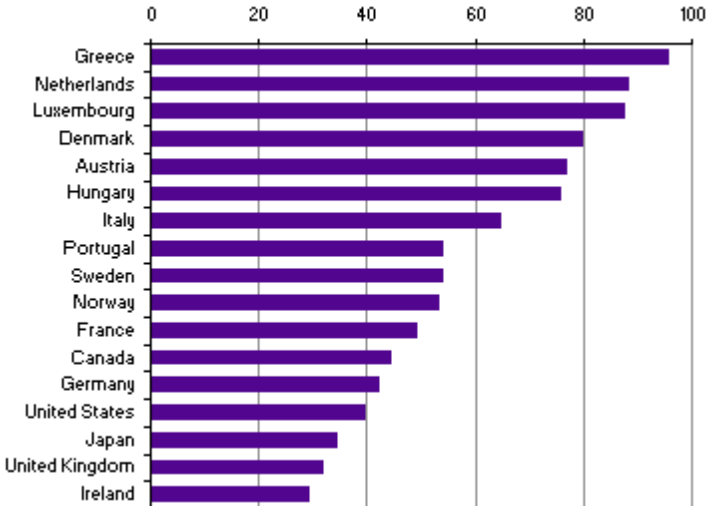
The schemes vary across the public sector, however, providing somewhat different levels of benefit. Funding arrangements also differ. For example, individual local authorities are usually members of a consortium with others, which collectively manages the pension fund for all their employees. This would be an accumulated fund of savings by individuals and contributions by employers, creating an investment fund managed to optimise both long-term investment potential and security. In contrast, the central civil service pension system has no identifiable fund but relies on continuing government commitments to pay pension entitlements from the central exchequer (through future taxation).

As the private sector has become envious of the pensions available to public employees, there has been an increasing tendency to present this arrangement as taxpayers being asked to pay for excessively generous public sector pensions. Initially this has led to the government requiring greater monthly contributions from public sector employees, but is also being used to justify a move away from the final salary schemes. It is reasonable to anticipate further pressure from the media, the private sector and some politicians for continued weakening of public sector pension schemes.

The public and private systems are both constrained by a limit on tax benefits for individual pension funds (whether real or notional), currently set at about £1.5 million. However, while the public system does not provide for the individual owning the specific fund, some provision in the private sector is based on actual contributions and savings, so that the individual can manage a tangible fund with the possibility of both drawing interest on the fund and maintaining ownership.

Moreover, while sound pension benefits are part of the culture of the public sector, private sector pensions often rely on voluntary arrangements without the security of compulsion. This places the UK at the bottom of comparable mandatory pension systems in similar countries:

Gross replacement rate for an average earner from mandatory pension schemes in selected OECD countries^{1 2}



Source: OECD Pensions at a Glance 2011

¹ Netherlands, Denmark, Hungary, Norway and Sweden have a private component in their mandatory schemes.

² For the UK, the model includes all state pensions (the basic and additional state pension and Pension Credit) in mandatory pension schemes; there is no private component.

The public sector has also for some time provided benefits such as maternity and paternity leave and childcare provision at a level higher than is generally available in the private sector. Indeed there is a long tradition of private sector opposition to such benefits, manifest in pressure by the UK government to reduce the requirements of EU regulation. A further example is the working time directive, often presented as an impediment to business competitiveness rather than as a protection of workers' rights.

The growing tendency towards outsourcing of public services has created additional pressures on individuals as pensions have been transferred to the private sector. While there is some protection for individuals through the 'transfer of undertakings' (TUPE) regulations, in practice the main motive behind outsourcing is often the lower costs that can be achieved by reducing both the number and the quality of jobs.

The coalition government's policy more widely has been to reduce the size of the public sector, to 'create room' for private sector growth. This has brought some successes in achieving growth in the number of private sector jobs, potentially offsetting losses through cuts in the public sector. However, there is scant evidence (if any) of positive impacts on growth or improved productivity in the economy. This may be explained by those 'new' jobs being part-time and low paid, with a consequent loss of demand in the economy as more highly paid jobs have been lost.

The net result of these various pressures has inevitably been to create uncertainties for public sector workers about their security and their entitlements, with unavoidable impact on morale. While there seems no doubt that these entitlements are relatively good compared with private sector counterparts, there is little pressure to improve the latter and a growing tendency to present the differences as unfair through parts of the media and political world, creating pressure for further worsening of public sector working conditions. The 'direction of travel' is therefore one of reducing benefits for all sectors.

Recent Developments

The picture that emerges from this set of circumstances is unclear and it is difficult to present a positive view of future prospects. UK governance, both generally and more specifically in relation to social protection, lacks the structure and certainty of a written legal constitution enshrining, for example, the principle of subsidiarity or devolved institutional roles. The public sector is buffeted by the twin forces of severe financial restraint and continuous – seemingly chaotic – change. Its ethos of public service is denigrated as private sector values are imposed in the name of market efficiency, with unproven benefits. The wider public faces economic pessimism, job insecurity, and worsening services. Those in genuine need face a new benefits system designed to encourage people to find paid work and sceptical of those unable to do so.

Perhaps the most striking feature of this current UK context is its contrast with the optimism and humanity of seventy years ago when, despite much greater economic challenges, one of the world's most successful systems of social protection was created.

Graham Garbutt

Annex: the following data are taken from online publications provided by the Office for National Statistics: www.ons.gov.uk, where further and more detailed information is available.

2.1 Disease

Cancers (neoplasms), circulatory diseases and respiratory diseases were the broad disease groups of the ICD-10 (International Classification of Diseases) with the largest numbers of deaths in 2011. Cancers accounted for 30 per cent of all deaths, while circulatory diseases (which include deaths from ischaemic heart disease and strokes) and respiratory diseases (including deaths from pneumonia) accounted for 29 per cent and 14 per cent of all deaths respectively.

Over the course of the 20th century, there have been fairly steady decreases in mortality rates for these three broad disease groups in England and Wales. The reasons for this include improvements in the treatment of these illnesses.

Government backed initiatives to improve people's health through better diet and lifestyle, for example, the Department of Health's White Paper entitled 'Choosing Health: making healthy choices easier' published in 2004 could also have contributed to improvements in mortality rates.

2.2 Disability

More than 10 million people were limited in daily activities in England and Wales in 2011.

The percentage of people with activity limitations has fallen slightly since 2001; by 0.3 of a percentage point in England and 0.6 of a percentage point in Wales; however, prevalence remains 5 percentage points higher in Wales, a similar difference to that in 2001.

People whose activities are limited 'a lot' because of a health problem or disability was more than 3 percentage points higher in Wales (11.9 per cent) than in England (8.3 per cent) in 2011.

Across English regions there was a general north-south divide with percentages of people limited a lot or a little in daily activities lower in the south and higher in the north.

The North East region (21.6 per cent) had the highest percentage of activity limitations and London (14.2 per cent) the lowest.

The London borough of Wandsworth (11.2 per cent) had the lowest percentage of activity limitations and Neath and Port Talbot in Wales (28.0 per cent) the highest.

The ten English local authorities with the lowest percentage of activity limiting health problems or disabilities were located exclusively in London and the South East.

London and other large urban conurbations in England such as Manchester experienced the greatest reductions in activity limitations since 2001, while rural local authorities, such as East Lindsey in Lincolnshire, experience the greatest rise in prevalence.

The percentage of activity limitations in Liverpool, the most deprived¹ English local authority, was 10.4 percentage points higher than Hart in Hampshire, the least deprived local authority.

The level of inequality by area disadvantage groupings has fallen since 2001 by 3.2 percentage points in Wales and by 3.3 points in England.

2.3 Maternity

In 2010, the estimated number of conceptions in England and Wales rose by 1.4 per cent to 909,245 from 896,466 in 2009. This increase is a continuation of the trend in the rising number of conceptions recorded since 2001, despite a slight fall (of 0.8 per cent) between 2007 and 2008. This is the first time since the Abortion Act (1967) came into force that the number of conceptions has risen above 900,000. Prior to 1969, the first year for which abortions data are available, the number of conceptions was equivalent to the number of maternities.

The conception rate for 2010 has increased to 82.3 conceptions per thousand women aged 15–44, from 80.9 in 2009, a rise of 1.7 per cent. The proportion of all conceptions resulting in a maternity in 2010 was 79.2 per cent. This proportion has remained fairly stable over the last two decades.

The under 18 conception rate for 2010 is the lowest since 1969 at 35.5 conceptions per thousand women aged 15–17.

The estimated number of conceptions to women aged under 18 also fell to 34,633 in 2010 compared with 38,259 in 2009, a decline of 9.5 per cent.

The estimated number of conceptions to girls aged under 16 was 6,674 in 2010, compared with 7,158 in 2009 (a decrease of 6.8 per cent).

In 2010 there were an estimated 909,245 conceptions in England and Wales, compared with 896,466 in 2009, an increase of 1.4 per cent.

Conception rates in 2010 increased in all age groups, with the exception of women aged under 20.

2.4 Dependents

There were 7.7 million families with dependent children in the UK in 2012, 1 in 7 of which had three or more dependent children

Married couples had a higher average number of dependent children in their family than other family types, at 1.8 children per family compared with 1.7 on average

The UK has a higher percentage of households with three or more children than three-quarters of European Union countries

Nearly 9 in 10 couple families with three or more dependent children had either one or both parents working

2.5 Occupational hazards (accidents and occupational diseases)

The statistical links between occupations and causes of death have been investigated in a report published by the Office for National Statistics (ONS) and the Health and Safety Executive (HSE).

The job groups accounting for the largest numbers of deaths of men from asbestos-related disease were carpenters, production fitters, electricians, plumbers and gas fitters, and certain groups of construction workers.

Coal miners had the highest mortality from other pneumoconiosis, but non-coal miners and quarry workers had the highest proportion of deaths from silicosis. This group also had a high proportion of deaths from tuberculosis, which is a recognised complication of silicosis.

There was high proportional mortality from almost all the causes of death associated with alcohol in both male and female publicans and bar staff, male caterers, cooks and kitchen porters and seafarers. This was a similar finding to that of the previous decennial supplement, covering the period 1979-90.

Sino-nasal cancer is a recognised hazard of occupational exposure to wood dust (especially dust from hardwoods used in the manufacture of furniture), dust from vegetable tanned leather (used to make the soles and heels of welted boots and shoes), and some nickel compounds. In addition, a link has been proposed with inhalation of textile dust^{6 7}. Relatively high PMRs were observed in carpenters, and especially in cabinet makers (who tend to work more with hardwoods than carpenters). There was also a significantly elevated PMR in female spinners and winders, but not in other textile jobs either in men or women. No clear excesses of mortality were apparent in leather and shoe workers, electroplaters or welders.

Aircraft flight deck officers, who had significantly elevated mortality from melanoma in 1979-90¹ again had high mortality from the disease. High rates of melanoma in pilots and aircrew have been reported in several other studies and some researchers have suggested that their exposure to cosmic radiation could be a contributing factor. Otherwise, the findings for skin melanoma do not point to occupational hazards.

Shift work and work-related stress have been suspected of contributing to occurrences of ischaemic heart disease, but no occupational hazard was suggested by the results. Recently, shift work has been associated with increased rates of breast cancer, but this analysis provides no support for those findings (see section on Other Cancers below).

There were significantly raised PMRs for pneumococcal and unspecified lobar pneumonia in sheet metal workers and welders who are exposed to metal fume. This pattern has been seen in analyses relating to earlier periods. Among men, an estimated excess of approximately 1300 deaths over the 10 year period were associated with accidents that could reasonably be attributed to work, the largest contributing categories of accident being motor vehicle accidents (500 excess deaths), injury by machinery (117) and falls from buildings (96).

Among women, the excess mortality from injuries that were likely to be occupational was much smaller (52), the main contributions being from motor vehicle accidents (29 excess deaths). More than 4 per cent of the deaths occurring to female lorry drivers and other motor vehicle drivers at working age were accounted for by motor vehicle accidents.

Among both men and women, the occupations with highest mortality from suicide were in health related occupations such as doctors, dentists, nurses and veterinarians. Male farmers also had high PMRs for suicide.

2.6 Age

Life expectancy at birth in England and Wales in 2009-2011 was 78.7 years for boys and 82.6 years for girls.

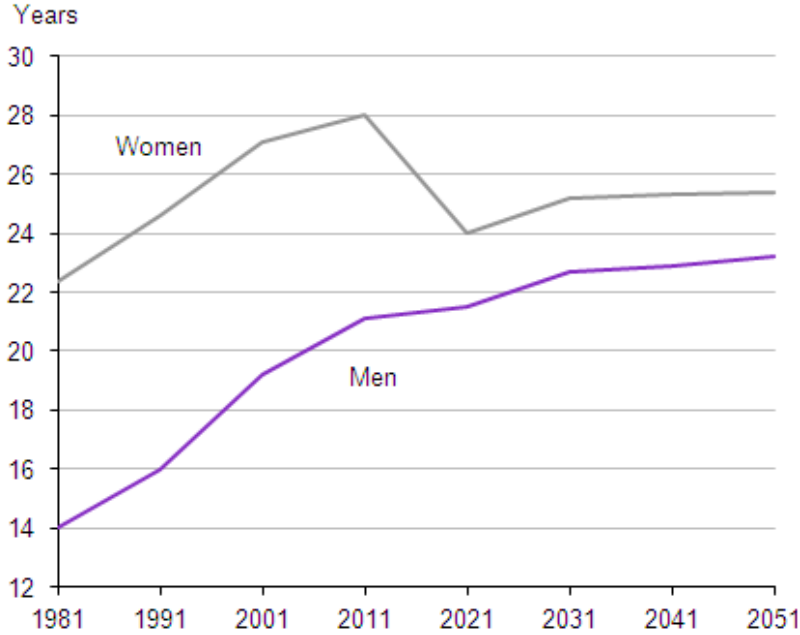
The gap between life expectancy at birth for boys and girls has narrowed from six years in 1980-1982 to four years in 2009-2011.

Over the last three decades life expectancy at birth has increased by four hours per day for females and six hours per day for males.

According to mortality rates in 2009-2011, 91% of baby girls and 86% of baby boys born in this period will reach their 65th birthdays. This has increased from 84% and 74% respectively in 1980-1982.

The chance of surviving from birth to age 85 has more than doubled for men over the last three decades from 14% in 1980-82 to 38% in 2009-2011.

Cohort life expectancy at State Pension Age, UK



Source: ONS

2.7 Unemployment/ job loss

The employment rate for those aged from 16 to 64 was 71.4%, virtually unchanged from September to November 2012 but up 0.9 percentage points from a year earlier. There were 29.70 million people in employment aged 16 and over, down 2,000 from September to November 2012 but up 488,000 from a year earlier.

The unemployment rate was 7.9% of the economically active population, up 0.2 percentage points from September to November 2012 but down 0.3 from a year earlier. There were 2.56 million unemployed people, up 70,000 from September to November 2012 but down 71,000 from a year earlier.

The inactivity rate for those aged from 16 to 64 was 22.2% (the lowest since 1991), down 0.2 percentage points from September to November 2012 and down 0.7 from a year earlier. There were 8.95 million economically inactive people aged from 16 to 64, down 57,000 from September to November 2012 and down 285,000 from a year earlier.

Total pay rose by 0.8% compared with December 2011 to February 2012, the lowest growth rate since September to November 2009. Regular pay rose by 1.0 per cent over the same period, the lowest growth rate since records began in 2001.

SITES OFFICIELS

- Allemagne : Bundesregierung
- <http://www.bundesregierung.de/>

- Allemagne : portail du CIDAL
- <http://www.amb-allemande.fr/ambassade/portail/politique/index.html>

- Autriche : www.help.gv.at
- <http://www.help.gv.at/>

- Belgique : Belgium federal government on line
- <http://www.belgium.be/eportal/application?languageRedirected=yes>

- Bulgarie : site du gouvernement
- <http://www.government.bg/>

- Chypre : gouvernement
- http://www.moi.gov.cy/moi/pio/pio.nsf/index_en/index_en?opendocument

- Danemark : [Danmark.dk](http://www.danmark.dk)
- <http://www.danmark.dk/>

- Espagne : Ministerio de administraciones publicas
- <http://www.map.es/>

- Estonie : gouvernement
- <http://www.valitsus.ee/>

- Finlande : Virtual Finland
- <http://virtual.finland.fi/>

- France : www.service-public.fr
- www.fonction-publique.gouv.fr

- Grande-Bretagne : Civil service
- <http://www.civilservice.gov.uk/>

- Grande-Bretagne : Documentation officielle
- <http://www.official-documents.co.uk>

- Grande-Bretagne : site officiel du gouvernement
- <http://www.direct.gov.uk/Homepage/fs/en>

- Grèce : Hellenic Republic - the Prime minister's office
- <http://www.primeminister.gr/>

- Hongrie : Premier ministre

- <http://www.meh.hu>
- Irlande : Gouvernement d'Irlande
- <http://www.irlgov.ie/>
- Italie : Gouvernement italien
- <http://www.palazzochigi.it/>
- Portail italien à destination du citoyen
- <http://www.italia.gov.it/servlet/ContentServer?channel=HTTP&pagename=e-Italia/HomeHttp>
- Lettonie : Présidence de la République
- <http://www.president.lv/index.php?pid=410>
- Lituanie : gouvernement
- http://www.lrvk.lt/main_en.php
- Luxembourg : Portail de l'administration luxembourgeoise
- <http://www.etat.lu>
- Pays-Bas : Overheid.nl
- <http://www.overheid.nl/>
- Pays-Bas: Gouvernement
- <http://www.regering.nl/index.jsp>
- Pologne : The official website of Poland
- <http://www.poland.pl/>
- Portugal : Infocid
- <http://www.portaldocidadao.pt/PORTAL/pt>
- Portugal : Visite o governo
- <http://www.portugal.gov.pt>
- Roumanie : Site officiel du gouvernement
- <http://www.gov.ro/franceza/>
- Slovaquie : gouvernement
- <http://www.government.gov.sk/english/>
- Suède : Regeringskansliet
- <http://www.regeringen.se>
- Suède : SverigeDirekt
- <http://www.sverige.se/>