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(b) Review of recent social policy reforms for a fair and competitive Europe
- 2014 Report of the Social Protection Committee

Delegations will find attached the report on the above subject submitted by the Social Protection Committee. The key messages which are drawn from this report are contained in doc. 13693/14, with a view to the Council meeting (EPSCO) on 16 October 2014.



Review of recent social policy reforms for a fair and competitive Europe

2014 Report of the Social Protection Committee

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Abbreviation	Full name
EU28	European Union (28 countries)
EU27	European Union (27 countries)
BE	Belgium
BG	Bulgaria
CZ	Czech Republic
DK	Denmark
DE	Germany
EE	Estonia
IE	Ireland
EL	Greece
ES	Spain
FR	France
HR	Croatia
IT	Italy
CY	Cyprus
LV	Latvia
LT	Lithuania
LU	Luxembourg
HU	Hungary
MT	Malta
NL	Netherlands
AT	Austria
PL	Poland
PT	Portugal
RO	Romania
SI	Slovenia
SK	Slovakia
FI	Finland
SE	Sweden
UK	United Kingdom

1. Introduction

The present annual review delivers on the **Social Protection Committee (SPC)** Treaty-based mandate (art.160 of TFEU) to monitor the development of social protection policies in Member States and the Union, including social inclusion, pension, health and long-term care. It is complementary to the SPC annual report on the social situation in the European Union¹. The report focuses on the most recent social policies' reforms over the period 2013-2014 and aims at assessing the main directions of reform efforts in the field of social protection, building on the instruments of the social open method of coordination (OMC). It is to be seen as a follow-up to the 2013 SPC report on "Social policy reforms for growth and cohesion: review of recent structural reforms 2013." It is based on the National Social Reports submitted by Member States in 2014² in the context of the social OMC as well as the Member States reporting done in the framework of the European Semester.

Assessing national reforms takes place - from a formal and institutional point of view - within the European Semester and culminates in country-specific Council recommendations on a proposal from the European Commission. Therefore, the purpose of this report is neither to replace this collective assessment mechanism nor to present a critical view on the various reforms and on their objectives. Its aim is to review these reforms by adopting a comprehensive approach to the social protection systems as a whole (social inclusion, health and long-term care and pensions).

The report includes a thematic section dedicated to youth exclusion as one of the most important social challenges resulting from the economic crisis. It is one of the very few comparative analyses available, which takes a strictly social protection view on youth exclusion and provides valuable information on the capacities and strategies of social protection systems to cope with the high number of young people who remain outside of the labour market.

The conclusions of the report aim at providing the Committee's contribution to the preparatory process leading to the adoption of the 2015 Annual Growth Survey (AGS) in terms of social policy challenges and policy reform priorities for the Union in the short-term. The review of health care policies and the relevant health aspects of the key conclusions have been adopted jointly with the **Council Working Party on Public Health at Senior Level**.

¹ <http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7695&type=2&furtherPubs=yes>

² All National Social Reports can be found at the following link:
<http://ec.europa.eu/social/keyDocuments.jsp?advSearchKey=nsr2014&mode=advancedSubmit&langId=en&policyArea=&type=0&country=0&year=0>

Table 1. Overview of social policy reforms for the period 2013-2014

	Social inclusion reform				Pension reforms							Health care reforms					Long-term care reforms	
	poverty reduction and supporting people's entry into the labour market	investing in children	social inclusion of ethnic minorities	housing/homelessness	tightening of early retirement	improved access to early retirement	increase in retirement age	harmonization of retirement age between men and women	contribution period	pension levels	Pension indexation	promoting affordability and security of funded and private pension schemes	structural changes in the organization and financing of health care systems	health service delivery (including e-health)	investing in the health workforce	cost containment and cost-sharing	enhancement of access to services and of patient's rights	
BE	•		•	•	•		•		•		•	•	•	•	•	•	•	•
BG	•	•	•			•				•		•	•	•	•	•	•	•
CZ	•	•	•	•														
DK	•	•	•		•	•												
DE	•	•	•		•	•	•		•			•			•			•
EE																		
IE	•	•		•			•				•							•
EL																		
ES	•	•			•		•			•		•	•	•	•	•	•	•
FR		•			•		•		•									
HR					•													
IT																		
CY	•	•			•		•		•			•	•	•	•	•	•	•
LV	•	•	•	•		•												
LT		•		•														
LU	•	•																
HU	•	•	•															
MT																		
NL	•	•	•	•														
AT	•	•	•		•		•					•	•			•	•	•
PL	•	•	•									•	•					
PT	•	•	•		•		•			•				•				
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SK	•	•	•	•														
FI	•	•	•	•														
SE	•	•	•															
UK	•	•	•	•			•				•	•	•		•	•	•	•

2. Recent reforms in the area of social inclusion, poverty reduction and Roma inclusion

As highlighted by the most recent SPC report on the social situation in the European Union³, the crisis leaves behind the legacy of fragile growth, too little and often low quality jobs and more people exposed to poverty and social exclusion. The Social Protection Performance Monitor (SPPM) and the scoreboard of employment and social indicators⁴ show that the social situation in the European Union is not improving while in some countries the situation is even worsening. 2012 survey data indicate that poverty has reached its 6 year-high: close to 25% of the European population was at risk of poverty or social exclusion. Since the adoption of Europe 2020 in 2010, there are close to 7 million more people living in poverty or social exclusion (an increase in more than 1/3 of Member States). In some Member States the annual growth of the relative poverty exceeds 2 percentage points. Rising material deprivation drives down living standards of significant parts of the population in some countries. Income inequality is growing across and within Member States, particularly in the countries that witnessed the largest increases in unemployment.

This year's results from the analysis of the key social indicators, part of the SPPM, show that the most recent social trends to watch (2011-2012) are related to an increase in poverty and social exclusion for the overall population, driven by a significant increase in the severe material deprivation rate and the share of (quasi-) jobless households, increasing depth of poverty, continuing increase in the number of children living in poverty and social exclusion, increase in youth unemployment and the working poor as well as in the housing cost overburden rate.

On this background, improving the functioning of social protection systems and reducing poverty has been a continuous focus of the Council recommendations to a number of Member States.⁵

The reform measures implemented by Member States addressing these issues can be broadly grouped as in the table below.

Overview of social inclusion reforms (2013 – 2014)

Area of policy reforms		Member States
Poverty reduction and supporting people's entry into the labour market	Support for entry into employment and active labour market policies	AT, BE, BG, CY, CZ, DK, ES, HU, IE, LV, NL, PT, RO, SI, SK
	Social assistance benefits and minimum income support schemes	BE, CY, IE, LU, PL, PT, RO, SI, UK
	Specific measures targeting groups	AT, BE, CY, FI, IE, LV, RO, SE, SI,

³ SPC (2014) *Social Europe: many ways, one objective*

<http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7695&type=2&furtherPubs=yes>

⁴ See Chapter 3 of the 2013 Joint Employment Report

⁵ http://ec.europa.eu/europe2020/index_en.htm

	at higher risk of poverty	SK, UK
Investing in children	Enabling access to child care	BG, CZ, DE, FR, LT, LV, SI, UK
	Supporting employment for people living in households with dependent children	AT, CY, CZ, DE, DK, ES, FR, FI, IE, LU, NL, PT, SE, SI
	Preventing child poverty	BG, IE, LT, LV, RO, SE, SI, SK
Social inclusion of ethnic minorities		AT, BE, BG, CZ, DK, FI, HU, LV, PL, RO, SE, SK
Housing/homelessness		BE, CZ, FI, IE, LT, LV, NL, SI

2.1 Measures for reducing poverty and supporting people's entry into the labour market

Most Member States continue to strengthen their policy responses to the economic slowdown, in line with National Reform Programmes and the Council recommendations. As labour market conditions have shown only fragile signs of recovery, many Member States have reinforced and consolidated the set of labour market measures they had adopted at earlier stage. These measures aim to preserve employment, support activation and promote re-integration in the labour market, while anticipating and managing the adverse impact of restructuring. New or reinforced measures focus on flexible working time arrangements, which are seen as effective means to maintain people in employment in response to short term shocks, as well as a way to further enhance active labour markets and ease labour taxation.

In **AT**, the relatively low risk of poverty and social exclusion has remained stable during the crisis. The government approach to preventing poverty focuses on support for labour market participation, but it does not substantially address the issues of quality of work and distribution of working time. Consequently, the poverty gap increased more steeply than the EU average between 2008 and 2011, although due to a modification of data collection these results have to be interpreted with caution.⁶

Moreover, a reform of the unemployment benefit system was enacted in **BE** in order to ensure an appropriate balance between the benefit and effective job search assistance and training opportunities. Several measures reducing the employees' social security contributions and increasing the work bonus have been taken. The cooperation agreement between the Regions and the Federal government foresees to increase the job search assistance intensity across the country. Over the past few years, policy makers have attempted to tackle the unemployment trap by means of targeted measures aimed at the bottom of the pay scale. The recent reform of the unemployment benefit system improves its overall design in several respects. The rate at which regular unemployment benefits are reduced over time has been increased, while activation policies and availability to work

⁶ See also SPC (2014) *Social Europe: many ways, one objective*. Country profile AT, note I, p. 376

requirements have been stepped up. Several activation policies have been gradually extended to include older age groups and the follow-up, job search guidance and retraining services by the public employment services have been improved. A new step was taken in the preparation of the reform of the scheme for benefits for persons with a disability aimed at the integration and the full and effective participation of people with disabilities in society.

The efficiency and effectiveness of active labour market policies (ALMPs) remain a challenge for **BG**. Given overall low spending levels on unemployment benefits, spending on ALMPs is particularly low, which is reflected in the low transition rates from unemployment to employment and in the relatively high share of long-term unemployed. A net impact assessment of the efficiency and effectiveness of active programmes and measures on the labour market as well as of the overall effect of ALMPs has been launched in 2013. The government has carried out an analysis to assess the impact of the minimum insurance thresholds on the dynamics of unemployment in the country, including on the process of dismissal of low-qualified workers. The first results showed no significant impact of minimum thresholds on low-skilled workers at aggregate level, whereas a more significant impact was observed in labour-intensive sectors. A second study was completed in May 2014.

On its turn, **CY** is also undertaking a comprehensive revision of its system of ALMPs, improving the design, administration, and monitoring of the different measures. With respect to the administration, a uniform monitoring and evaluation framework has been developed to be applied to all ALMP, and a common database is being established so as to improve coordination and automatic exchange of information between the different implementing bodies.

In **CZ**, further measures were introduced in the follow-up to the 2013 reform of the Public Employment Services with a view to developing methods for more effective monitoring and implementation of activation programmes. Many projects aimed at employment of people over the age of 50 have been supported by Public Employment Services. The financial support of the creation socially useful jobs has started to be very popular tool.

In **DE**, the risk of poverty and social exclusion has declined during the crisis. Unemployment has fallen - explicitly long-term unemployment and the numbers of people in very low work intensity households. But the still existing relative high risk of poverty increased slightly. Presently, the DE labour market offers more opportunities than rarely before. However, not all concerned have benefitted from the positive development of the labour market. The remaining long-term unemployed only benefit below-average from the positive labour market developments.

Thus, due to the demographic challenge and the positive labour market situation the **DE** Federal Government will focus its employment and labour market policies on tackling long-term unemployed, women not attached to the labour market and low skilled employees. Hence, **DE** aims at further reducing the number of long-term unemployed, at offering matching qualifications to low skilled and long-term unemployed persons, at placing them on the general labour market, and at creating equal opportunities in the field of education for all population groups. Particularly, **DE** aims at improving employment prospects for long-term unemployed persons by a program which comprises addressing the assessment of employers and acquiring jobs for long-term unemployed, stabilizing employment by coaching of employees, and a temporary financial compensation for employers during periods of reduced productivity of the former unemployed. Moreover, as of 1 January 2015, **DE** recently has introduced a national minimum wage of 8,50 € with the aim to reduce

the high inequality of market incomes. Last, but not least, in the case of neediness beneficiaries able to work still receive benefits within the framework of the basic provision for jobseekers to secure their subsistence levels.

Also in **DK** the focus of the social protection reforms undertaken recently is on activation policies. In January 2014 a reform of the social assistance system entered into force, which includes a range of active labour market policies. Furthermore, the unemployment benefit has been limited to a maximum of two years, which increased the reliance of many long-term unemployed on social assistance. In February 2014 an expert committee on active labour market policies made a number of recommendations on unemployment benefits for insured workers, mainly advising earlier, more individualised and job-targeted measures. Recommendations on activation measures for un-insured workers (on social assistance or without financial support), which are particularly relevant for groups at the margins of the labour market, are due later in 2014.

ES adopted in January 2013 a programme for professional requalification (PREPARA programme) which focuses on activation policies and on labour market reintegration. The transition to an evaluation and outcome-oriented system will be corroborated in the 2014-16 activation strategy. The strategy provides a framework for all the policy interventions and measures regarding active labour market policies and public employment services, with the aim of improving the employment of young workers, older workers and long-term unemployed, stepping up the quality of occupational training, reinforcing the links between passive and active labour market policies and supporting entrepreneurship. The **ES** government is also preparing several legislative instruments that are needed for the implementation of the activation strategy, most notably a common catalogue of employment services, which, inter alia, will detail the minimum services to be provided by the public employment service. Also, measures to better link active and passive labour market policies, including improving incentives to work, are being developed.

The **FR** authorities established a Responsibility and Solidarity Pact, which includes measures impacting on lower incomes: a reduction of up to 3% of employees' social contributions for wages up to 1.3 minimum wages as of 2015 and a reduction of income tax for low and average wages from 2014 onwards.

The **HU** authorities have taken a series of measures to strengthen active labour market policy measures and to enable the Public Employment Services to improve their skills-matching capacity. A number of reforms were initiated with the purpose of addressing the low activity rate, such as increasing retirement age and restricting early retirement, a review of the disability pension and benefit system, changes in unemployment and social assistance system, a widened public work scheme and easing return from parental leave.

In **IE**, under the Troika Memorandum of Understanding, a structural reform package was introduced to underpin growth and to reform social security spending. Labour market reforms were a major focus of the EU-IMF programme of financial assistance, with a focus on active labour market policies, job creation and entitlements reforms. Additionally, the IE government adopted measures to facilitate the adjustment to the labour market and strengthen activation measures, to reduce the risk of long-term unemployment and to tackle unemployment and poverty traps. The 'Pathways to Work' strategy seeks to put in place a modern activation system through the establishment of Intreo offices staffed by trained case-officers, which are expected to be operational by end-2014. Moreover, the IE

authorities have made significant efforts to foster job creation. The first Action Plan for Jobs was launched in 2012 to coordinate job-creation initiatives across all government Departments. It has become an annual process that increasingly involves stakeholders in the preparatory and monitoring phases. As part of its activation measures, the IE government set out its intention to reform the social benefits system by reducing the rate of Jobseeker's Allowance for young people: claimants aged under the age of 26 will receive a lower amount of support; claimants above 26 will continue to receive 188 Euro per week. In parallel, reforms improving the further education and training system sought to facilitate the re-skilling and up-skilling of the labour force. Recent legislative changes that provided for the dissolution of Vocational Education Committees and the establishment of new Education and Training Boards (ETBs) as well as the establishment of a new Further Education and Training Authority (SOLAS) have the potential to impact positively on the labour market and to increase social inclusion, by ensuring the efficiency and relevance of vocational training and education programmes, matching vocational training to labour market demands and activating the long-term unemployed.

In LV, the coverage for ALMPs continued to increase in 2014 as compared to previous year. The share of financing for public works in the total ALMP package has decreased from 31% to 25%. At the end of 2013, the LV authorities amended the legislation so as to define criteria for 'suitable job' (a job that cannot be refused while on unemployment) and provided a coherent legislative framework for job search assistance. As of 2013, a more targeted approach to encourage different groups of the unemployed to return to the labour market is being implemented including the introduction of a profiling system. A variety of measures, sequenced in the most effective order are offered to the target groups. The duration of unemployment benefit was extended to 9 months for unemployed irrespectively of the contribution period as of 1 January 2013. The LV government has also reduced the social security contributions while the Personal Income Tax non-taxable minimum was increased as of 1 January 2014. Further decreases of the Personal Income Tax Rate are planned from the beginning of next year. As a result of these reforms, the tax wedge on low wage earners for families with dependants has decreased, while the tax wedge on single earners decreased marginally and remains high. A pilot project has been carried out, focusing on a closer co-operation of PES with municipal social services and aiming at more effective labour market integration of long-term unemployed.

The NL authorities took relevant measures to increase the labour participation of people with a labour disability through a new Participation Act, which will be implemented from January 2015. The Participation Act aims to improve labour market participation of people with a labour disability through the merger and reform of several benefit schemes while shifting responsibility for their execution to the level of municipalities and reducing overall funding. The NL government has worked on a comprehensive reform of the unemployment benefits scheme and the employment protection legislation (*Ontslagrecht*), which has resulted in a new act call ('*Wet Werk en Zekerheid*'). Upon entry into force, in July 2015, the reforms will reduce the complexity and the costs of dismissal procedures by prescribing a clear dismissal route and decreasing the maximum amount of severance pay or 'transition payment' to EUR 75,000 or a yearly salary, improving the fairness and simplicity of the system. In addition, rules concerning flexible work are being tightened for employers. As concerns the unemployment benefit system, NL will gradually reduce the maximum duration of the publically funded unemployment benefits from 38 months in January 2016 to 24 months in 2019. Furthermore

the pace of accrual of unemployment benefits rights will be decreased and the period after which a benefits recipient has to accept all job offers will be decreased from twelve to six months.

PT has implemented a wide range of labour market reforms since the beginning of its Financial Assistance Macroeconomic Adjustment Programme. Active labour market policies have been streamlined with the aim of increasing its effectiveness in supporting employment creation, strengthening activation and offering more effective training opportunities. With a view to fostering job creation in open-ended contracts and addressing duality, severance payments for permanent contracts have been reduced and the conditions of fair dismissals have been eased. With the aim of facilitating wage adjustment, measures have been implemented to widen the scope for bargaining at firm level. Unemployment insurance benefits have been revised to increase incentives for a rapid return to work, while guaranteeing a sufficient level of protection and enlarging its coverage.

In **RO**, a new Law puts renewed emphasis on ALMPs, in particular vocational training, recognition of prior learning and mobility incentives and opened up to the long-term unemployed. The recently proposed reform is expected to support placement, especially for young long-term unemployed.

In **SK**, a reform of ALMPs has been in force since May 2013 in the form of an amendment to the Act of Employment Services with the aim of improving the targeting and efficiency of such policies. The reform focuses on the disadvantaged job seekers, in particular, the long-term unemployed, young people, persons over the age of 50 and job seekers with little or no education and provides for the streamlining of active labour market measures and for job matching schemes based on labour demand at regional level. In January 2014, the **SK** government introduced requirements for benefits recipients to accept work in order to continue to receive benefits, tightening benefit provisions to reduce abuse and increase incentives to work. The relatively low expenditure on active labour market policies — including education and training — declined over the past two years, as did the number of people taking part in relevant programmes. In January 2014, **SK** also introduced work conditionality for recipients of social assistance. The reform pursues a tightening of benefit provision in order to reduce misuse and increase work incentives. The coverage and adequacy of unemployment and social assistance benefits are below EU average. Furthermore, the relatively small spending on ALMP has further declined during the last two years and so did the number of participants. In November 2013, the **SK** parliament adopted an Act on Assistance for people in material need that introduced new measures and conditions for the activation of people in material need.

In 2013, with continuing low demand for labour, **SI** implemented new active labour market policy measures. The share of GDP invested in active labour market policies is low but increased in 2013 compared to 2012. The number of participants also increased, but the share of older workers remained roughly the same. A public works programme targeting the long-term unemployed totalling 43 million EUR was adopted in 2014. It promotes new activities in social enterprises for vulnerable groups, but it does not address the needs of low-skilled or older workers. An evaluation on the impact on segmentation of the 2013 labour market reform was carried out this year. The reform aims at reducing segmentation and introducing greater flexibility in the labour market by: reducing protection of permanent contracts, by simplifying dismissal procedures in case of individual and collective dismissals and by reducing dismissal costs. The first results point towards decreased

segmentation, while labour costs have been further tackled in four collective agreements renegotiated between the social partners after the adoption of the reform.

Member States (**BE, CY, FR, IE, LU, PT, RO, UK**) have also further enhanced their measures to support people's income. Several countries have adopted comprehensive packages to reinforce their safety nets. New measures have especially been taken in **BE, CY, SK** and **UK** in order to strengthen unemployment benefits while paying attention to avoiding disincentives to get back to work. Member States have reinforced minimum income schemes especially in countries where they appeared weak under the increased pressure created by the economic downturn. Almost all EU countries have some form of minimum income scheme at the national level, while those Member States that do not have one, such as **IT**, have some sort of schemes at the regional or local level. The schemes are generally conceived as a short-term form of assistance (though formally not time-limited in most Member States). They are means-tested and funded through the tax system (i.e. non-contributory). They mainly target people out of work but some Member States have extended their scope to provide in-work income support.

Several Member States (**AT, BE, CY, FI, IE, LT, LV, PL, RO, SE, SI, SK, UK**) also report on the specific support provided to groups at risk, notably youth, families with children and the disabled. Some Member States (**CZ, SE**) also reported on measures to ensure equal opportunities between women and men.

The **AT** federal social welfare office launched at the end of 2013 an employment campaign for people with disabilities, which includes different approaches to integrate people with disabilities in the labour market in the best possible manner.

In **BE**, the public authorities have taken a series of policy actions aiming at poverty reduction and fostering social inclusion, such as: the increase of social assistance benefits, the adoption of a new method for the calculation of social contributions for self-employed linked to the current economic situation, the reduction of VAT on electricity, actions to combat child poverty and the creation of a network of anti-poverty officials in the federal public administration in view of the more effective implementation of the federal anti-poverty plans. Thus, as of 1 September 2013, all social assistance benefits (integration income, income replacement allowance for disabled persons and income guarantee for the elderly) were increased by 2%. The social security minima were also increased: the minimum pension for employed and self-employed persons (+1.25%), the unemployment minima (+2%) and the invalidity benefit minima for regular (+ 1.5 %) and irregular (+ 2.0%) workers. Furthermore, as of January 2015, the social contributions for self-employed persons will be calculated according to a new method on the basis of the income of the year in which they are due, with a view to reducing the poverty risk among self-employed persons.

In **CY**, a new legislation aimed at enhancing the efficiency and effectiveness of the social welfare system including the Guaranteed Minimum Income (GMI) provision, while protecting persons in disadvantaged situations was enacted on 11 July 2014. The reform of the social welfare system focused on the replacement of the public assistance programme with the GMI scheme. The new GMI covers the basic needs defined on the basis of a new minimum consumption basket, delivered using budget standard method, and additional allowances for housing cost and municipal taxes. Its coverage has been expanded to include those not currently covered by the public assistance scheme (such as the working poor and the self-employed). The new scheme will be financed by rationalising

the targeting of the other social benefits through consistent and encompassing means testing mechanisms. A strong link between the implementation of the GMI and ALMPs has also been established in order to avoid benefit dependency.

In January 2014, the **CZ** government approved a comprehensive 'Strategy on Social Inclusion 2014-2020', which represents a complex approach to fighting poverty, combining access to housing, social services, access to health services and other elements. Further strategic documents have been prepared in order to promote equal opportunities for women and men, including support for a higher employment rate of women and measures to reconcile work, family and private life, such as the adoption of a Strategy for the equality between women and men 2014-2020 and the preparation of the Action Plan for a balanced representation of women and men in decision-making positions.

In December 2013 a political agreement was reached in **DK** on a sickness benefit reform. For persons with short periods of illness, the follow-up will now be closer. The 12-month limit is now abolished for persons with a 'life-threatening disease', which improves their financial security.

The **FI** government has recently introduced several national reforms in order to improve the efficacy, quality and cost-efficiency of social protection policies, such as measures for supporting employment and preventing exclusion, improving the status of immigrants, implementing of youth guarantee, developing of rehabilitation services, establishing a new policy for parents to share childcare leave.

FR adopted in January 2013 a 5-year plan against poverty and social inclusion which consists of 61 different measures. Significant actions have been taken, among which a 2% increase in the minimum income benefits on top of the inflation rate as well as increased minimum social benefits for low-income and single-parent households.

The **HU** government has also taken some steps to mainstream the objectives of the National Social Inclusion Strategy into all policy fields in order to reduce poverty. An evaluation of the implementation of the National Social Inclusion Strategy was first made in 2012 and it was followed-up in May 2013 on the basis of a monitoring system containing a specific set of indicators.

IE commenced a major reform of welfare provision for lone parents with children aged seven years and over, in order to improve the access to the labour market and to reduce a persistently higher rate of poverty. A transitional arrangement enables lone parents to claim jobseeker's allowance while exempting them from the conditions that require availability for and genuinely seeking work.

The **LU** government is currently planning a reform of the minimum income scheme in order to better respond to the needs of specific population groups and to specific situations. One of the most pressing challenges is represented by the number of people living in households with very low work intensity, which has increased slightly between 2010 and 2012 (from 5.5% to 6.1%), though it is still among the lowest in the EU. Particularly worrying is the in-work at risk of poverty rate for single parents, the second highest in the EU. The **LU** government proposed six measures to achieve the poverty target, which seek to increase activation among the beneficiaries of the guaranteed minimum income scheme, focusing on women and single parent families.

LT adopted a Law on Cash Social Assistance for Low-Income Residents, which became effective in 2013, enhanced the role of self-government with regard to provision of support to poor residents, created more favourable conditions to more efficiently and in a socially just manner provide this

support, to reduce possibilities for misuse of cash social assistance and promote quicker integration of persons into the labour market. In order to reduce the scope of illegal work and cases of non-accounted wages in the area of agriculture and to create more favourable conditions for increasing the amount of receivable income at own effort ensuring that these persons do not lose their right to cash social assistance, when granting cash social assistance, the part of income received in provision of agriculture and forestry services according to the receipt of agriculture and forestry services exceeding the amount of LTL 6 000 during the current calendar year shall be included in the income received by cohabitants or a single resident.

The **LV** government has made considerable efforts to combat poverty, by improving the coverage of social protection schemes, the adequacy of the benefits as well as the activation of beneficiaries. LV completed a large scale assessment of the social security system, including social assistance, in June 2013. The study provides basis for evidence-based reform of the social assistance schemes, among other social protection policies. In December 2013, the government has agreed on the directions of the reform and has announced the next steps but implementation of the reform is not planned before 2017. However, already in 2013 different income support measures were budgeted for families with children and for persons with disabilities. The aim of recent changes is to tackle poverty and social exclusion by raising the state material support for certain groups of population at the risk of poverty and social exclusion, primary – families with children and people with disabilities. One of the budget priorities of the Law on the Medium-Term Budget Framework for 2014, 2015 and 2016 set by the Latvian government is to revise the labour tax burden with an aim to reduce income inequality and improve the quality of life, including an aim to reduce the tax burden on the economically active population and groups of population at the highest risk of poverty (particularly families with children and low-income earners). The key measures to reduce labour taxes are as follows: as of January 1, 2014, the monthly non-taxable minimum of personal income tax (hereinafter – PIT) has been increased from EUR 64.03 to EUR 75; as of January 1, 2014, the rate of monthly personal income tax relief for dependants has been increased from EUR 113.83 to EUR 165; as of January 1, 2015, personal income tax rate will be reduced from 24% to 23%, while as of January 1, 2016 – to 22%.

The **LV** government also decided to increase disability benefits as of 1 July 2014: the benefit for a disabled person in need of care was increased from 142 EUR to 213 EUR, while the state social security benefit for persons with disability was increased by approximately 20% according to disability group and whether the disability is since childhood. A policy planning document on (Guidelines for Implementation of the United Nations' Convention on the Rights of Persons with Disabilities for 2014–2020) was adopted, revising and extending the list and the scope of social services for persons with disabilities and specifying the system for determination of disability. Another planning document (Guidelines on Development of Social Services for 2014–2020) specifies measures for the deinstitutionalisation process for disabled and children (revising requirements for placing people in the institutions, development of a deinstitutionalisation action plan, development of a new financing model whereby money follows client and others. On December, 10, 2013 the Cabinet of Ministers adopted the Guidelines for Development of Social Work for 2014-2020.

PL introduced in June 2014 a Nationwide Large Family Card. The card is designed to provide large families with discounts for, e.g.: cultural, educational, recreational, and transport services. Currently 101 entities participate in the programme, providing large families with a variety of discounts as of

August 13, 2014. There is great interest in the programme among large families; within months since the launch of the programme cca 235 thousand applications for the large family card have already been submitted.

In **PT**, despite the efforts to alleviate the negative social impact, the fiscal consolidation process as well as increased unemployment had negative implications on poverty and inequality. In particular, two consecutive changes in the national legislation on the Minimum Income Scheme (*Rendimento Social de Inserção*) in 2010 and 2012 led to the decrease of the income threshold for eligibility, therefore reducing coverage especially for large families. Additionally, the PT government adopted three main initiatives aiming at strengthening social inclusion and at alleviating the social consequences and the increase in poverty rates following from the economic crisis and the fiscal adjustment process: a Protocol of Cooperation with social organisations, the Framework Law on Social Economy and a Fund for restructuring the solidarity sector.

On its turn, **RO** has also taken some steps towards the adoption of several strategic measures to alleviate poverty, such as drafting the National Strategy for combating poverty and promoting social inclusion 2014-2020, the National Strategy for the protection and promotion of child's rights 2014-2020 and the Early School Leaving Strategy, as well as revising the National Roma Integration Strategy. However, poverty reduction remains a major challenge particularly in what regards the in-work poor. Families with children are particularly exposed. Poverty rates for households with high and very high work intensity remain the highest in the EU, which points to insufficient earnings and benefit support for people in work. A national poverty reduction and social inclusion strategy is under preparation. As regards the measures to improve the efficiency and effectiveness of social transfers, some limited progress was registered towards adopting a law establishing a Minimum Insertion Income. Further, the RO Government passed an Emergency Ordinance aimed at simplifying the social assistance schemes by combining three existing social transfers (the Guaranteed Minimum Income, the family allowance and the heating benefits). These measures have increased the family allowance and the guaranteed minimum income which aimed at compensating beneficiaries for the increase in the electricity and gas prices.

The **SE** authorities have initiated a series of reforms of the social protection schemes, such as providing a shared child allowance and increasing the housing allowance for households with children. Since the **SE** welfare system is based on the activation and labour market participation, most transfer systems are earnings related and qualification rules are based on labour market participation. While **SE** has one of the highest female employment rates in the EU, the intensity of their labour market participation is significantly lower than for men due to a high share of part-time employment and career breaks for caring reasons. The system of parental benefits has been modified (as from 2014) to counter delays in the labour market entrance of migrant women due to long parental leave periods.

SK adopted a new policy reducing tax wedge for low-paid workers. An amended Act on Social Insurance (in force since November 2013) offers long-term unemployed and their employers an exemption from social and public health insurance contribution for 12 months.

The **UK** Government is currently implementing a reform aimed at reducing jobless households, preventing increases of poverty in a context marked by budget consolidation and broadening access to affordable high-quality and fulltime childcare services. Regarding welfare reform, the **UK**

Government has continued with the introduction of the Universal Credit, focusing on simplifying benefits and improving work incentives. The Universal Credit as a major long-running programme will allow individuals to keep more of their income as they move into work by introducing a slower withdrawal rate (65%) of benefits when their earnings increase. This tapering effect is an important part of a successful strategy to tackle the weak incentives to work existing in the **UK**. Estimates of the welfare reform suggest that the Universal Credit will reduce the number of people facing the weakest work incentives and overall strengthen financial incentives to work. The patterns vary across the population, and particularly between first and second earners in couples: while Universal Credit strengthens the incentive for couples to have one person in work rather than none, it also weakens the incentive for both members of a couple to work rather than just one. This may disproportionately affect women as the majority of second earners. Other welfare changes may reduce the effectiveness of social policies in addressing poverty challenges by impacting the adequacy of benefits. The Government's benefit cap from April 2013, limiting maximum weekly benefit payments for families and for single adults who do not have children or whose children do not live with them, will primarily affect larger families living in areas with high housing costs and disabled people, who face additional living costs. Many working-age benefits and tax credits, as provided by the Welfare Benefits Up-rating Act, will be increased by 1% a year in the period 2013-2016. This adjustment is below the projected inflation rate and means three years of cuts in real terms. As a result all working-age households receiving benefits will be affected, but the poorest households will see the largest proportionate fall in their incomes. The success of the Universal Credit on employment and poverty reduction will depend on effective implementation and support services. Improved incentives for many households to enter the labour market can be expected, with weakened incentives for second earners.

2.2. Investing in children's welfare and in childcare

Reducing child poverty and breaking the poverty cycle across generations implies investing early in the well-being of children and their families by developing integrated strategies that combine prevention and support.

Single parents and their children are particularly exposed to higher poverty risks and need targeted support, which appear as a particular challenge in **DE, IE, LU, LV** and **RO**.

Having a skilled and motivated workforce is one of the elements influencing the quality of ECEC services. A recent review⁷ of research evidence across all EU28 Member States analysing the impact of the working conditions and ongoing training of the ECEC workforce on the quality of the services provided and in particular on the outcomes for children of attending ECEC services. The review shows that intensive Continuous Professional Development programmes with a video feedback component have been found to be effective in fostering practitioners' competences in care giving and language stimulation and, regarding children outcomes, there were significant gains in terms of language acquisition and cognitive development. Long-term CPD initiatives accompanied by pedagogical guidance and coaching in reflection groups proved to be effective for enhancing and

⁷ Eurofound (forthcoming) "Impact of continuous professional development and working conditions of early childhood education and care practitioners on quality, staff-child-interactions and children's outcomes: A systematic synthesis of research evidence".

sustaining the quality of ECEC, as well as in improving children's cognitive and social development services over long periods of time. Staff: child ratio and class-size have positive effects on the quality of practitioners' practices and on staff-child interaction. This is in line with research evidence from outside of the European Union⁸.

As part of the implementation of the Social Investment Package, the European Platform on Investing in Children (EPIC) will identify and evaluate good practices for investing in children, in particular related to early childhood education and care, parenting support, and child participation. EPIC has been set up to share experience and expertise on different areas related to child and family policy.

A recent report by Eurofound⁹ describes the changing quality of life across the EU for different types of families with children and compares their living standards and social situation. Themes that emerge from the findings include the particular challenges facing lone parents, the greater difficulties facing jobless families since the onset of the crisis, and the increasing extent of conflict parents experience in seeking to balance their work and family lives. Poverty and deprivation are problematic not only from a social-justice perspective, but may also inhibit future social mobility. The findings call for targeted actions to help lone parents back into work and for support policies that protect the most vulnerable types of families.

For parents, the cost of childcare acts as an additional major barrier to work and can be particularly influential in the determination of the net income gains for second earner. In **BG**, **CZ** and **SI** for instance, single parents with low wages are financially better off staying at home and caring for their children themselves. Inactivity traps also exist in countries where childcare is much more affordable for low-wage single parents, such as in the **CZ** and **SI**.

In January 2014 a draft law on child groups was approved by the **CZ** government. The law creates conditions for establishing private child groups at less demanding standards compared to public childcare facilities and introduces tax incentives to provide and to take up this form of care. However, by end-2013 the few remaining public nurseries were closed. The authorities expect that this service will be taken over by professional private child-minders recognised under the Trade Licencing Act. The **CZ** authorities are considering several relevant measures for 2014 and 2015 that should further improve the availability of childcare services. The authorities envisage providing municipalities with additional resources, partly co-financed with EU Funds, to build additional childcare capacity. With a view to mitigating the differences between children entering compulsory education, the last year of pre-school education is planned to be made compulsory. Moreover, the government also intends to support hiring of professional teachers to company-based kindergartens. While the outlines of these measures are yet to be specified, they have the potential to improve the participation rate of women with young children in the labour market.

DE has also made some progress in further increasing the availability of fulltime childcare facilities but only limited progress in increasing the availability of all-day schools. Thus, it has accelerated the

⁸ Eurofound (2014) Early childhood education and care: Working conditions and training opportunities: <http://www.eurofound.europa.eu/publications/htmlfiles/ef13101.htm>

⁹ Eurofound (2014). Quality of Life in Europe: Families in the economic crisis. <http://www.eurofound.europa.eu/publications/htmlfiles/ef1389.htm>

expansion of early childhood education and care facilities in view of the introduction from 1 August 2013 of a legal right to a childcare place for all children between one and three years. The number of all-day schools has quadrupled between 2002 and 2011, however from relatively modest levels. At present, only 6.1 % are compulsory all day schools. The federal government has announced a further increase in funding, jointly with the *Länder*, to increase quantity and quality of all day schools.

In **FR**, the multiannual plan against poverty and social inclusion also contains measures targeting families with dependent children, such as improving access to school canteens and providing extra childcare places (with 10% reserved for children from low-income households).

With regards to the particular issue of childcare, two specific initiatives have been recently introduced in **IE** during 2013 and 2014. One initiative provides subsidised afterschool child care places to support low-income and unemployed persons to return to the workforce, while the second provides childcare places for unemployed persons who participate in community employment schemes which provide training and experience to support activation into employment.. These initiatives represent a positive step in addressing the wider issue of disincentives to female labour market participation.

LT adopted a Law on Benefits for Children which provided for the following benefits to be granted to persons raising children and/or guardians of children from the state budget: a lump sum child benefit for a new-born child or for an adopted child amounting to 11 basic social benefits (hereinafter referred to as the "BSB") (LTL 1 430); a child benefit equal to 0.75 BSB (LTL 97.5) or 0.4 BSB (LTL 52) (the amount depends on the age of the child); a guardianship (curatorship) benefit amounting to 4 BSB (LTL 520); a targeted guardianship (curatorship) benefit supplement in the amount of 4 BSB (LTL 520); a lump sum settlement benefit for persons who have been established child guardianship (foster care), amounting to 75 BSB (LTL 9 750); a lump sum benefit for a pregnant woman equal to 2 BSB (LTL 260); a benefit for a child of a serviceman in initial mandatory military service amounting to 1.5 BSB (LTL 195).

In **UK**, the supply of childcare has risen in recent years, but the cost, quality and availability of childcare remain as barriers to parental employment. Childcare poses particular problems for second earners in couples, and single parents, while significant and increasing trends have been registered for involuntary part-time work among women as well as male and female part-time employment due to family responsibilities. The UK Government has launched a public consultation for its Child Poverty Strategy 2014-17. A key part of this and the welfare reform should be improving viable childcare options to enable and encourage women with children to take up work, or to increase their working hours. While the **UK** government has announced and introduced several measures including free hours of childcare, vouchers and tax breaks, its costs in the UK remain high on an internationally comparable basis. The 2013 Budget provided that tax-free childcare vouchers will be introduced from autumn 2015, supporting 20% of childcare costs up to a limit of GBP 1 200 (EUR 1 410) per child per year. Additionally GBP 200 million (EUR 235 million) of support will be phased in from April 2016, which is equivalent to 85% of childcare costs, for qualifying households in which a single parent or both earners in a couple pay income tax. On the other hand, childcare tax credits and benefits have been capped at 1% from April 2013 for three years. Available evidence show that young children from disadvantaged backgrounds (below 3 years) are the least likely to attend childcare facilities. To the extent that the cost and availability of childcare results in women taking involuntary part-time

employment, there is a risk that the declining trend in the gender pay gap is reversed and the gender gap in pensions widens.

Many countries with low levels of joblessness (**CY, LU, SI, FI, AT, NL, SE**) and several with medium levels (**CZ, DK, DE, PT**) have given significant attention to policies to make work pay for parents and avoid inactivity traps. In addition to family-related measures, the **FR** authorities adopted in July 2014 a comprehensive law on equality between women and men, which includes measures for more balanced rules on child-birth leave and for income equality. In **LU**, a high share of working single parents and a decrease of low work intensity in single parents households have been achieved in particular by improving availability and affordability of childcare services (through high investment in supply and childcare vouchers and reduced fees for families at risk of poverty), in combination with investment in education for the low skilled. **LV** has addressed disincentives to work for parents by introducing from 2014 a right to work and to receive childcare and parental benefits simultaneously. In **SE** an incentive to seek work was introduced in the social assistance scheme aiming at increasing the participation in the labour market for the recipients. The government has also facilitated the possibilities for children in families depending on social assistance to participate in organised leisure time activities to the same extent as other children.

Children growing-up in poverty and social exclusion are less likely than their better-off peers to do well in school, enjoy good health and realise their full potential. Thus, poverty represents the single greatest barrier to educational achievement, affecting career prospects and increasing the likelihood of the transmission of poverty along the life cycle. Child poverty and the transmission of disadvantage across generations produce significant costs not only for those concerned, but also for society as a whole. It is broadly acknowledged that public expenditure linked to mitigating the adverse effects of poverty and social exclusion at an early age would be lower than those of dealing with the consequences of childhood poverty across the life cycle. Therefore, several countries took measures to increase child-related benefits.

In **BG**, the most significant measures reported in relation to the implementation of the National Strategy for Reducing Poverty and Promoting Social Inclusion 2020 include: the increase of monthly benefits for a second child and for twin, for children with permanent disabilities as well as financial support to cover the heating costs for elderly and children. The monthly benefits for children are strongly targeted and conditioned on regular school attendance and pre-school attendance. Since the beginning of 2014 the amount of the monthly allowance for children with permanent disabilities has also been increased. In addition, in 2014 monthly allowances for pocket expenses will be obtained by all students placed at specialized children institutions, as well as in residential-type social services – transitional home, crisis center and a center for family-type accommodation. The **BG** government has taken some steps towards ensuring concrete delivery of the National Strategy for Reducing Poverty and Promoting Social Inclusion 2020 as well as improving the accessibility and effectiveness of social transfers and services, in particular for children and older people. Most notably, the adoption of a National Strategy for Long-term Care by the Council of Ministers in January 2014 provides for the continuation of the process of deinstitutionalisation of elderly people and people with disabilities in care, as well as for the expansion of network of accessible and quality services in the community and at home.

ES government approved a second strategic plan for childhood and adolescence (PENIA II), which together with the 2013-2016 national action plan for social inclusion and the comprehensive plan for family support (PIAF) announced by the government provide a relevant policy framework for the active inclusion of families with dependent children.

IE launched a new evidence-based area based childhood programme designed to tackle child poverty through the expansion of prevention and early intervention services which were assessed to be successful during a pilot phase. The programme will mainstream the lessons from the pilot phase by increasing the number of disadvantaged areas from three to 13, at a total cost of €30 million. This initiative will support a recently announced child-specific poverty target, part of the national social target for poverty reduction. The target will be supported by a multi-dimensional social investment plan, to be developed under the national policy framework for children and young people.

The **LT** government approved the Action Plan of the Transition from Institutional Care to the Provision of Services in a Family and Community for the Disabled and Children Deprived of Parental Care 2014–2020. One of the main aims of the Action Plan is to ensure conditions for all children to be raised in their families, or, in the case of children deprived of parental care, to be raised by foster or adoptive parents or in social families and to receive assistance in the community. In order to achieve this aim, social, education, cultural, health and legal services will be provided in a complex manner, evaluating the needs of the development of children's and parents' social and positive parenthood skills, temporary housing, motivation to work and job search, treatment from addictive or other disorders, mediation or other services, and developing the infrastructure of complex services provided in municipalities and their accessibility to children and parents. The Action Plan shifts a particular focus on the strengthening of child's guardianship in a family; therefore, the system of professional guardians will be implemented. The model of activities of professional guardians will be developed, and it will cover the search for guardians, their selection, training and evaluation, the financing mechanism and assistance system, including the plans to provide "respite" services for families raising or caring of disabled children.

In **LV**, there has been a significant progress in addressing the child poverty, such as increases in child-related benefits and in the support for single-parent families as of 1 January 2014. Moreover, the LV government also increased the Personal Income Tax non-taxable threshold for dependants (from 99 EUR to 113 EUR from 1 July 2013 and to 165 EUR per month from 1 January 2014). The 2013 and 2014 budget foresees increases in the child related benefits, the minimum parental benefit and their combination, vouchers for support services for children with disabilities and the provision of free lunches in schools for grades 1 and 2. Since 2013 there has been a state support introduced with an aim to eliminate queues for pre-school education institutions of local governments has been introduced to help the parents successfully balance the work and family life, thus improving the material condition of families with children.

In **RO**, a law on the protection of children rights was revised in the second half of 2013, while the National Strategy for the protection and promotion of child's rights 2014-2020 was drafted and is planned for adoption by the end of this year. The Strategy includes measures on the transition from institutional to alternative care for children and for preventing abandonment and abuse.

In **SK**, a National action plan for children was adopted in June 2013, but it does not sufficiently address child poverty and access to adequate resources. The 2013 amendment of Act on Social

Services introduced new types of services creating better legal conditions for the development of community-based care (e.g. support to home care, shelters, families with children), but further measures facilitating deinstitutionalisation more effectively are necessary. Although the financial contribution to childcare is to be increased in 2014, legislative and budgetary framework for the provision of childcare for children 0-3 is still under preparation in line with the National Reform Programme. However, more strategic promotion of quality early child education and care is needed.

2.3. Measures to foster the social inclusion of ethnic minorities (including Roma)

Specific measures and projects to foster the social inclusion of people with a migrant background or belonging to ethnic minorities, including Roma have been implemented at national level, but there are still too few systematic measures in place. In a number of countries (**FI, HU, BG** among others) there are positive examples of targeted support measures facilitating the access of Roma to employment. Mainstream measures in preschool education introduced in BG are promising for the primary education of Roma children. In the Member States with the largest Roma communities (**BG, CZ, HU, RO, SK**) the access to quality inclusive mainstream education remains a key challenge, alongside early school leaving.

The **AT** government is increasing the efforts on facilitation the social advancements of persons with migrant backgrounds in Austria by breaking down structural and linguistic barriers. Investment for children is increased including by the increase of family allowance and the extension of childcare offers.

In **BE**, some segments of the population, in particular people with a migrant background face above-average social and labour market exclusion risks in all Belgian regions. Over the year 2013, all three Regions have taken measures to deal with the social and labour market inclusion of people of migrant origin. These measures aim at improving participation in early childhood education and care and raising average educational outcomes, reducing high levels of poverty and social exclusion, as well as facilitating access to the labour market by limiting its segmentation and increasing professional mobility.

In **BG**, some limited progress has been made mainly in the areas of employability and qualification for the Roma community along the lines of the National Strategy on Roma Integration. While some of the measures planned in the fields of education and employment are under execution, small scale local and civil actions still need to be scaled up and integrated into a comprehensive and systematic approach towards the inclusion of Roma children into quality mainstream education and the integration of Roma into the labour market. The new government reveals intentions to backtrack on some of the steps forward previously made regarding the implementation of the national Roma integration strategy (covering Roma education, employment, health, housing as well as the issue of anti-discrimination) in particular in terms of governance and dialogue mechanisms with all stakeholders, leading to an important crisis with the Roma civil society organisations.

The **CZ** government is currently implementing an Action Plan 'Equal Opportunities' adopted in 2012 aiming at improving equity in education of Roma children, but the progress is slow. The share of Roma children in practical schools (schools with adapted educational programmes for children with mild mental disability) is decreasing only marginally; but new assessment and diagnostic tools are being developed to avoid placing socially-disadvantaged children in such schools, and a regular

monitoring of the share of Roma pupils in schools was introduced in 2013. The adoption of a law on children's groups aiming at increasing the capacity of services in early childhood education and care is expected this autumn. However, its inclusiveness remains poor, especially in light of the need to reduce inequalities and the need to target Roma children.

In **DK**, employment rates of the foreign born population remain low, particularly among female immigrants. A strengthened and more gender balanced labour market participation among foreign born population is essential in order to boost labour supply and secure better inclusion of all groups on the labour market. When drafting and implementing the future active labour market policies reform, it will be essential to ensure that the more individualised and job-targeted measures also take into account specific obstacles faced by this group.

Also in **HU**, Roma are particularly affected by unemployment, discrimination in the labour market and poor living and health conditions, with 60 % living without basic amenities. Since 2011, the government has taken a number of measures in order to improve social inclusion under the aegis of the Hungarian National Social Inclusion Strategy, but results are modest. The strategy and its action plan have been recently revised. Improving access to quality inclusive mainstream education for disadvantaged children, in particular Roma, remains a challenge.

The **PL** government has drafted a Programme for social integration of Roma for 2014-2020 which is expected to be adopted by the end of 2014. This programme provides for integration measures in 4 main areas: education, housing, health and the labour market. In order to support the implementation of these measures, the PL government has allocated the amount of PLN 4.4 million for activities in the field of education seen as the primary tool for social integration and about PLN 1 million in the area of housing investment.

In **RO**, the National Roma Integration Strategy adopted in December 2011 is still under revision. The delivery of revised action plans has been delayed to autumn 2014. During the year, already existing programmes in the area of pre-school education, the use of the Romani language in schools and training of Roma school mediators, as well as positive discrimination programmes for Roma in higher education have continued. Scaling up and reinforcing educational support measures to increase Roma school attendance and performance remain a challenge.

Also in **SK**, the employment of Roma is far below the average of non-Roma living in same deprived region. Data show that improving educational participation and attainment of younger Roma (when compared with older age groups) does not translate into growth in employment, which also points to important structural barriers, such as discrimination.

Expenditure on social protection in **SK** remains among the lowest in the EU and the effectiveness of social transfers to reduce poverty has slightly decreased during the crisis. Besides deprived living conditions for marginalised Roma communities, the key challenge is the risk of poverty or social inclusion for children (26.6%). The adequacy and coverage of the income support scheme to alleviate poverty, in particularly among households with more children and low work intensity, is insufficient (the non-coverage rate of social assistance is at 30%).

In order to increase the participation in early childhood education and care which is in **SK** currently among the lowest in the EU (the rate being much lower for children from marginalised Roma

communities), compulsory enrolment for children from socially disadvantaged environment is being discussed, as well as free participation for socially disadvantaged pupils from the age of 3. Initiatives to improve educational outcomes for Roma pupils are overly reliant on EU co-financed projects.

In **SE**, migrants are also beneficiaries of regular labour market programmes and wage subsidies (step-in jobs, new start jobs) and there is a push to develop effective methods for validation of foreign qualifications in order to shorten the transition to the right job. For this purpose, the **SE** government has amended the Introduction Act to enable earlier and more active involvement by the PES in the integration process. The “work-first” principle has been strengthened so that newly arrived migrants cannot reject a suitable job offer without risking losing their introduction support. At the same time individuals can retain their introduction and housing allowances for a limited period to reduce the marginal effects during the transition to work.

2.4. Housing and homelessness

Housing affordability is an important challenge considering that housing costs represent a significant proportion of people’s income in most EU Member States. Housing costs are on average the most important single expenditure item relative to income. For a significant part of the population housing costs account for over 40 % of disposable income, which can significantly reduce the capacity of the household to adequately cope with all the other needs besides accommodation, even if the relevance of a relatively high housing cost burden on household welfare obviously depends on the level of household income. Despite the weight of housing costs in total disposable income, especially for the population at risk of poverty, expenditure on housing-related benefits remains very limited in most Member States. Only a few countries (**IE**, **FI**, **LV** and **NL**) have adopted policy measures on housing-related benefits, while **CZ** reported on plans for developing a law on social housing.

The **CZ** Government approved "The Concept of Preventing and Tackling homelessness issues in the Czech Republic until 2020" which should also contribute to the target of poverty reduction. It includes topics ranging from promoting access to housing and healthcare to promoting awareness and cooperation of all relevant stakeholders. It forms a basis for a planned law (expected to take effect in 2017) on social housing which should clearly lay down the rights and duties of the Government, municipalities and other stakeholders, especially in the light of the planned decentralisation of social services (as from 1 January 2015).

The **ES** authorities introduced a temporary moratorium on evictions for households that meet vulnerability criteria and reached an agreement with banks to establish a social housing scheme (*fondo social de vivienda*), where banks transfer a proportion of their housing stock into a social rental sector.

FI introduced a series of reforms aiming at reducing the homelessness. The housing allowances system is also being modified with a view to removing obstacles for employment.

The **IE** Government launched a new housing-led approach to homelessness with the aim of ending long-term homelessness by 2016. The initiative also includes a national bed management and data system to assist local authorities to address the dynamics of homelessness. In 2013, EUR 45 million was provided towards the operational costs of homeless accommodation and related services.

In **LT**, the government drafted the Law on Support for the Acquisition or Rental of Housing, which is currently under debate in the **LT** Parliament. The draft law governs a new form of provision of support for the acquisition or rental of housing, namely compensation of a part of rental or lease payments, and sets forth that families and individuals entitled to social housing and renting housing from natural or legal persons under market conditions become entitled to a compensation of part of rental or lease payments. In 2013, LTL 18.7 million (LTL 5.4 million more than in 2012) were invested from the state budget of the Republic of Lithuania in the development of social housing stock. These funds were used to supplement the stock with 257 units of housing. The funds from the state budget, allocated for the development of social housing stock, meet as few as 0.8 per cent of the demand for social housing. Currently, the **LT** Ministry of Social Security and Labour has been drafting a Programme for the Development of Subsidised Housing Stock 2014–2020. Thus, LTL 173 million have been envisaged for the implementation of the programme from the European Regional Development Fund. These funds are planned to be used to acquire or equip 1,150 units of social housing. The implementation of the measures aiming to increase housing availability to vulnerable groups of population will commence in 2016.

The **LV** authorities have also taken a series of measures to address homelessness. In July 2014 the Parliament adopted legislative changes regarding housing benefits. The housing benefit can be paid not only to cover costs of rent and utilities, but also to cover property management fees. The conditions related to access to housing for orphans' or children without parental care were improved. In order to protect the households from the increased costs of energy after liberalization of the energy market on 1 January 2015, the government has foreseen the introduction of electricity benefit (5 EUR per month) for needy¹⁰ low income¹¹ households which are large families. The government is working on proposals to protect the consumers who have taken mortgage loans for their only housing. The working group have been established and proposals for legislative amendments will be submitted to the government by the end of this year.

NL is implementing comprehensive reforms on the housing market in order to increase the availability of social housing for the households in greater need of it. For this purpose, a system of income-related rent increase was set up with a view to improve the accessibility to and affordability of social housing for the low income households (especially for households not eligible for housing subsidies). The government is also preparing legislation for splitting the services of general economic interest of social housing corporations from the rest of their activities.

The **SI** government is currently working on a National Housing Programme aiming at optimising the current system of non-profit housing provision, regulated non-profit rents and provision of the necessary funds for the partial subsidy of non-profit rents for the socially disadvantaged. In the summer and early autumn of 2013, consultations with the Housing Board (board of experts, which advises the minister responsible for housing on key strategic decisions in this area) were carried out and submitted to the National Assembly.

In addition to the policy measures adopted by these Member States, it is important to mention the pilot project "Housing First" launched on 1 September 2013 by the local authorities from 5 major **BE**

¹⁰ Household is classified as 'needy' if the monthly income during the last three months is below 128.06 EUR per person.

¹¹ Threshold for 'low income households' is set by each municipality, but it cannot be lower than the threshold for 'needy' households.

cities (Antwerp, Ghent, Brussels, Liège and Charleroi). The guiding principle of this pilot project is the unconditional right to have a roof over one's head. With that certitude, people who are in a situation of homelessness or housing exclusion can evolve towards living a regular life. In addition to security of tenure, numerous types of guidance are offered simultaneously.

2.5. Conclusions

In addition to the upgrade of educational and qualification opportunities, the expansion of quality childcare, and the effective promotion of fair, good-quality and productive jobs, well-targeted tax and benefit systems are among the most important instruments to prevent and address income poverty. In this context, there is a need for pro-active public policies to improve opportunities and transitions at the lower end of the labour market and at the bottom of the income distribution. This need e.g. is well-summarised in the concept of social investment, which is intended to guide the design and financing of European welfare states as part of the effort to achieve and support inclusive and sustainable growth.

Differences in the effectiveness and efficiency of social spending depend on multiple factors. Firstly, there is great diversity in the level of poverty and inequalities before social transfers, depending on the distribution of original income (i.e. earnings from work, including self-employment income, capital income and pensions¹²). Segmented and polarized labour markets¹³ will typically produce high levels of inequalities before transfers, which would then require higher degree of redistribution. Secondly, important differences in the size and design of social protection expenditure can help explaining differences in the redistributive effects, across income and population groups. Key features include the composition of expenditure by function and by type, the progressivity of taxation, the combination of universal and means-tested benefits and the labour market friendliness of spending (i.e. the level of spending and design of services supporting integration in the labour market and the disincentive that might be embedded in the tax and benefit systems¹⁴).

3. Recent reforms to achieve adequate and sustainable pensions

The area of pensions has been one of the most reform-intense policy areas in EU Member States in recent years. The fiscal challenges caused by the economic and financial crisis and the need for strong fiscal consolidation efforts in a number of Member States have had important implications for pension budgets and pension policies.

The pension reforms undertaken over the period 2013-2014 combine different actions which can be grouped around the following five policy levers: a) early retirement; b) pensionable age; c) contributory periods; d) level of pension benefits and pension indexation; e) second and third pillars

¹² In this context, pensions are regarded as original income because their main function is to redistribute income over the life cycle.

¹³ Segmentation refers to a situation where a group of well protected and well paid workers coexists with a group of workers in less paid, precarious jobs, without much opportunities for those in precarious jobs to progress towards better jobs. Polarization refers to several aspects of job creation that lead to a relative increase of both low wage and high wage jobs (See ESDE 2011); it also refers to the fact that new jobs tend to benefit to job rich households (women entering the labour market as second earners) and do not easily reach jobless households. These are long term trends observed in most EU countries before the crisis and have been accelerated by the crisis.

¹⁴ E.g. inactivity or unemployment traps.

pensions. Through these main policy actions, Member States pursue enhanced adequacy and sustainability of their pension systems. While putting public finances on a sustainable path is a top economic priority, there is an increasing recognition that unless future pension adequacy is addressed now, policy-makers will face a delicate political situation in the future stemming from an increasing risk of poverty among pensioners.

3.1 Reducing early retirement options

Changes in early retirement options 2013-2014	
tightening	AT, BE, PT, CY, ES, SI, HR
improved access	DK, PT, BG, LV, DE

SE, FI and **HU** did not report any changes to the early retirement options, implemented by new legislation in the period 2013-2014. **BE** is in the process of implementing its 2013 reform which sees the early retirement age of 60 in the old-age pension schemes being increased by 6 months every year since 2013, in order to attain the age of 62 in 2016. The minimum number of career years has also been increased from 35 years before reform (general scheme for wage earners and self-employed) to 38 years in 2013, 39 years in 2014 and 40 years as of 2015. In 2014 complementing measures have been taken to promote working at least until the statutory retirement age (65) and even later. **PT** has frozen until the end of 2014 access to early retirement options for all beneficiaries but long-term unemployed persons. **CY**, as part of its comprehensive December 2012 pension reform, introduced early retirement reduction factors under the General Social Insurance Scheme (GSIS) and the Government Employees Pension Scheme (GEPS) so that pensions granted on early retirement are actuarially reduced. With regards to GEPS only the part of the pension that corresponds to the service after 1.1.2013 is affected. **ES** has increased the age for early retirement, setting a maximum of 4 years of anticipation in the case of involuntary job loss and 2 years in the case of voluntary leave from the labour market. The maximum amount of accrued pension won't be higher than the resulting from reducing the maximum pension (published every year in the State Budget) in a percentage of 0,5% for every quarter of a year of anticipation. Access to partial retirement has also been tightened through an increase in the requirements for eligibility. Measures have been also introduced to limit the compatibility of work and pensions and set at 50% the amount of retirement pension compatible with work. **SI** will be raising the eligibility criteria for access to early retirement pension until 2018 for men and 2019 for women, in 2014 with 4 months. In 2014 the age required to acquire the right to an early retirement pension is 58 years and 8 months with 40 years of pensionable service for men and 58 years and 4 months with 38 years and 8 months of pensionable service for women. In HR retirement in the period 1 January 2014 to 31 December 2030 the right to early retirement requires that the insured is of 60 years of age and 35 years of service. Since 1 January 2031 the age requirement increases to three months each year until January 1, 2038, when the right to an early retirement pension is acquired when the insured reaches 62 years of age and 35 years of service.

AT amended the entitlements of the “corridor pension” and “the pension subject to very long insurance periods” (“Hacklerregelung”). For the “corridor pension” the required insurance period

increases stepwise to 38.5 years in 2014, to 39 years in 2015, 39.5 years in 2016 and 40 years in 2017. Since 2014, access to the “pension to very long insurance periods” is substantially tightened: a) by increasing the respective retirement age (62 for men and 57 for women and further increasing to 62); b) by increasing the number of required contribution months for women (stepwise from 504 to 540 months), c) by reducing the number of periods which count as “substitutional insurance periods”: only times spent in the military service and/or alternative civilian service and times spent on raising children are credited as contribution months.

DK, PT, BG, DE and **LV**, on the other hand, have implemented measures, which facilitate the access to early retirement options (in some countries for specific categories of individuals). **DK** introduced as of 1 January 2014 a reform on senior anticipatory pension which provides people with a long and existing attachment to the labour market and with no more than five years remaining until public old-age pension age with a special possibility of applying to the municipality for anticipatory pension and have their application considered quickly. **PT** has introduced at the end of 2013 the possibility for individual with long careers to qualify for a reduction of the age granting access to old-age pensions (four months per calendar year if contributory career exceeds 40 years). However, this reduction may not result in access to pension before age 65. To provide additional social protection to those of pre-retirement age workers who are unable to enter the labour market, **LV** introduced an early retirement option in legislation as a permanent norm (previously as a temporary norm) as of 01.01.14. People with a social insurance record of at least of 30 years have the possibility of early retirement two years before the statutory retirement age. The amount of early retirement pension is 50% of the normal pension. When the statutory retirement age is reached, the pension amount is 100%. According to **DE's** reform, the retirement pension for individuals insured for a particularly long time will be extended from 1 July 2014 through a time-limited special regulation. Insured parties with 45 years of contribution payments (including periods of unemployment) should be entitled to retire as of the age of 63 without deductions. The average effective pension age allowing early retirement without deductions, shall be gradually increased again to age 65. **BG** formalised on 1 January 2014 the conditions to having access to servicemen pension as having worked a total of 27 years with paid contributions, of which 2/3 as serviceman to the Republic of Bulgaria Defence and Armed Forces, regardless of age. Further to that with regards to early pension access for persons who have worked in difficult and harmful labour conditions, an adopted amendment applying to December 31st, 2014, sees access to pensions available to persons who have worked for 10 years in the conditions of the first-category of labour or 15 years in the conditions of the second category of labour conditional upon reaching the age of 47 years and 8 months for women and 52 years and 8 months for men under first-category labour or 52 years and 8 months for women and 57 years and 8 months for men under second-category labour and if they have had a sum of age and periods of contribution equal to 94 for women and 100 for men. It is expected that in 2014 this will lead to 3200 newly granted pensions.

3.2 Retirement age

Changes to the retirement age, 2013-2014

increase	BE (survivors' pensions), HU, RO, CY, DE, SI, FR, ES, PT, IE, UK, LV, ES, HR, AT
harmonization of retirement age between men and women	RO, SI, UK
acceleration of current reforms	DK
no upper limit	UK

A number of countries have increased the retirement age in the period 2013-2014, a part of an on-going trend to improve pension sustainability and pension adequacy. In **LV** the statutory retirement age is being increased gradually from 01.01.2014 by three months every year until reaching 65 years by 2025. The statutory retirement age in 2014 is 62 years and 3 months. **ES** has implemented a gradual increase of the legal retirement age in the period 2013-2027 until reaching the required 67 years old in year 2027. In **FR**, legal retirement age and full rate pension age continued to increase gradually. The effective retirement age also increased: 62 years in 2013 (61.1 years in 2007). **HU** has observed a progressive increase in effective retirement age, 60 years in 2012 and 2013, with an observable increase of 2 years between 2005 and 2013 for men and an average increase of 1.5 years for women. In **RO**, the standard retirement age is being increased to 63 for women by 2030 and to 65 for men by 2015. In **PT**, as of 2014 and 2015, the normal age of entitlement to old-age pension rose from 65 to 66 years. From 2016, it will vary according to the evolution of life expectancy. In 2013, the average retirement age of new pensioners has arrived at 63.4 years. **CY** has also introduced an automatic adjustment of the statutory retirement age every 5 years in line with changes in life expectancy at the statutory retirement age, to be applied in 2018 and the first revision will cover the period 2018-2023 with respect to both GSIS and GEPS. With respect to GEPS, normal retirement ages is gradually extended by 2 years from 63 to 65 over the period 2013-16. **DE** is raising the statutory age of retirement gradually to 67 by 2029. For 2014 (those born in 1949), the statutory retirement age is 65 and 3 months. Over the course of the coming years it will be raised by one month per birth year up to the age of 66, and as of 2024 (those born in 1959) by two months per birth year up to the age of 67 (those born in 1964 and after). Corresponding increases will be implemented for other age limits. **IE** has abolished the State Pension (Transition) and standardised state pension age at 66 as from January 2014. The State pension age will be increased to 67 in 2021 and 68 in 2028. In its Pensions Bill 2013-2013, the UK has made provisions to rise state pension age to 67 in 2018. **ES** has legislated gradual increase in the legal retirement age in the period 2013-2027 to the required age of 67 years in 2027. From 1 January 2013 the statutory retirement age has begun its rise reaching age 65 and month. In 2014 the legal retirement age is 65 years and two months.

In **AT** many of the measures adopted in the course of the second fiscal consolidation package in 2012 focus on a gradual increase of the actual retirement age. The new disability ("IP Neu"), which went into effect on 1 January 2014 for all persons under the age of 50 (as of that date), aims to achieve the sustained (re-)integration of people with disabilities into the labour market by way of medical and vocational rehabilitation. Unlimited-term disability pensions are only available to people with permanent disabilities. The Social Security Amendment Act (SVÄG 2014), which provides for effective steps towards incentives to retire later, is currently in the legislative. For example, the bonus for remaining employed longer and drawing an old-age pension later ("postponement bonus") will be raised from 4.2% to 5.1%.

SI, RO and the **UK** have implemented specific provisions for the harmonization of retirement age between men and women. **SI** has put in place a transitional period (2013-2016 for men and 2013-2020 for women) to raise the retirement age to 65 years for both sexes and for persons who were able to retire before the age of 61 (W) and 63 (M) and have completed 20 years of pensionable service, in accordance with prior legislation. The ages for both men and women will be increased by 6 months per year: for the insured men from 63 to 65 years of age and for the insured women from 61 to 65 years of age. The **RO** government announced in December 2013 that the Public Pension Law will be amended so as to increase the statutory retirement age for women at 65 as of 2035, thus bringing it in line with the statutory retirement age for men which will already reach 65 in 2015. The **UK** Government has brought forward the equalisation of state pension age for men and women at age 65 by two years to 2018, with State Pension age rising to age 66 in 2020.

DK has accelerated gradual increase by 2 years altogether of the eligible age for public old-age pension and for voluntary early retirement pay was brought forward by 5 years.

The **UK** has abolished the Default Retirement Age, meaning most people can now retire when the time is right for them. It's now easier to work beyond State Pension age.

In **BE**, as of 2015, access to survivor pensions is not possible anymore for people becoming widows or widowers before the age of 45 (progressively increased to the age of 50 by 2025).

3.3 Changes to the duration of contributory periods

BE, DE, SI, FI, HU have not implemented changes to the length of the contribution period necessary for access to pensions in the period under consideration (2013-2014). In **BE** the current contribution period entitling to a full pension is 45 years for employed persons in the private sector, for self-employed persons and for civil servants appointed under the general public sector scheme. However, if certain specific public sector schemes give entitlement to a full pension after a shorter contribution period (preferential calculation fractions), in most of these schemes the minimal contributory period has recently been raised and harmonised at 38 years (in 2013 as a result of the 2011 pension reform). In **DE**, a general qualifying period of five years is mandatory for an individual to be able to claim the standard old-age pension. The qualifying periods are longer for other pensions, depending on the particular pension type.

BG has frozen the increase of the contribution period required for obtaining the right to retirement pension by workers in the conditions of third-category labour. As a result, men acquire the right to retirement pension if they have a contribution period of 37 years and 8 months, and women – if they have contribution period of 24 years and 8 months in the third-category labour. The expected financial effect is an increase in the expenses for pensions by BGN 45 500 000 and an increase in the number of the newly-retired people by 15 300 in 2014. As of January 1st, 2014, the right to retirement pension for servicemen pursuant to the Law on Defence and the Armed Forces of the Republic of Bulgaria, will be granted regardless of their age upon having 27 years of total contribution period, 18 of which were actually spent working as servicemen pursuant to the Republic of Bulgaria Defence and Armed Forces Act. The changes introduced helped retain the requirement for minimum contribution period that servicemen should have in order to be entitled to retirement

pension. In 2014 men and women who have worked in difficult and harmful labour conditions may retire upon coming to a certain age, if they have worked 10 years in the conditions of first-category labour or 15 years in the conditions of second-category labour. Furthermore, as of January 1st, 2014 the Bulgarian government decided that by December 31st, 2020 inclusive, teachers would be entitled to retirement pension upon reaching a contribution period of 25 years and 8 months for women and 30 and 8 months for men. Thus the level of the required teacher's contribution period for the entitlement to early teacher's retirement pension was retained.

RO, IE, LV, FR, CY, ES and **SI** report increases in the contribution period. **RO** will increase the minimum contribution period to 15 years by 2015, for both women and men, while the full contribution period will gradually reach 35 years, for women by 2030 and for men by 2015. In **CY**, as of 1 April 2013 gradual extension of the minimum contributory period (one year per year) from the current 10 to 15 years over the period 2013-17 in relation to the award of the old-age pension under the GSIS at normal retirement age is taking place. In **SI**, the required years of pensionable service without an additional purchase for the acquisition of the right to an old age pension for women will be raised by 4 months per year and will amount to 40 years in 2018. **LV** is rising the minimum contributory period from 10 to 15 years from 2014 onwards. The minimum length of social insurance period will be increased further in 2025 to reach 20 years. Similarly, in 2012 **IE** raised the minimum number of paid contributions for entitlement to the State Pension (Contributory) (SPC) scheme and increased the number of payment rate bands with the aim of more fairly reflecting the proportionality of attachment to the workforce by the claimant. **IE** further intends to move to a total contributions paid model and replace the current averaging system to reflect contributions made over a working life. **FR** has introduced a gradual increase to 43 years of the required insurance period for a full rate pension for people born in 1973 or later. **ES** has gradually increased the required number of contributory years in order to reach the 100% of accrued pension. One will need 37 years of contribution as compared to 35 years previously.

Changes to the duration of contributory periods, 2013-2014	
increase	IE, FR, LV, CY, ES, SI, RO
freeze	BG ¹⁵

Increasing the length of the contributory periods for pensions is a policy measure used by a number of MS as lever, together with increases in retirement age, to signal to workers that access to a pension without an actuarial reduction depends on the necessary length of employment history.

3.4 Pension levels and pension indexation

Changes to pension levels, 2013-2014

¹⁵ For workers in the conditions of third category

increase	BG, LV, FR, DE
decrease	PT
freeze	CY

BG, LV, DE and **FR** have implemented measures with the aim of improving or strengthening pension adequacy.

BG has also implemented increases in pension benefits (ref. Act on the Budget of National Public Insurance for 2014) – as of July 1st, 2014 the minimum amount of the retirement pension by 3% which in turn has led to an increase in the minimum amounts of all pensions related to labour activity, which are dependent upon this amount; as of July 1st, 2014, by 9% the maximum amount of one or more pensions received without their allowances (for newly granted pensions and sickness pensions); as of July 1st, 2014, by 2.7% the social old-age pension, thus leading to a change in the minimum amounts of all pensions not related to labour (social invalidity pension, military invalidity pension, civil invalidity pension and personal pension), as well in the pension allowances which are calculated as a percentage of the social old-age pension. Further to that, as of 1 January 2014, teachers receiving early retirement pensions saw a decrease in the penalty due to lacking the required age from 0.2% of the pension to 0.1% of the pension each month. The Bulgarian government expects that these measures will positively impact pension adequacy by increasing with 4.7% the average pension (from BGN 293.96 to BGN 307.64). Some additional instruments for increasing pensioners' living standards were also implemented – "Christmas supplement" (a lump-sum payment in addition to the December 2013 pension) to pensioners below a certain level of income (BGN 251 inclusive).

In **LV**, to provide support to people who have earned a low wage (wage below the national average in the years relevant for the calculation of pension start-up capital (i.e., 1996-1999) but who have at least 30 years of social insurance period, the pension calculations will use the national average wage instead of individual wage (legislative changes adopted on 03.04.14.). As a result, the pension amount for this group will increase. To address the problem of old age poverty due to low pensions, the government is also planning to review the possibility of introducing a minimum pension (basis pension).

FR has targeted retirees with the lowest incomes by revaluating twice in 2014 the solidarity allocation for old people. The help for an extended health care in favour of the pensioners below the poverty line will also be increased by 10 %. The 2014 pension reform also improves the lowest pensions for the self-employed in agriculture, by guarantying a minimal pension of 75 % of the minimum wage for a complete career from 2017.

DE has improved pension insurance benefits. The child-rearing work of all mothers or fathers of children born before 1992 will be recognized with an additional earning point (*mother pension*) in the old-age security system from 1 July 2014 onwards. Furthermore, two measures provide greater security to people with reduced earning capacity: For one, these individuals are to be treated as if they had continued working two years more than they have, earning the previous average income.

Secondly, the last four years before the reduction in earning capacity occurred are not to be counted, if they reduce the value of this non-contributory supplementary period. To ensure that the statutory pension insurance system can continue to guarantee or restore the earning capacity of insured parties through the provision of integration service in the future, a demographic component in the annual adjustment of the rehabilitation budget was introduced. It aims to ensure that the temporary additional funding needs, resulting from the baby-boom generation reaching an age where they require intensive rehabilitation services, is factored in when setting annual pension insurance expenditure on integration services. The demographic component must be taken into consideration as a separate factor in addition to the expected development in gross salaries and wages per employee.

In **PT**, pensions of above € 1,000 will be subject, in 2014, to an extraordinary solidarity contribution (CES), overall rates between 3.5% and 10% on the total value of pensions.

CY has implemented a freeze to all types of pensions granted under both GSIS and GEPS for the period 2013-2016.

Changes to the indexation of pensions, 2013-2014	
increase	BG
return to full indexation	CZ, LV
freeze	FR, PT ¹⁶
removal of compulsory indexation	ES
reduce	AT ¹⁷

In the period since September 2013, **BE** has adapted a number of pension benefits¹⁸ in order to apply the existing legislation regarding the adaptation of social benefits to the evolution of prosperity, in addition to the yearly adaptation to the evolution of consumer prices.

¹⁶ with the exception of minimum pensions from the general system of social security and pensions of the non-contributory scheme safeguarding the more vulnerable groups

¹⁷ except for minimum pensions

¹⁸ On 1 September 2013: Pensions of employed and self-employed persons that took effect in 2008 (five years old): + 2%; Amount of the minimum entitlement per career year for employed persons: + 1.25%; All guaranteed minimum pensions: + 1.25%; The amounts of the income guarantee for the elderly: + 2%;

On 1 January 2014: Small guaranteed minimum pension for employed persons: + 2.51% extra (family amount) and + 0.80% (amount for single persons and survivor's pensions)

On 1 September 2014: Pensions of employed and self-employed persons that took effect in 2009 (five years old): + 2%

The approved State Budget for 2014 sees **PT** maintaining the suspension of the scheme of automatic updating of pensions, including the nominal freeze of invalidity pensions, with the exception of minimum pensions from the general system of social security and pensions of the non-contributory scheme safeguarding the more vulnerable groups. Similarly, **FR** will also not adjust pensions for a year, except for the modest pensioners who will see their purchasing power preserved.

The **CZ** government approved an amended Act on Pension Insurance in 2014, according to which starting in 2015 pensions will be adjusted by 100% of the growth of consumer prices and 1/3 of the growth of real wages. At the same time, a special provision of the amendment shall guarantee that the pensions in 2015 will be increased at least by 1.8%. The main goal is to stop the decrease of the real value of pensions and to prevent the decrease of the standard of living of pensioners.

In **LV**, pension indexation was suspended during the crisis (2009-2012). As of 2014, the pensions (or share of pensions) up to 50% of the previous year's average monthly contribution wage (285 EUR in 2013) will be indexed once a year according to the actual consumer price index and 25% of the wage index.

In order to improve pensions' adequacy, **BG** updated all pensions, excluding those not related to labour contributions, by an average of 8.4%. This increase was aimed at compensating for the temporary termination of their update for the period between 2010 and 2012 which was part of the measures to limit public expenditure during the economic crisis. This has led to a decrease in the elderly poverty. As of July 1st, 2014, the update of the pension following the so called "Swiss rule" – 50/50, whereby the percentage by which pensions get updated, depends on the inflation level and the average insurance income during the previous calendar year. After applying the pension update policies in 2014 it is expected that the net replacement rate will increase to 57.9 % compared to 2013 (57.8%).

In **ES** compulsory indexation to the evolution of the price index is removed. Pensions are indexed according to a mathematical formula that takes into account the income and expenses of the system, trying to reach equilibrium in the medium and long term. There is a minimum limit of revaluation, 0.25% and a maximum of revaluation, the price index + 0.50.

AT has reduced the pension indexation in both 2013 and 2014, except for minimum pensions – 1pp below the CPI for 2013 and 0.8pp below the CPI for 2014.

3.5 Promoting the affordability and security of funded and private pension schemes

Implemented reforms 2013-2014	
Improvement of access	BE, UK
better security	IE

Few Member States have implemented policy reforms to facilitate the use of funded and private pension schemes through improvement in the access and security among others.

In February 2014, the **BE** social partners agreed on the principle of harmonising the second pillar pension conditions and benefits for blue and white collar workers. In practice, the workers and the employers have agreed to no longer make a distinction between blue and white collar workers in new pension schemes as of 1 January 2015 and to not increase the existing differences. As of 1 January 2025 there may be no more differences between blue and white collar workers as regards the supplementary pension, at sector level as well as at company level. The equalisation only applies to entitlements that will be acquired in the future. The **UK** Pensions Bill 2013-14 contains a number of provisions to further strengthen workplace pension provision by providing for the introduction of automatic transfers for defined contribution arrangements using a "pot follows member model" where members' pensions' pots move with them as they move jobs. This will help workers keep track of and engage with their savings and in doing so should lead to better retirement outcomes; providing to allow the restriction of scheme charges, and the imposition of governance and administration requirements on schemes; giving the Pensions Regulator (the regulatory authority) a new objective to minimise any adverse impact on the sustainable growth of sponsoring employers, when carrying out its functions in relation to defined benefit scheme funding. This objective is designed to help support the long- term economic health of a sponsoring employer, which in turn protects members' benefits.

IE amended its Pensions Act in 2013 in order to strengthen the powers of the Pensions Board to provide the power to wind up a pension scheme. In addition, the Social Welfare and Pensions (No. 2) Act 2013, provides for a fairer and more equitable distribution of scheme assets in the event of the wind up of an underfunded scheme. It facilitates a greater sharing of the risk when a scheme is underfunded between all the beneficiaries, while still providing for priority protection of pension benefits. Governance changes were also approved to restructure the Pensions Board and to amalgamate the Pensions Ombudsman and the Financial Services Ombudsman. These changes are aimed at strengthening regulation and ensuring greater consumer involvement and opportunities to input into matters of pension policy. The Pensions Board has been replaced by the Pensions Authority and is responsible for pensions' regulation. A separate Pensions Council with a majority of members representing consumer interests will advise the Minister on pension policy.

3.6 Conclusions

A big share of pensions reforms are undertaken in order to improve pension systems sustainability and reduce public deficits and focus on prolonging working life, limiting early retirement options and conditioning pension access to longer contributory period. But there are also a number of reforms which have as their objective to improve the adequacy of pension benefits and the access to funded pension schemes as a way to improve income in old-age.

4. Recent reforms for accessible, high-quality and sustainable health care and long-term care

In the wake of the economic and financial crisis, many European governments, but not all, have cut spending on healthcare services. At the same time, unemployment, financial strain and reduced prevention have increased the need for certain healthcare services, while falling disposable income

has made access to healthcare more difficult for many EU households. Eurofound's report identifies the groups most likely to face barriers to healthcare as a consequence of the crisis, including a number of new groups that have been generally overlooked by policymakers. It suggests a range of policy pointers, including the need to consider mitigating measures in tandem with policy reform, and suggests policymakers and service providers might consider reviewing crisis responses once financial pressures on EU Member States begin to ease. Access to high quality health care from an early age is indispensable for people to grow and live in a healthy condition that enables them to contribute to society. Poverty and inequalities in access to health care translate into illness, disability to work, dependency and more poverty. Investing in health for all and reducing inequalities in access to health care is essential for enabling people to work and contribute to the economy. Particular attention is needed for people in vulnerable situation such as older people and disabled, ensuring them access to health services as close as possible to their community (including rural areas) thus avoiding institutionalisation.

Over the last 18 months, many Member States undertook health care reforms to respond to external pressure on their health care systems stemming from e.g. the population ageing and the associated increase of chronic diseases. New opportunities to make health care more efficient have occurred for example due to the diffusion of new health technologies. The induced higher expectations of patients stimulate improvement work within health care. The lack of growth and the protracted recession in some countries adds an additional challenge to the sustainability and performance of health care systems. For health systems financed through contributions based on wages, the severe unemployment crisis in some Member States is adversely affecting the inflow of revenues into the health insurance arrangements. For health care systems with tax-based financing, the lack of growth reduces the taxes revenues in some countries used to fund the health care systems.

Limited budgets and difficulties in accessing healthcare services are not new; they should not be too easily attributed entirely to the crisis, and are unlikely to ever disappear altogether. The crisis has been one influence among many on hugely complex health care systems, interacting with, and sometimes dominated by, other major drivers of change in healthcare.

It is evident that many people have experienced difficulties accessing healthcare services in some countries as a consequence of the crisis. People have been affected by the crisis at the health care-provision level, in terms of reduced coverage or availability, in certain areas of the country. Many have also been affected by impacts at household level, in increased need for healthcare services and reduced resources for accessing services.

Against the background of the widening gap between the need for and the supply of long-term care a number of Member States also reformed their long-term care systems.

This review of health and long-term care system reforms is not a critical assessment of progress made. Rather, it shows the areas of health and long-term care policy that have been subject to structural reforms and it identifies common trends of policy development at EU level (see table xx). The aim of this chapter is to provide a comprehensive strategic overview of reforms in the fields of health and long-term care, which represent a strand of the Open Method of Coordination.

As shown in the table below, the reforms implemented over the last 18 months combine one or more of the following policy developments:

1. Structural changes in the organisation and financing of the health care systems
2. Health service delivery (including e-health)
3. Investing in the health care workforce
4. Cost-containment (cap on health expenditure growth, costs-sharing and optimising pharmaceuticals spending)
5. Enhancement of access to services and of patients' rights
6. Long-term care

Overview of policy reforms in the fields of health and long-term care (2013-2014)

Areas of policy reforms			Member States
Health care systems	Structural changes in the organisation and financing of the health care systems	Policy changes	AT, BE, BG, CY, CZ, DE, ES, FI, FR, IE, LV, PT, RO, SI, SK, UK
	Health service delivery (including e-health)	Services delivery	BE, BG, CY, ES, FI, LV, SK, PL
		E-Health	AT, BE, ES, FR, MT, PL, RO, SI, SK, UK
	Investing in the health care workforce	Pay increase	LV
		Professional development and better working conditions	BE, BG, ES, LV, RO
	Cost containment and cost-sharing	Cap on health expenditure growth	BE, BG, CY, DE, ES, FR, LU, PT, SK
		Optimising pharmaceuticals spending	BE, BG, DE, ES, FR, LV, HU, RO, SI, UK
		Cost sharing	DE, LU, LV, SI, PT
	Enhancement of access to services and of patient's rights	Access to services	AT, BG, FI, FR, EL, ES, IE, LV, LU, PT, RO, SE
		Patients' rights	ES, FI, LV
Long-term care			AT, BE, BG, DE, ES, FI, IE, LU, NL

4.1. Structural changes in the organisation and financing of the health care systems

The economic and financial crisis had a severe impact on the health care sector in several EU Member States, on both the supply and demand sides. On the supply side, the economic and financial crisis led in some countries to reduced funding for health and long-term care services as a result of budget cuts and lower tax revenues, while the demand for health and long-term care services increased in some countries as a result of a combination of factors contributing to worsening health among the general population.

Therefore, many Member States have adopted measures to reduce the impact of the economic crisis on health care by securing sufficient funds for the health care sector during the crisis, improving the utilisation of existing resources within the health care sector and ensuring the protection of patients' rights and entitlements.

The measures taken by some Member States in order to restructure and reorganise the health care sector were aimed at a more efficient and cost-effective utilisation of the available financial and human resources, re-defining funding priorities, reorienting and reorganising health care services. This has often required the division and concentration of health care services between hospitals and care centres in order to increase capacity use, while improving the quality of those services.

BE envisages a new financing system for hospitals, which should result mostly in the reduction of overconsumption of medical care.

BG adopted a National Health Strategy for 2014-2020 presenting a new strategic framework in the area of health. The strategy was accompanied by an Action and Financial Plan which lists the specific measures under each policy together with their deadlines and responsible institutions, as well as funding sources. A revision of the National Health Map was proposed as an instrument for regulation of hospital care on the basis of regional and local needs.

CY is preparing major reforms related to the implementation of the National Health System as well as reforms relating to public hospitals and other health facilities and the organisation and management of the Ministry of Health. According to existing timeframes, the new National Health System (NHS) is expected to be fully in place by mid-2016. Measures have been already taken to simplify exemptions for access to free public health care, based on income and disease-related criteria only. As a consequence, a compulsory health care contribution for public servants and public servant pensioners of 1.5% of gross salaries and pensions was adopted in April 2013. Financial disincentives were put into place to minimise the use of unnecessary medical services and goods and to steer patients towards the right levels of medical care.

CZ recently adopted the Health 2020 National Strategy which is a comprehensive policy framework for the protection and promotion of health and the prevention of disease. The CZ government plans to develop an action plans for this strategy in the course of 2014. Additionally, the CZ authorities will start implementing the reform of psychiatric care approved in 2013.

The **FI** government has prepared an ambitious reform of the social services and healthcare system. The new law, which should come into force in 2015, provides that the responsibility for arranging social welfare and health care services will be allocated principally to five social and welfare and health care (SOTE) regions. Partly as a result of the health care reform plans, the National Institute for Health and Welfare announced in October 2013 a seven-point initiative to strengthen primary health care. It envisages that primary health care should be financed with public funds, but that services under predetermined uniform criteria can be provided by public, private, or third-sector service providers.

FR has adopted a new Health National Strategy which provides the framework of public policy for the years to come. The priority is to promote prevention and health education, to reduce inequalities in access to health care, to preserve their high quality level and to transform the health system's organisation to make it more efficient, more accessible and adaptable to the demographic and socio-economic issues. The Health National Strategy will be implemented by the future public health law in 2015.

In **IE**, health care has also been subject to reform and restructuring recently and further changes are planned. The current government's broad policy aim is to provide a single tier health system supported by universal health insurance based on need, not income. The main thrust of this will be a strengthening of primary care facilities and the reform of the acute hospital sector. A White Paper on Universal Health Insurance was published in April 2014, describing the phases that will lead to the implementation of Universal Health Insurance (UHI) through the development of a formal purchaser/provider split and the dissolution of the Health Service Executive. It is planned that the system will move from a tax-funded system to a combination of UHI and tax funding. In July 2013, seven new HSE directorates were established in the areas of Hospitals, Primary Care, Social Care, Mental Health, Health and Well-Being, Child and Family (which is being separated from health services and a new Child and Family Agency is being set up).

PT took several measures to increase the efficiency and equity of the health system, namely by reorganising the hospital network to reduce costs and to achieve more effective management of human resources, besides a programme of financial incentives to reduce waiting lists for surgery. One measure is being implemented with the aim of improving access to health care: the reform of primary health care is now ongoing, with a view to increase the offer of Family Doctors to the generality of citizens, thus minimizing the asymmetries, either of regional or social nature..

RO continued to undertake healthcare reforms aiming at improving the efficiency, quality and accessibility of the sector. In May 2014, the RO government published a decision on the approval of a package of services and Framework Contract which regulates medical assistance in social health insurance system for the years 2014 – 2015. According to the package, the basic package includes emergency services, preventive services, primary care and medical services in the community, specialised ambulatory and hospital services. The regulatory framework for the provision and monitoring of healthcare services was improved by order of the RO Ministry of Health and National Health Insurance House.

SI amended the Health Services Act in order to enable the merger of ten independent public health institutions into only two public health institutions, i.e. The National Institute of Public Health (NIJZ) and The National Laboratory for Health, Environment and Food (NLZOH). The purpose of the merger was to strengthen the core activities of public health, to pool experts and equipment and to achieve greater management prudence and efficiency. The National Institute of Public Health and The National Laboratory of Health, Environment and Food became operational on 1 January 2014. The National Laboratory of Health, Environment and Food is also taking over the tasks of the medicines control laboratory as provided for, among other things, in the Medicinal Products Act adopted on 24 February 2014.

SK adopted a Strategic Framework for health 2014-2030 in December 2013. The Strategy sets medium and long-term objectives in the areas of outpatient care, inpatient care and public health. The reform focuses also on the reclassifying of hospitals and of the range of healthcare they can provide, determining catchment area and reviewing existing types and organisational structures of healthcare facilities of inpatient healthcare. For this purpose, a programme of renewal of health infrastructure of hospitals will be initiated with the aim of making a more effective use of the human sources, buildings and medical equipment.

Division and concentration of care services implies a good coordination of care services and communication structures between primary and secondary care and between the various health care facilities. Care coordination is particularly pertinent in the context of ageing and the ensuing multi-morbidity and chronic diseases, which result in greater use of different types of health and social care services at the same time. Encouraging the use of primary care instead of direct use of specialist care while strengthening referral systems from primary to other types of care is one of the health policy reforms that are being implemented by some EU Member States to improve resource use in this sector. In some Member States, this has been achieved by enforcing a compulsory referral system with a gate-keeping role for primary care physicians (general practitioners).

In **AT**, the recent "Health Reform 2012-2013" aims to overcome the institutional fragmentation of health care services in order to achieve better coordination in the planning, governance and financing of the inpatient and outpatient services with the view to control the growth of health care expenditure. In 2013-2014 the targets for health care provision have been agreed between the federal level and the provinces.

The **DE** government set up a task force to prepare a hospital reform that would further enhance the coordination between inpatient and outpatient care.

LV adopted a plan to strengthen primary care (Primary Health Care Development Plan 2014-2020) in order to improve the delivery of the health care services. There are also plans to use the ESIF funding in 2014-2020 to support development of the health network guidelines and quality assurance systems in the priority areas (cardio-vascular, oncology, prenatal and neonatal, mental health).

In **UK**, health and long-term care is a devolved competence and therefore England, Scotland, Wales and Northern Ireland have implemented reforms which aim at a greater integration and delivery of health and social care services. In parallel to that, England's Care Act adopted in June 2014 creates a

legal framework for the Better Care Fund, a £3.8bn fund to enable local authorities to integrate these services. The reforms will be rolled out by April 2016. In Scotland, the Public Bodies Act 2014 puts in place the legislative framework for the integration of health and social care services. A Social Services and Well-being Bill was passed in Wales in March 2014 so as to consolidate the adults' and children's social care law. Northern Ireland carried out a review of health and social care services which set out a new model of care involving promoting preventative and early intervention measures, avoiding unnecessary hospital admissions and putting the individual at the centre of provision. Key changes will include more care delivered in the home, an increased role for GPs and increased use of community and social care services.

ES initiated in 2012 a health reform through Royal Decree-Law 16/2012, in order to contribute to the sustainability of the National Health System. During 2013 and 2014 complementary measures have been carried out such as the update of the basket of services of the National Health System according to efficiency criteria and scientific based decisions, control of the pharmaceutical expenditure or public health strategies for a better access to health services. Spain continues working in relevant areas such as health professionals and e-Health.

4.2. Health services delivery

In order to improve the delivery of health care services, health monitoring, easing the access to health care and increasing the quality and sustainability of health systems, several Member States implemented ICT and eHealth solutions that have the potential to improve the collection and storage of data (electronic records, registries, and administrative data) as well as the information exchange among staff in various health care settings, allowing for better care coordination and patient mobility.

AT decided in 2012 to introduce a so-called "Electronic Health Register" (*Elektronischer Gesundheitsakte*; ELGA). Hereby, individual data about the medical history, treatments, prescribed drugs etc. get filed electronically, with (selective) access to this data for independent physicians, hospitals and (to a more limited degree) also pharmacies. The aim of this information system is to help to prevent suboptimal treatment caused by a lack of information on the side of the – in some cases many – treating physicians. One other goal is to avoid costly multiple medical examinations and multiple prescription of drugs, which is not only inefficient in financial terms but also implicates health risks.

BE has launched an e-health action plan for 2013-2018 and introduced monitoring tools to assess the health status of patients in various health care facilities (BelRAI). BE is also preparing a reform to better adapt its healthcare system to the needs of people with chronic diseases, which should result in the transfer of organisational competences in the field of primary health care and in structural changes related to the normative framework for hospitals.

In **FR**, the deployment of telemedicine is one of the Health-territory Pact's commitments and one of the issues of the new Health National Strategy. Some experiments on the deployment of telemedicine have been introduced by the Annual social security financing law in 2014. These experiments should enable the organizational, technical and financial obstacles to be identified, in order to encourage the development of telemedicine.

MT has recently introduced electronic patient records to improve the quality of the service rendered to patients. **RO** and **SK** have also accelerated the implementation of eHealth schemes, which will allow the transfer of information between the hospitals and other healthcare facilities of inpatient and outpatient healthcare, while stressing continuity of healthcare.

SI set up a pilot project for the prescription and distribution of medicinal products (e-prescription), which has already been rolled out at national level throughout the year 2014. Moreover, infrastructure projects were implemented within the framework of the e-health project, in order to secure the interoperability of all the health care centres and the sharing of patient data. Also, in January 2014, a radiologic portal information solution was introduced, enabling the exchange of radiological information in a digital form (picture archiving and communication system - PACS) among the healthcare providers.

In **UK**, the Scottish authorities plan to introduce an online electronic patient record for all the inhabitants as part of the overall 2020 Vision for Healthcare.

ES published a Royal Decree 702/2013 to update the individual health card regulation. In November 2013, 10 Regions could produce the summary clinical history (HCR) and there were clinical records for 19.3 million citizens available, 9.7 million citizens have access to all services of the HCDSNS system, 3.7 million citizens can only see their clinical records. In March 2014, the total number of electronic prescriptions through the National Health System were 77%.

Several Member States introduced an element of activity-based or case-based management of health care services, usually based on diagnosis-related groups (DRGs), a way of categorising patients according to diagnosis and intensity of resources required, in an attempt to establish a comparable structure of health care costs.

From a cost-effectiveness perspective, the **BE** authorities took a series of policy measures in this direction, such as the planned decrease in the number of beds in hospitals, the introduction of a performance-based payment system, the strengthening of care integration focusing on the gatekeeping role of general practitioners and the restructuring of the hospital sector and the promotion of prevention programmes.

In August 2014, the **PL** authorities amended the law on healthcare benefits financed from public funds so as to improve the efficiency of the allocation of public resources in short and long term. The project provides for the introduction of regional maps of health needs, which will set priorities for contracting health benefits. Moreover, it aims at regulating the supply of health benefits in order to adjust development of medical infrastructure to the health needs. In addition, the project aims to improve the administration of waiting lists for healthcare services, as well as the availability of healthcare services for cancer patients.

In **SK**, the Strategic Framework for health 2014-2030 envisages the introduction of a cost-based payment system (diagnosis-related group) and the implementation of an integrated model of health care/integrated care centres. This model aims at strengthening the role of general practitioners as

gate-keepers to the health care system, as well as at strengthening and expanding general outpatient and nursing care.

In addition to performance-related measures, some Member States are also developing human resources strategies to promote training and education, support upgrading of skills and improve working conditions in the health sector.

The **BG** authorities amended the quality standards for 16 medical services. Improving the quality of health care services, as well as the working conditions for the emergency care staff were among the priorities of the health care reforms. Therefore a Strategy for the development of emergency medical care has been developed with the aim of regulating the coordination between emergency care centres and others medical facilities and improving the specialisation of the emergency care staff. Additionally, this Strategy envisaged the introduction of diagnostic related groups (DRG) as a main hospital payment mechanism.

In **CY**, working time arrangements of health care staff were modified in order to increase the accessibility of public health care services.

ES established in 2013 the Spanish Network of Health Technology Assessment that has contributed to the updated the basket of services of the National Health System according to efficiency criteria and scientific based decisions, including areas such as dietetic products and orthoprosthesis.

4.3. Investing in the health care workforce

The types of problems in relation to capacity differ across countries. Acceleration of staff shortages (for example nurses and anaesthetists) is among the core problems in **BG**, **HU** and **RO**. Decreased pace of investment in healthcare infrastructure is a key issue in particular in the countries that have had low public expenditure in healthcare long before the crisis, such as **BG** and **RO**. Decreased healthcare facilities in some remote rural areas apply to all these countries. Increasing waiting times for hospital services are a key problem in **SI** and **SE**.

In **BE**, several initiatives have been taken to support the staff in the health care sector, such as establishing new conditions for the recognition of several medical professions (e.g. psychologists and psychotherapists) as well as for the recognition of the professional experience for various categories of health care personnel (e.g. nursing assistants).

In order to strengthen the capacity of the health care workforce to face the increasing demand for care, the **LV** government decided to increase the minimum remuneration for health care professionals by 10-12.5% as of 1 January 2014.

In **RO**, the National Health Strategy 2014-2020 puts forward measures to develop the institutional capacity in the health care sector at all levels and the organisation of care (health care staff shifts, management of waiting lists, primary care, quotas of patients for general practitioners, the GPs role as gatekeepers, the choice of providers, home or out-patient care).

ES is working in regulations to facilitate the mobility of health professionals among different regions, the planning of health professionals, the training and accreditation of professional degrees and qualifications and the establishment of Clinical Management Units.

4.4. Cost-containment and cost-sharing

While country specificities can be observed, there are different pricing and reimbursement policies, directed at providers and users, which are being put in place in some Member States to encourage an effective use of medicines. As the pharmaceutical expenditure is increasing, health care policies aiming at cost-containment become the focus of national health authorities and policy makers. Whereas health care in EU Member States is to a large extent publicly funded, both in social health insurance or in tax-funded systems, this is less the case for pharmaceutical spending, where private co-payment can be extensive. However, the optimisation of the costs of medicines used in both the in-patient and out-patient care settings can be achieved through different measures, for example price freezes and cuts, mandatory discounts and rebates granted by producers and distributors of pharmaceuticals to purchasers.

Some countries introduced mechanisms to share the financial risk of a budget overshooting between all stakeholders (manufacturers/wholesalers or pharmacists and payers). Overall, rebates, claw back and payback policies are widely used and powerful policy tools for cost-containment. Increasingly, public tendering is used to increase price competition and to reduce purchase prices. Several EU Member States used public tendering for purchasing pharmaceuticals, which led to achieving considerable reductions of prices. The use of generics is also an important tool to lower prices of pharmaceuticals. BE has taken actions to contain costs, through the introduction of a new system for the reimbursement of medicines (the Mediprima system), reduction of prices of medicines, tackling "unnecessary" medical examination (X-rays, CT scans, etc.).

BG has adopted a National Health Strategy for 2014-2020 containing an Action and Financial Plan that provides for cost-savings through tighter control on pharmaceutical spending in order to improve the sustainability of its health care system.

The **FR** authorities have taken measures to contain the growth of pharmaceutical expenditure by encouraging the use of generic drugs and better price-setting, introducing price cuts for clinical laboratories and radiologists, providing incentives for lowering health care volumes including through a stricter control of prescription patterns by physicians, as well as by optimising the purchases made by hospitals.

Cost-sharing requires patients covered by a health insurer to share the cost of the pharmaceutical product acquired. Cost-sharing may be applied as deductibles, co-insurance or co-payment. Co-insurance, whereby patients pay a percentage of the price of the medicine, is the most commonly used in the case of pharmaceuticals. The rationale for using cost-sharing is to increase the price sensitivity of patients, reduce the unnecessary use of medicines and generate income for and reduce expenditure of public payers.

ES published Royal Decree 177/2014 to regulate the reference price system and to regulate the information system of price and reimbursement of medicinal products and medical devices through the National Health System. A centralized purchase platform was launched involving in 2013 15 Regions and launching 9 call for tenders for medicines and medical devices. Since July 2012 to August 2014 through different measures in pharmacy there have been 3874.2 million euro savings.

Most EU Member States have cost-sharing rules. These may vary by applying differentiated reimbursement rates, such as 100% reimbursement for vital, 80% for chronic and 60% or lower for other medicines. Also, most often (vulnerable groups of) patients are protected from excessive out-of-pocket payments through specific (often means-tested) rules, such as reduced cost-sharing rates, exemptions, tax deductibles of cost-sharing or annual co-payment ceilings.

In **CY**, the basket of publicly reimbursable medical services and goods was reassessed on the basis of objective criteria, including cost effectiveness, while the fees for the use of medical services by non-beneficiaries were increased by 30% in order to reflect the associated costs of service.

DE adopted a number of policy initiatives, including a financing reform of the statutory health insurance system, which fixes the contribution rate at 14.6%, to be paid on equal terms by employers and employees. Given the large surplus of the general health fund, the DE government decided last year to abolish the so-called “practice fee” (*Praxisgebühr*), a co-payment of 10 Euro paid once in a quarter by every patient visiting an outpatient practitioner, and to reduce tax subsidies to the statutory health insurance from the planned 14 billion Euro per year to 10.5 billion Euro in 2014 and 11.5 billion Euro in 2015. The DE government also decided to prolong until 31 December 2017 the cost-containment measures introduced in 2010, such as a statutory price freeze for pharmaceuticals without reference prices and an increase from 6% to 7% of the manufacturer discount for prescription medicines.

The initiative put forward by the **FI** National Institute for Health and Welfare in October 2013 focuses on the principle that money should follow the patient. That means that the service providers will get a predetermined, partly fixed, reimbursement according to the patient's choice of service unit, which will give service providers further incentives to attract patients with good access, high quality and a client-oriented approach.

LU government decided last year that persons with modest incomes would no longer have to pay their health care expenses up front, and the patient's own contribution of 12% would be covered by the communal social welfare office. Cost-containment measures have been taken up in the past years and have shown positive effects during the financial crisis. However, the government intends to keep up reform efforts during the next few years as the national health insurance is expected to be in deficit again by 2015.

LV authorities continue discussions on raising additional finance for health, including consideration of the possible implementation of insurance principle in the health care system. The objective of the reform is to increase public financing of health care and to improve the affordability of health care services.

In **PT**, the user fees and tax exempt system were revised in order to ensure equal access to the health care system. The 'Memorandum of Understanding' with the Troika started in 2011, provided a series of policy measures on the supply side such as cuts in the financial incentives of the programme to reduce waiting lists. The bulk of measures impacting patients came into effect in 2012, including the increase in co-payments and limitations to hire new staff (but also the reduction in the price of medicines and, in the area of quality, the introduction of therapeutic guidelines).

In **RO**, co-payments for inpatient spells were introduced in March 2013, capped at RON 10 (2.28 EUR) per admission. Moreover, the procurement system for medicines and medical devices for hospital use was improved in 2013 through a centralised procurement scheme, which led to significant savings.

In **SI**, co-payments have increased for ambulance transport, dental prostheses and some ophthalmological appliances as a result of the partial redistribution of the burden of the health expenses to insurance companies that offer complementary insurance. In February 2014, the SI government adopted a new Medicinal Products Act, which will further enable medicinal products suppliers to reduce the price of medicinal products and to adapt to market conditions faster. The Ministry of Health will also have an opportunity to set a mandatory price discount on certain medicinal products.

In **UK**, the English authorities introduced a new Pharmaceutical Price Regulation Scheme has also as of 1 January 2014 which will run for 5 years. The aim is to control the price of medicines and limit the profits pharmaceutical companies can make from their NHS sales.

4.5. Enhancement of access to services and of patients' rights

Difficulties in accessing healthcare have long been more common among certain population groups. While there is great heterogeneity within these groups, they include people living in countries with poor overall access or in remote areas; those with low health literacy, poor education and low incomes; people with greater healthcare needs in general (such as people with disabilities, elderly people and people with chronic illnesses) or who belong to a specific disadvantaged ethnic minority (such as Roma), as well as migrants, lone parents, the long-term unemployed, homeless people. Some groups have increased in size (long-term unemployed, homeless), and some have been impacted by cuts in services facilitating access for them (such as health mediators for migrants in **PT** or the Traveller Health Budget in **IE**).

In some countries, the crisis has also resulted in the emergence of new groups that were not considered to be in a vulnerable situation before the crisis, such as people who experienced a reduction of their disposable income (including self-employed which cannot pay for insurance anymore), the loss of a job or a social benefit that came with insurance or the reduction of coverage for certain health care services because of staff or budget cuts.

Member States have various schemes in place to facilitate access to health care services for groups in vulnerable situations. The crisis has in some countries increased the number of people who are entitled to benefit from some of these schemes, relying on them for accessing health care. Sustaining

these measures has to some extent mitigated the impacts of the crisis on access to healthcare services, at least for the groups covered by existing schemes.

In **AT**, in September 2010, the *Bedarfsorientierte Mindestsicherung* granted health insurance, along with a financial benefit, to people who live in poverty.

ES changed through Royal Decree-Law 16/2012 the pharmaceutical co-payment system including three criteria to established the percentage to be paid by the user (income, age, illness). This new system has established three levels of co-payment according to the income of the patient, varying from 0 to 60%. Since this new system entered into force several groups of the population are exempt of pharmaceutical co-payment (all of them paying 40% before 2012), being: holders of insurances and beneficiaries being persons affected by toxic syndrome and people with disabilities; persons receiving social integration allowances; persons receiving non-contributory pensions; unemployed persons who have lost the right to unemployment benefits while staying at this situation; persons with treatments resulting from occupational accidents and occupational (estimated as 2 million people). Retired persons are included in the corresponding level of co-payment, according to their income, with a maximum level to be paid of 8.26 euros. 18.59 euros or 62 euros per month depending of their incomes (below 18,000 €; between 18,000- 100,000€ or above 100,000€).

ES fulfil with the transposition of Directive 2011/24/UE through Royal Decree 81/2014 to establish the conditions to guarantee patients' mobility and facilitate the access to a healthcare of quality and safety. It also launched in 2013 the Chronicity Strategy of the National Health System and is developing the Strategy for Promotion of Health and Prevention of Disease.

In **EL**, unemployed people are entitled to health insurance for up to two years of unemployment. In September 2013, Greece launched a 'Health Voucher' programme, targeting both the long-term unemployed who had lost insurance coverage and also their dependants. The vouchers are valid for four months and cannot be renewed, but provide for up to three visits to a GP or diagnostic centre, and up to seven visits for pregnancy care. Hospital care is not covered. In November 2013, a measure was implemented that gave self-employed who were in debt to the insurance fund access to health insurance benefits if they were complying with a debt settlement process. Since late June 2014, all uninsured persons are formally entitled to access to medicines and hospital care, subject to medical need. Non-emergency cases involving uninsured persons have to gain the approval of a committee in case hospital care is needed. Emergency cases, of insured and uninsured persons, are entitled to access to the emergency departments of public hospitals. Under these new rules, access to medicines for uninsured persons is also covered by EL National Organization for Health Care Services Provision (EOPYY). The cost of these new provisions for the uninsured is covered by a separate budget line of the Ministry of Finance.

In July 2012, **FR** increased the income threshold below which people are entitled to a financial allowance to acquire complementary health insurance. It also facilitated access to state medical assistance (AME) for undocumented migrants.

In **IE**, legislation has been passed to extend 'GP only cards' to all children under the age of six, that is, an additional 240,000 children, allowing them free access to GPs. The date for implementation is

subject to contract negotiations with health providers. The 'medical cards' cover primary and hospital care, free of charge for the user (some are 'GP only cards' introduced in 2005). People with incomes below a certain threshold are entitled to these cards, including many who are unemployed. In 2008, 1.4 million (30% of the population) had a medical card; 1.9 million (40% of the population) had a medical card in August 2013. At the end of last year, the RO government launched a draft National Health Strategy 2014-2020 for public debate as well as an evaluation and monitoring plan. The strategy aims to address a wide range of public health issues, such as improving the access to health care by ensuring a comprehensive insurance coverage as well as affordable quality services. Furthermore, the strategy envisages the setting-up of a communitarian system for medical and social services, primarily targeting the rural population and those with disadvantaged backgrounds, including Roma. In order to improve the access of vulnerable groups to health care services, the implementation of 18 preventive and curative programmes in the field of women and children's health continued throughout this period.

In **SE**, in July 2013, in a new law all undocumented children were guaranteed access to public healthcare free at the point of delivery. Adult undocumented migrants now have the same rights as asylum seekers: they can access healthcare 'that cannot be postponed', ante- and post-natal care, family planning, termination of pregnancy and dental care that cannot be postponed, provided that they pay a 6 EUR fee for every visit to a doctor or dentist. Doctors have discretion in judging whether a condition cannot be postponed.

Schemes have also been adjusted or created in an attempt to maintain access for groups in vulnerable situations. Several governments have eased the access to health care services for groups in vulnerable situations by removing co-payments and expanding coverage.

In **BG**, public insurance covers basic hospital care (free for users) and primary care against an out-of-pocket fee of 1% of the minimum income (just below BGN 4 or EUR 2 in 2014). From 2014, retirees pay half the fee for primary care and the other half is publicly funded, particularly important for those who depend on the public pension only, and receive no support from family members.

In **FR**, the new Health National Strategy aims to extend the third-party payment system to the entire population by 2017.

LU aimed to improve access for people finding it difficult to make 'upfront' payments, establishing a 'third-party payer system' from January 2013. It was already under development before 2007 with the intention of targeting indebted households, those close to the poverty line and those facing higher housing costs.

In 2012, **LV** continued the measures under the Social Safety Net Strategy introduced at the onset of the economic crisis in October 2009, exempting households with a monthly income below LVL 90 per head (128 EUR) from co-payments. Moreover, the LV authorities established in 2014 a Medical Risk fund in order to improve patients' rights and provide protection against risks for the health care workers. Also, legislative changes were adopted to ensure physical access to health care institutions for people with disabilities as of 1 July 2014.

In **PT**, the income threshold for co-payment exemptions for low-income families was raised, covering a larger group with 2.8 million qualifying in 2013, up from 1.9 million in 2006.

4.6. Long-term care

AT has taken significant steps towards improving the financing and provision of long-term care services through the extension of Long-Term Care Fund up to 2018 as well as through its efforts to streamline the administration of long-term care benefits. The long-term care fund, which was extended to 2016 with an additional EUR 650 million and is planned to be further extended until 2018 with EUR 700 million, provides an interim solution for the financing of care services. The efforts of the AT authorities have focused on health rehabilitation and preventive care in the context of the reform of the invalidity pension taking effect as of 2014. AT also implemented a care leave benefit on January 1, 2014 which supports the caring and nursing family member taking care leave or part-time care leave and helps family members to better coordinate work and care.

In **BE**, the 6th State Reform transfers some competences on long-term care to the community level as from mid-2014. In March 2013, the government proposed a new Act towards a legal recognition of informal carers, which aims at defining specific categories of carers as well as the financial and other consequences deriving from the formalisation of this status. In addition, the BE authorities have implemented a nation-wide system of monitoring the health status and living conditions of elderly people in different care settings (Bel RAI).

In **BG**, the long-term care system has expanded considerably in recent years as a result of actions aimed at deinstitutionalisation and provision of more community-based services and services in family environment. Despite some progress, the institutionalisation of people with disabilities and elderly people is still predominant. The new government programme includes plans for avoiding care dependency through enhanced prevention, rehabilitation and independent living. In early 2014 a National Strategy for Long-term Care was adopted by the Council of Ministers. It is aimed at network development of accessible and quality services in the community and at home for elderly people and people with disabilities.

In **DE**, the *Pflege-Neuausrichtungsgesetz* (PNG), introduced in January 2013, improved benefits of respite care for persons receiving care allowance and extended the benefits for dementia patients. To finance the additional expenditures resulting from the PNG, the contribution rate to the social long-term care insurance (LTCI) has been raised by 0.1 percentage points to 2.05%. At the same time, an additional optional private LTCI (PNG) subsidised with a maximum of 60 Euro per year has been introduced. The new government plans to implement the new definition of care dependency (*Pflegebedürftigkeitsbegriff*), which will lead to an extension of care services and eligibility, notably for dementia patients. To this end and with the aim of creating a long-term care fund (*Pflegevorsorgefonds*), the contribution rate for long-term care is planned to be increased in total by 0.5pp over the legislative term (0.2pp already in 2015, then 0.3pp at a later stage). The government also plans to improve the financial support for appropriate housing for older people.

FI adopted legislation on social and health services for older people with a stronger focus on prevention, rehabilitation, independent living and home care as well improving care co-ordination in

July 2013. Thus, the FI parliament adopted an “Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People” in December 2012 which entered into force in July 2013. The act concentrates on ensuring healthy ageing and good functional capacity at old age. Local authorities must offer health examinations, appointments and home visits that support wellbeing, health, functional capacity and independent living in particular for those members of the older population whose living conditions and life situations are on the basis of research results or general life experience considered to involve risk factors increasing their need for services. In addition, local authorities must draw up a plan on measures to support the wellbeing, health, functional capacity and independent living of the older population as well as to organise and develop the services and informal care needed by older persons. The plan also must underpin living in the own home and measures to promote rehabilitation.

In **IE**, the main government policy regarding long-term care is to maintain people in their homes for as long as possible, with homecare packages and homecare support services. When this is no longer appropriate, financial support is available to support access to quality long-term residential care. The National Carers Strategy was published in 2012. The National Positive Ageing Strategy, published in 2013, is the over-arching blueprint for age related policy and service delivery across Government and society in the years ahead. Work is well advanced on the development of a National Dementia Strategy.

LU prepared in 2013 a thorough evaluation report of its long-term care system setting the basis for reforms of the sector. Thus, the LU government announced a reform of the dependency insurance aiming to ensure that dependent persons receive the services needed and organise the corresponding financing. It is planned to standardise the procedure of needs assessment, to review the financial support for housing adaptations and to redefine the role of informal carers.

NL is in the process of passing through a major structural reform of its long-term care system, planned for implementation from January 2015. The main objectives of the reform are related to cost reduction, quality improvement and a stronger role for informal carers. The reform plans provide for the transfer of some responsibilities in the current long-term care system (AWBZ) to municipalities and health insurance companies. This transfer of responsibilities is accompanied by budget cuts under the assumption that efficiency gains are possible under the new implementation structure. As a result of these measures, the nominal budgetary expenditures for LTC for the years 2013-2017 are expected to remain at the same level.

4.7. Conclusions

In the last 18 months, important health care reforms have been implemented in the EU. Some Member States have enacted new legislation or amended existing legislation in order to enhance the effectiveness of their health care systems (ES, FR, MT, PL). Other MS opted for improving the existing mechanisms of their health care systems (BG and SK). FI will soon start the implementation of an important reform which will change the governance of its health care systems and the division of labour between its level of governments.

Access to quality health care can contribute to addressing social exclusion and poverty and thus is a crucial element of social investment, contributing to saving cost of care in the long-run. Access to and quality of health care are important factors in addressing health inequalities.

Besides the need to maintain accessibility to high quality healthcare services, inequality in health is of great concern. While most Member States have universal coverage and systems in place to support vulnerable groups in accessing healthcare, in practice many people have problems in accessing healthcare services when they need them. Various groups have traditionally been at risk of experiencing problems related to access to healthcare services. Even in countries where the highest proportion of people report to have no problem at all in accessing healthcare services because of distance, cost, or waiting times at the venue or in making an appointment, over one third of the population do experiences at least one of these problems.

While it is sometimes hard to distil its impact from other causes, the recent financial and economic crisis is likely to have affected healthcare services in two ways. First, the crisis is likely to have increased demand for certain healthcare services. Second, financing has come under pressure in particular as a result of reduced public budgets, in combination with decreased incomes among users. Sustaining access to high quality healthcare in the context of the crisis is therefore particularly challenging for policy makers and service providers.

5. Thematic focus: Youth exclusion and social protection

5.1 Introduction

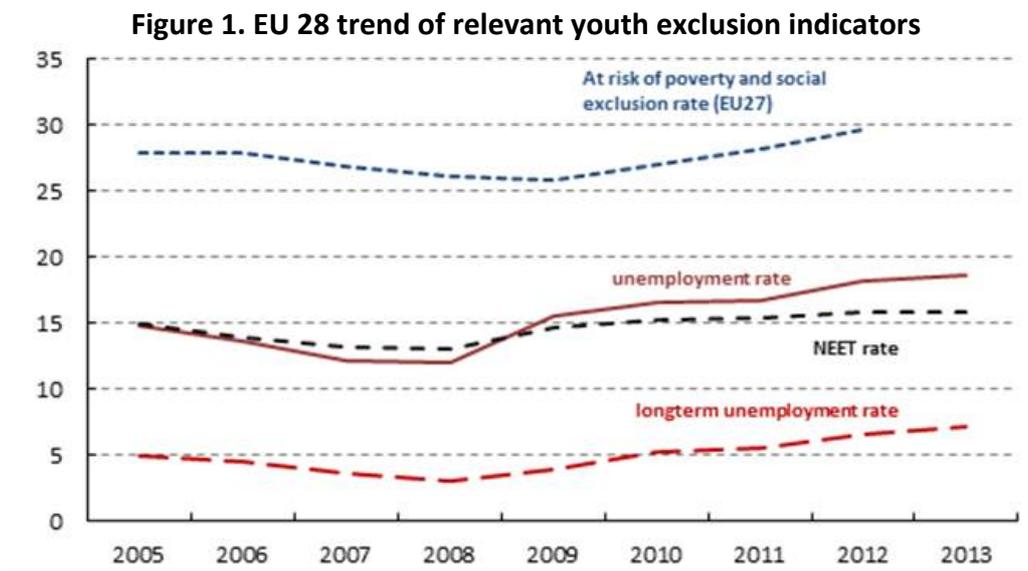
The increase of youth unemployment has been one of the most serious consequences of the economic and financial crisis in Europe. It reached its peak in the first quarter of 2013 with 23.6 % of young people unemployed 15-24 for EU28.¹⁹ Country differences are large: In Greece (58.3 %), Spain (55.5 %), Croatia (49.7 %), Italy (40.0 %), Cyprus (38.9 %), Portugal (37.7 %) and Slovakia (33.7 %) youth unemployment rates in 2013 were particularly high. Germany (7.9 %) and Austria (9.2 %) were the only Member States with a youth unemployment rate below 10 %.

13% of all young people aged 15 to 24 were in 2013 neither in employment, nor education or training. What has also been worrisome is the duration of unemployment for young people: In 2013, more than one third of unemployed people under 25 had been unemployed for more than 12 months. Young people are also over-represented in temporary and part-time work with less on-the-job training, lower wage levels and poorer long-term employment and career prospects. They face both structural and cyclical difficulties in entering the labour market. Structural difficulties are especially pronounced for those lacking sufficient qualifications and having e.g. not completed upper secondary education.²⁰

¹⁹ 23.4% for 2013 in total; Eurostat.

²⁰ Early school leaving rates declined since 2010 by 1.9 percentage points. In 2013 12% of all 18 to 24 years olds did not have upper secondary education, LFS Eurostat 2013. Especially the early school leaving rates in Spain, Portugal and Greece decreased during the last years, partly due to the lack of employment opportunities for young people and therefore limited pull-factors from the labour market.

The impact of the great recession and its aftermath on young people has attracted significant attention in recent years. The focus has so far mainly been on labour market inclusion. This is comprehensible given the urgent youth employment challenge – the youth unemployment rate for 15-29 year olds went up from 12% in 2008 to 18.7% in 2013^[2], while long-term unemployment for this age group has more than doubled and was at 7.1% in 2013 (2008: 3.1%). At the same time the share of those young people not in employment, education or training increased by 2.9% to 15.9% in 2013. Overall, there are nearly 7 million young people less in employment today compared to 2008^[3]. Yet and as illustrated by Figure 1, the situation of young people has worsened beyond the labour market and has more broadly affected their social inclusion. In fact, Eurostat data shows that 29.7% of young people aged 15-29 were at risk of poverty or social exclusion in 2012^[4], compared with 26.2% in 2008^[5].



Source: Eurostat (accessed 21.02.2014), indicators: yth_incl_010, yth_empl_100, yth_empl_120, yth_empl_150, age group 15-29; Eurofound calculations

Comparing data for this age group with other age cohorts shows that youth are the group most at risk of poverty and social exclusion today (closely followed by children under 16 years of age). The contrast with older people aged 65 and older is particularly stark and the gap between both groups has actually increased in the majority of countries in recent years. Across the EU 27, the gap has widened from a 2.9 percentage point difference in 2008 to a 10.5 percentage point difference in 2012.

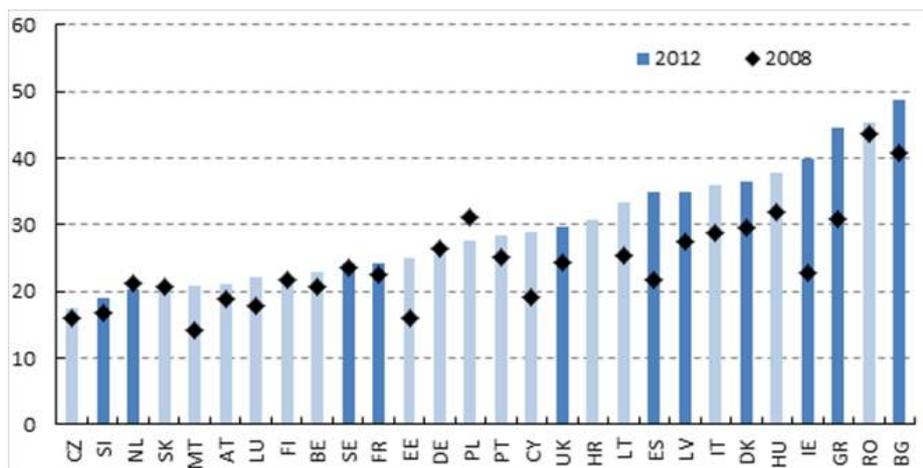
Figure 2. Share of young people at risk of poverty or exclusion, 15-29

^[2] All data Eurostat, accessed 04.09.2014, latest data available is for 2013 (2012 for AROPE).

^[3] Eurostat, yth_empl_010, accessed 04.09.2014

^[4] Data available for EU27 only.

^[5] No data available for 2013.



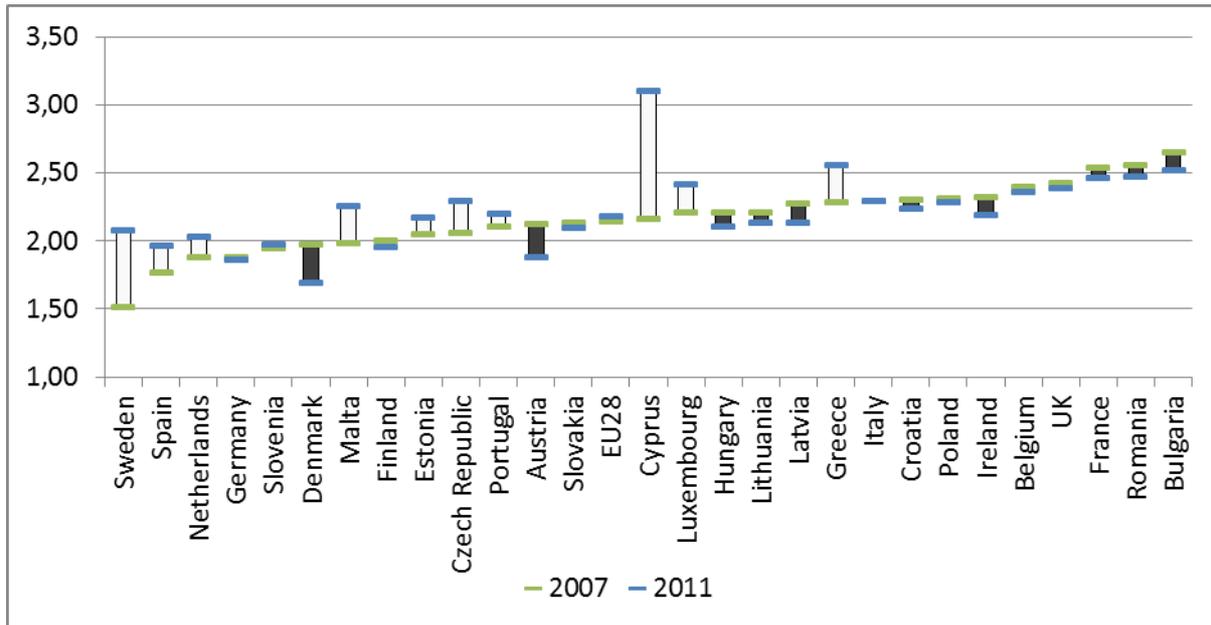
Source: Eurostat (accessed 04.09.2014), indicators: *yth_incl_010*, no data for HR for 2008, own illustration. Looking at the perceived social exclusion among young people completes this picture. The perceived social exclusion index is based on Eurofound's European Quality of Life Survey (EQLS) and represents a valuable complement to the AROPE rate. The index measures the extent to which young people actually *feel* excluded, based on responses to several questions²¹. In 2011, the lowest levels of perceived social exclusion were found among young people in Denmark, Germany, Austria and Finland and the highest in Cyprus, Greece, Bulgaria and Romania. In most countries young people on average did not feel more socially excluded in 2011 than in 2007, but in some countries such as Cyprus, Sweden and Greece there has been a significant increase (see Figure 2).

Lack of employment opportunities has a significant impact on perceived social exclusion (Eurofound, 2012). A recent Eurobarometer Survey of the European Parliament shows that independently from the personal social and economic situation, more than 50% of young people, aged 16 to 30, in the EU have the feeling that young people have been marginalised in their country by the economic crisis²².

²¹ The perceived social exclusion index refers to the overall average score from responses to the four statements: 'I feel left out of society', 'Life has become so complicated today that I almost can't find my way', 'I don't feel that the value of what I do is recognised by others', 'Some people look down on me because of my job situation or income', where 1 = 'strongly disagree' and 5 = 'strongly agree'.

²² Flash Eurobarometer of the European Parliament (EP EB 395), European Youth in 2014, analytical synthesis, p7

Figure 3. Perceived social exclusion of young people by country, 2007 and 2011



Source: Eurofound, based on the EQLS social exclusion index

Factors that increase the risk of social exclusion are multiple and some young people are more vulnerable than others. Amongst them are young people with migration background or from ethnic minority groups; Roma; those with lower educational levels; homeless or those at risk of homelessness and young people with health conditions or disabilities²³.

Unemployment, poverty and social exclusion impact on the life of young people in many ways and often long-term. They limit access to education and training, to quality services and to housing. They reduce young people's opportunities to participate in public life, reduce self-esteem and subjective well-being and lead to stigmatisation. Even if at EU level data on young people's mental wellbeing indicate no significant change since 2007, changes are visible in some countries. Data from Eurofound show a notable decrease in mental well-being in Ireland and Sweden calling for more attention to issues of mental health.

Accelerated by the crisis, the situation of all young people, independent from their socio-economic background, presents intrinsic risks factors. Governments recognise more and more the need for measures to ease access to labour market with adequate social protection of young people. Youth is historically a relatively new concept and the time span defined as 'youth' is getting longer due to growing education and training requirements. It is often characterised by high expectations for personal, educational and professional development, by full legal liability and at the same time economic dependency. But transitions to adulthood no longer follow a linear sequence of steps – finishing education, getting a job, moving out of the parental home, forming a family. Young people

²³ see EACEA (2013), *Youth Social Exclusion and Lessons from Youth Work, Evidence from Literature and Survey*, http://eacea.ec.europa.eu/youth/tools/documents/social_exclusion_and_youth_work.pdf accessed 22.02.2014) and EC (2012), *Social Inclusion of youth on the margins of society, policy review and research results*, Luxembourg, Publication Office of the European Union, http://ec.europa.eu/research/social-sciences/pdf/social-inclusion-of-youth_en.pdf (accessed 22.02.2014).

today follow pathways, which are increasingly prolonged, complex and individualised²⁴. A recent study from Eurofound confirmed that in 2011 more young people lived with their parents than in 2007 with young men more likely to find themselves living with their parents; unemployment is a key barrier to full independence.²⁵

Young people facing poverty, material deprivation and social exclusion are often less able to respond to the requirements of society or to fulfil own expectations. They lack the necessary resources and support; their social and family situation can hinder or delay development processes. Many young people suffer not only from one disadvantage, but experience multiple challenges in their life.

While access to work and (re-) integration in the labour market is the most important and efficient way to guarantee adequate living standards, economic independency and ensure adequate income in old age, many young people need comprehensive support to enter the labour market, including further training, but also concrete support in dealing e.g. with dysfunctional family settings, social and financial problems. They need support to find fulltime employment and to be able to leave precarious work arrangements, part-time work or unqualified jobs.

Most Member States have policies and initiatives in place to prevent and address youth unemployment. Many measures aim to provide education, training or apprenticeship opportunities. They try to better align vocational and general education, reduce the number of early school leavers and provide tailored job seeking assistance. The Youth Guarantee has been an important policy initiative for addressing youth unemployment, aiming to provide all young people with a job or training opportunity within four months following their registration to the PES. The youth guarantee has proved to be effective in preventing long-term scarring effects and temporary or permanent disengagement from societies²⁶. Some countries placed it already at the core of their strategies (PT, AT, BG, HR, LT, PL, RO among others). Looking at Youth Guarantee Implementation Plans in Member States confirms also that the concept of the Youth Guarantee has the potential to foster comprehensive approaches in addressing young people, including outreach activities to those furthest away from the labour market and not yet registered with the PES or any other services. An inclusive Youth Guarantee concept can address the needs of young people with multiple disadvantages and combine social support, targeted education and training measures and assistance in finding employment. It can be understood as a social investment approach by addressing the specific problems of individual young people at a decisive phase in their life, preventing or at least reducing the risk of social exclusions in future.

While it is assumed that future economic recovery and the policy initiatives taken by Member States in the context of the Youth Guarantee will have substantial positive impact on the youth unemployment problem, this crisis and its substantial impact on the social situation of young people has presented us also with the question as to the extent to which European social protection systems are well prepared to address the specific needs of young people. Besides providing sufficient

²⁴ S. Kovacheva and A. Pohl (2007), *Disadvantage in youth transitions: constellations and policy dilemmas*, in H. Colley, P. Boetzelen, Bryony Hoskins and T. Parveva (eds.), *Social inclusion for young people: breaking down the barriers*, Council of Europe, June 2007.

²⁵ Eurofound (2014), *Social situation of young people in Europe*, Publications Office of the European Union, Luxembourg

²⁶ Eurofound(2012), *Youth Guarantee: Experiences from Finland and Sweden*.

assistance to individual young people, they need to compensate for a possibly prolonged youth exclusion from the labour market and its consequences such as foregone contribution periods to social insurances and limited benefit entitlements.

Youth exclusion was identified by the SPC as one of the social trends to watch since the launch of the Europe 2020 strategy and will be a subject to a thematic review in the course of second half of 2014²⁷. This section of the report aims at reviewing the specific provisions of social protection systems for young unemployed people on the basis of reporting done by 22 Member States (AT, BE, BG, CY, CZ, DE, DK, FI, HU, HR, IE, LT, LU, LV, NL, PL, PT, RO, SE, SI, SK, UK). The focus is on access to income support and unemployment benefits, health care services and the acquisition of pension rights. The analysis also incorporates, where relevant, recent Eurofound research on the specific topic of social protection and youth exclusion.

5.2 Access to income support

In most Member States, access to income support is granted to all people fulfilling the basic eligibility criteria. It aims at guaranteeing a minimum decent living standard for people on low or no income. In general, it does not have any conditionality related to age or previous attachments to the labour market. With sometimes important exceptions, young people who are outside of the labour market have full access to this type of benefit. Exceptions can concern the level of support (depending on the living and family situation of a young person) and specific activations measures linked to the receipt of social assistance.

In IE, the statutory Supplementary Welfare Allowance (SWA) scheme, administered by the Department of Social Protection, is the 'safety net' within the overall social protection system. There are progressively differentiated increasing rates depending on age (18-24, 25, 26 and over). Jobseeker's Allowance, which is a means-tested payment, is available to persons over 18 years of age who are unemployed and have an income need and are available for, capable of and genuinely seeking full-time work. As part of targeted measures to encourage young persons to engage in education and training, lower rates of Jobseeker's Allowance are paid to young persons under the age of 26 if they do not engage in approved development programmes (similar to the differentiated payment rates for SWA). Young people engaged in such programmes can receive higher rates.

In the UK, young people can claim income-based Jobseeker's Allowance²⁸, subject to some specific conditions in case they are under 18 such as the responsibility for a child or the readiness to enlist in the armed forces within 8 weeks of the offer being made. Income-based Jobseeker's Allowance may

²⁷ SPC (2014) Social Europe: Many ways, one objective. Annual report of the Social Protection Committee on the social situation in the European Union (2013)

<http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7695&type=2&furtherPubs=yes>

²⁸ Jobseeker's Allowance is a benefit designed to keep claimants close to the labour market to enable them to move more quickly off benefit and into sustainable employment. There are conditions that apply to all age groups, attached to being eligible to continue to receive Jobseeker's Allowance, and sanctions are used to ensure claimants meet those conditions. All claimants are required to meet the basic labour market conditions, which include being available for work, actively seeking work and having a signed up-to-date Jobseeker's Agreement/Claimant Commitment. Active job search, engagement with advisers and participation in some employment support programmes are mandatory requirements. Failure to meet any of these requirements could lead to disentitlement or a sanction, intended to encourage participation and take up of the support on offer.

also be paid at a lower rate for young people up to age 25²⁹. For young people not qualifying for a Jobseeker's Allowance, may receive support on a discretionary basis if they would otherwise suffer severe hardship.

In NL young people up to the age of 27 year old who go to the municipality to apply for a social assistance benefit, are obliged to look for a job or a training course for four weeks before they can officially submit their application for a social assistance benefit. After the four week search period the municipality assesses whether the young person has made a sufficient effort to find a job or a training course. If this is the case and they meet all other legal requirements, the social assistance benefit will start on the date they first applied to the municipality. Young people from 18 to 21 years of age receive lower standard social assistance benefits than people of 21 years of age or older. This is justified by the assumption that the social assistance benefit is a safety-net benefit and young people up to the age of 21 years are still able to rely on the maintenance obligation of their parents.

In SE, according to the Social Services Act, municipalities are entitled to require that anyone who receives social assistance participates in labour activation measures. A priority group for municipalities are young people. Municipal activation programmes are organized and administered locally and can range from mandatory work requirements to training and education with large variations in both quantity and quality between different municipalities. The measure requires that an individual assessment should be made and the measure offered to social assistance recipients helps developing the individual's ability to find employment. Municipalities are asked to ensure specific support for unemployed young people under age 20. They are required to keep themselves informed about young people who are not in upper secondary education and are under the age of 20. Following a Youth Guarantee concept, it is their obligation to offer them appropriate individual measures.

In AT, young people who have no income due to unemployment can principally claim BMS (= social assistance) if they fulfil the general conditions. BMS has a strong component of integration into the labour market, so that unemployed recipients of this benefit who are capable of work have to make an effort to integrate themselves into the labour market with the support of the Public Employment Service (AMS). Due to the rising number of young people claiming BMS in recent years, the government programme has given a specific emphasis on the social integration, training and integration into the labour market of young people.

Access to income support	
Availability to all qualified people regardless of age	LU, SK, CZ, PT, CY, FI, DE, BE
Availability to all qualified people with specific arrangements for young people	IE, NL, UK, SE, AT

5.3 Access to unemployment benefits

The insurance-based nature of unemployment benefits linking them to previous work history makes it difficult if not impossible for young unemployed people with very little or no work experience to

²⁹ Universal Credit will provide a new single system of means-tested support. It will create a simpler, fairer benefits system and aims to make sure claimants are better off in work than on benefits.

get access. In a number of Member States (SK, HU, IE, CZ, PT, CY, DK, UK, FI, NL) the legislation is unified for all insured people, including young unemployed people. In order to be entitled to unemployment benefits, an insured person must have paid insurance contributions for a given period of time prior to registration as a job seeker. Minimum contribution periods vary between four months and 24 months; the maximum duration for receiving unemployment benefits can in some countries be longer than the contribution period, in most cases this period is shorter.³⁰ Receipt of unemployment benefits is in most cases also linked to being available for, capable of and genuinely seeking full-time employment.

Confronted with high youth unemployment rates, some countries have modified the eligibility criteria for young people. PT has shortened the obligatory work period in 2012 (from 450 to 360 days in the last 24 months) in order to be able to claim unemployment benefits with the aim of protecting unemployed younger workers with shorter employment records and more frequent entries and exits of the labour market.

Also SI lowered in April 2013 the conditions for young people under 30 years of age to obtain unemployment benefits. The minimum period for receiving unemployment benefits is three months for a completed period of employment of at least 9 months. However, since a large number of young people have fixed-term employment contracts and precarious work, the changed legislation now entitles a young person under 30 years of age to 2 months of financial compensation, provided that a working period of 6 months has been completed.

In AT, while entitlement to benefits from unemployment insurance is based on a specific minimum insurance period of 52 weeks of work within a period of 24 months, for young people under the age of 25, this period is at least 26 weeks within a period of 12 months before the claim is made is sufficient.

Already before the crisis and the increase of youth unemployment, it was possible for all people above 16 in SK to pay voluntary unemployment insurance, regardless of their work situation, which can give them additional rights to access of this type of benefit. This can especially be interesting for young people with long education and training periods.

In SE, since December 2007 'Job guarantee for youth' is the labour market policy programme in place for young unemployed people (16-24) registered as jobseekers. It aims at them getting a job or beginning or resuming education as quickly as possible. Participants who have reached the age of 18 receive financial support while participating in the Job guarantee for youth. The support is paid by the Swedish Social Insurance Agency (Försäkringskassan). An individual can participate in the guarantee until they begin full-time work or start studying outside of the guarantee, for example, at a higher education institution. The maximum period in the Job guarantee for youth is 15 months. After 15 months in the programme the person is enrolled in the job and development guarantee.

In DK, young recipients are entitled to and under an obligation to participate in an activation scheme after 13 weeks of unemployment. In some municipalities, young people are enrolled in an activation scheme already from the first day of unemployment (immediate activation). For every six months of

³⁰ OECD Report on 'Social Policies for Youth: Bridging the Gap to Independence. Scoping paper for the Working Party on Social policy, 2013, p. 80

unemployment, young people are entitled to receive offers of and under an obligation to accept activation schemes. In LU, after a waiting period of 26 to 39 weeks, young people without a prior employment record are entitled to an allowance of 40-70% of the minimum wage. Finally, in RO, after a waiting period of two months, school leavers without a contributions' record can receive an allowance of 50% of the value of the 'reference social indicator' (used to set social benefits) for a period of six months.

In HR, the right to unemployment benefits is acquired if a person at the time of termination of employment has been employed for at least nine months in the last 24 months. Therefore, young people without work experience and those with sporadic work experience do not have access to compensation and the extent of coverage of young people who receive unemployment benefit is limited. On average, out of a total of 70,479 recipients, young recipients are 11,530. The basis for determining the amount of unemployment benefit is the average salary, minus the mandatory insurance contributions made in the three-month period preceding the termination of employment or service. Young people are entitled to a financial assistance of Rs 1,600.00 per month (from 1 July 2013 and reimbursement of traveling expenses), unless participating in professional education without employment or education of the unemployed. In 2013, such a right has acquired a total of 13,451 young people, and for the financial assistance of this kind were paid a total of 201,096,502 kuna.

Access to unemployment benefits	
Linked to employment history with no special conditions or restrictions applicable to young people	SK, HU, CZ, IE, PT, CY, DE, FI, BE, NL
Linked to employment history with specific provisions for young people	SI, AT, SE DK, LU, RO, HR
Possibility of voluntary unemployment insurance contributions	SK

Special social protection arrangements for young unemployed people – the case of Belgium and Denmark

In BE, after they have finished their studies and under certain conditions, young unemployed persons can receive professional integration benefits. These benefits are aimed at young persons who have not yet worked long enough to receive unemployment benefits. To qualify for the professional integration benefits, the person concerned: 1) has to be no longer subject to compulsory education; 2) has to have finished a basic study or learning programme; 3) may no longer be a full-time student; 4) has to be younger than 30 years at the time of application; 5) has to be registered with an employment service as a full-time or part-time jobseeker, 6) has to have completed a professional integration period of 12 months, and 7) has to have fulfilled the condition regarding the activation of the job-seeking activities (job-seeking and cooperation behaviour). During the professional integration period, the job-seeking activities are assessed. When the young person has completed

the professional integration period and has been assessed positively, he or she will receive professional integration benefits for a maximum period of 36 months (extension possible for certain categories of people). The amount of the benefit varies according to the age and the family situation (with dependent family members, single, cohabiting). Young persons can receive specific benefits during their professional training or internship or when they become self-employed as well as bridging benefits. The internship benefit is granted to young persons who do an introductory internship (instapstage) with an internship provider in order to get acquainted with the labour market. The coaching benefit can be granted to young persons who are trained in preparation of a first employment contract. The completion benefit is a once-only benefit that can be granted to young persons who have completed a vocational training programme. The establishment benefit can be granted for a maximum period of six months to non-working jobseekers who do not fulfil the qualifying conditions, who are no longer entitled to unemployment benefits because of a sanction and who prepare to get established as a self-employed person. The amount of the benefit is equivalent to the professional integration benefit. The bridging benefit can be granted to young persons who work in the context of part-time compulsory education and whose employment or apprenticeship agreement has temporarily been suspended partially or entirely due to a strike or a lock-out.

In **DK**, as a result of the cash benefit reform, young people under the age of 30 and with no qualifying education are no longer entitled to cash benefits. Instead, they will receive educational assistance – a new service on a par with the state education grant. This is in line with the general goal of the Danish employment policy to have young people with no education embark on an education programme and young people with an education find employment. For young education-ready people, the assistance is similar to the state education grant, meaning that the young people have no financial incentive to receive educational assistance instead of completing an education. Education-ready people are young people assessed to be able to embark on an education programme within one year and who are expected to complete the education programme on general terms. Activity-ready people are young people who are not directly assessed to be able to embark on and complete an education programme. The reason for this may be academic, social or health-related problems. As education is the goal, activity-ready people must – like the education-ready people – receive an education order on day one. To begin with, an education order for activity-ready people does not entail an order to embark on an education programme, but will, on the other hand, extensively comprise activities and services that may help them be able to embark on and complete an education programme. Activity-ready people may be in need of a longer process with such activities and services before being ready to complete an education programme. Activity-ready young people are entitled to an allowance on top of their educational assistance if they request an activity. Like other young people, they will receive educational assistance, but they will receive an allowance for the time they spend on an activity.

In the Danish system, an individual contact process is planned and completed in consideration of the interests and needs of the individual young person. Young cash benefit recipients under the age of 30 are contacted within one week and will be offered active services within one month. The range of tools available in initiatives aimed at young people consists of three types of schemes - on-the-job training, wage subsidies, counselling and upgrading of skills. Furthermore, the Government focuses on ensuring enhanced initiatives for people having difficulties reading and writing. Today, the job

centres are under an obligation to assess the need to perform a reading and writing test in their first interviews with a young person. If the test shows that the young person is in need of lessons to upgrade his or her proficiency in reading, writing and arithmetic, the job centre may arrange dyslexia lessons or preparatory adult education. The box below shows the rates applicable to different recipients of educational assistance and cash benefits. Education-ready people are exclusively entitled to educational assistance, whereas activity-ready people will also receive an activity allowance for the periods during which they are active.

Cash benefit and educational assistance (see the Act on an Active Social Policy, Consolidation Act No. 190 of 24 February 2012 as amended)¹. DKK per month	
<i>Cash benefit</i>	
Under the age of 25, living at home	3,324
Under the age of 25, living away from home	6,889
Age of 25-29, living at home	3,324
Age of 25-29, living away from home	6,889
<i>Activity allowance on top of cash benefit</i>	
Age of 25 or above, living away from home	3,800
Age of 25 or above, living at home	7,365
<i>Educational assistance</i>	
Under the age of 25, living at home	2,524
Under the age of 25, living away from home	5,857
Age of 25-29, living at home	2,524
Age of 25-29, living away from home	5,857
<i>Activity allowance on top of educational assistance</i>	
Under the age of 25, living away from home	1,032
Under the age of 25, living at home	800
Age of 25-29, living away from home	4,832
Age of 25-29, living at home	8,165

Source: National Social Reports for BE and DK

The level of coverage and the access to benefits differs across Europe. Overall, young people not in employment, education or training, in South Europe are less covered by income support than in Northern or Central Europe.³¹ Linked to the very nature of individually awarded benefits such as unemployment allowances, young people are much more often covered by benefits awarded at household level such as social assistants, housing or family benefits. The access to all type of benefits and in relation to this the risk of poverty differs according to the living situation of young people, e.g. living with their parents or on their own. Nevertheless, the difference in receipt can be small if the parents are receiving income support/ social assistance as well.

In terms of maximum duration of coverage, in many countries, the period for which it is possible to claim unemployment benefit is linked to the amount of time over which contributions have been paid. Accordingly, in these cases, younger people eligible for benefits tend to receive them for a shorter period than older workers because they have not been in employment long enough to build up a lengthy contributions' record. In addition, because young people are likely to earn significantly lower wages than their older counterparts, especially if they are employed on probationary or training contracts, and, in any case, are more likely to work part-time, the benefits they receive can

³¹ OECD (2013), Working Party on Social Policy, "Social Policies for Youth: Bridging the Gap to Independence", p. 78

be considerably less. This is particularly so for young women, who typically earn less than young men and are more likely to be employed part-time.

There is also a group of young people not getting any kind of income support. Reasons for this lack of coverage might be rooted in the structure and accessibility of the different forms of income support and in the low level of registration of young people, especially NEETS, with public employment services or social services/ local authorities. OECD estimates for 2011 that more than 50% of NEETs did not receive any type of income support in ES, IT, PL and PT. In Northern Europe and most Continental Europe the rate is about 30% (except SE 40% and FI 20%).³²

Outreach activities and easy access to services are therefore important. Already discussed within the concept of the Youth Guarantee are one-stop-shops for young people to avoid that services are scattered, have conflicting requirements on young people and are inefficient in their results. An example for one-stop shops is the Youth Employment Agency in Hamburg, Germany (*Jugendberufsagentur*; <http://www.hamburg.de/jugendberufsagentur/ueber-uns/>). The agency combines the public employment services, social services, educational authorities and local authorities.

Apart from the level of services and income support available for young people, also the quality of services is important. As a project from the Council of Europe pointed out³³, young people often perceive social services as not youth-user friendly, too complicated or contradictory in requirements. Training of staff in social services targeted to young people is relevant.

5.4 Access to health care services

Investing in the health of young people is not only important for the individual young person, but also crucial in a life course perspective as it lowers the risk of health costs later on. The health of young people is influenced by health related behaviours such as tobacco and alcohol use, diet and exercise patterns, overweight and obesity, but also by wider social and economic factors with the most disadvantaged groups of young people facing most difficulties in accessing quality health services. Health compromising behaviour and conditions that arise during adolescence impact on health across the life course.

Access to quality health care is determined by basically the costs of health care services and the availability of the right services at the right time; services targeted at young people as well as health education are important to improve coverage and out-reach.

In countries where health care services are provided through public health insurance with universal coverage (UK, CZ, PT, SE, SI, DK, FI), young people have access to health care services at all times. In UK, where treatment in general is free but there can be charges for some treatments, young people who receive (or are included in an award of) certain income-related benefits are entitled to full help with health costs. In CZ, citizens contribute to the health insurance fund according to their capacity and receive healthcare according to their needs. Health insurance for the unemployed is paid by the

³² OECD (2013), Working Party on Social Policy, "Social Policies for Youth: Bridging the Gap to Independence", p.89

³³ www.coe.int/enter

State. In PT, all unemployed, including young people, are covered by the exemption from payment of user fees on access to health care, since they hold no income.

In some countries, access to health care services is related to the receipt of social benefits or registration as job seekers (SK, HU, IE, AT, BE). In SK, for young people registered as job-seekers the state is the payer of health insurance. This is also the case for dependent children under the age of 25 if they are in preparation for occupation by studying at a secondary or higher education institution. The young unemployed are not obliged to pay general practitioner or specialist fees.

In HU, individuals, by virtue of some gainful activity and the contribution payments attached, are eligible for all health care services. In the case of people not engaged in gainful activity and minors, no separate contributions are required but they need to be residents and they must only avail themselves of services in kind. Jobseekers, regardless of age, do not have to pay separate contributions but only if they receive cash benefits. If they are only registered but not receiving monetary benefits, they are not entitled to these contributions.

In IE, eligibility for healthcare is based on residency. Any person who is accepted as being ordinarily resident in Ireland is entitled to either full eligibility (category 1) or limited eligibility (category 2) for health services. Young persons aged 16–25 years are entitled to a medical card (full eligibility - category 1) where their weekly income is derived solely from social protection allowances/benefits or Health Service Executive allowances. These include recipients of Jobseeker's Allowance and Jobseeker's Benefit or where they are dependants of medical card or general practitioner-visit card holders. Young persons can also, in cases of undue hardship or where it would be unduly burdensome to provide general practitioner or medical and surgical services, be granted a medical card and, if they are financially independent. Where a young person is an applicant returning to work or involved in Government approved/sponsored employment incentive schemes, he/she will continue to retain entitlement to the medical card or general practitioner visit card for three years provided he/she is moving to full or part-time employment after being unemployed for 12 months. If a young person is participating in a Government approved/sponsored scheme, he/she can retain the card for the duration of the scheme.

In AT, every recipient of benefits from unemployment insurance is covered by health insurance. An additional option to obtain cover under health insurance legislation is the receipt of the means-tested minimum income (BMS). Both are linked to the receipt of benefits regardless of age.

In BE, people who are in a situation of supervised unemployment (persons who receive unemployment benefits, but also persons who temporarily do not receive unemployment benefits because of a temporary suspension or sanction) are entitled to the reimbursement of their medical expenses. They do not have to pay personal contributions to their health insurance funds in order to preserve their entitlements. Young unemployed persons are entitled to increased health care reimbursements on the basis of their status, e.g. when they have received the integration income or an equivalent benefit from the Public Social Welfare Centre for an uninterrupted period of three months or when they are entitled to benefits for persons with a disability (social assistance), or on the basis of a means test. In this last case, the applicant has to prove that his household had a low income during the calendar year preceding the application.

In DE, under certain circumstances young unemployed persons are compulsorily insured in the statutory health insurance system, such as in situations where they are to be empowered in a youth welfare institution to pursue gainful employment, are claiming short-term unemployment benefit, or – under certain circumstances – long-term unemployment benefit. In case they do not otherwise have entitlement to health provision in the event of illness and fall within the scope of the statutory health insurance system is subject to subordinate compulsory insurance (nachrangige Versicherungspflicht) in the statutory health insurance system if their place of residence or usual abode is in Germany.

In CY, young unemployed people under 25 are considered as family dependent and have the same rights as their family. Similarly, in AT, up to the age of 18, children/young people are principally considered to be members of a family. This status continues for a period of up to two years if the young person is unemployed. They benefit from co-insurance with family members. Co-insurance up to a maximum age of 27 is also possible for young people in education and training.

While young people in Europe seem to be largely covered by either a health insurance scheme or public health care services, only few countries report on initiatives to address the specific needs of young people in health care. They are strongly related to the rapid biological and psychosocial changes during adolescence and the resulting vulnerability of young people. This vulnerability can be especially high as a result of individual and environmental factors such as marginalisation, social exclusion and lack of parental support³⁴.

In 2013 the Swedish government published two reports addressing health among children and adolescents, highlighting especially the challenge of increasing mental health issues among young people since the 1990's. Also for Europe, data show that 15 to 20% of the adolescents suffer from one or more psychological or behavioural problems such as dread and phobias, post-traumatic stress, depression, eating or learning disorders, substance abuse, juvenile delinquency, school absenteeism, and suicide. Problems can start already at the age of 14 and often go unrecognised. The European project ADOCARE also looks at adequate care structures for adolescents and analysing good practices in different countries (<http://adocare.eu/>).

In this context also the growing number of NEETs might raise concern: Young people not being in employment, education or training are more likely to develop mental and physical health problems. The increase youth unemployment might also require subsequent investment in health services to cope with growing demand from young people.

Difficulties in accessing health care by young people also emerge in the European Quality of Life Survey (EQLS). 44% of young respondents indicated that waiting time has made access to medical care at least a little difficult, while 37% indicate that they experienced a delay in getting an appointment. Finding time to go to the doctor (due to work or care responsibilities) is an issue for 32% of young people, and cost of medical care is a problem for 31%. The distance to travel to the doctor or hospital is a less frequent problem, experienced by 18%. There is variation between countries in the importance of these barriers: cost is a major barrier in CY and IE but not so much in

³⁴ WHO 2014, Health for the World's Adolescents, Summary, p.6

UK and DK. In some countries multiple barriers to access exist, for example in EL and IT delay, waiting time and cost all seem to be an issue experienced by a significant proportion of young people.

Compared with 2007, barriers in accessing health care, especially cost, have become more prevalent in some countries, especially EL, MT, NL, IE and SK.

Table 3. Reasons for difficulty accessing healthcare, as reported by young people, 2011

	Distance	Delay in getting an appointment	Waiting time	Cost	Finding time
Austria	7%	29%	31%	14%	21%
Belgium	10%	20%	33%	26%	31%
Bulgaria	22%	23%	39%	30%	20%
Cyprus	15%	20%	36%	51%	19%
Czech Republic	19%	35%	53%	22%	25%
Germany	19%	41%	52%	27%	37%
Denmark	17%	22%	24%	7%	34%
Estonia	21%	43%	36%	23%	19%
Greece	38%	65%	68%	64%	39%
Spain	11%	26%	37%	10%	14%
Finland	18%	32%	29%	22%	19%
France	11%	26%	34%	32%	37%
Hungary	17%	37%	42%	19%	18%
Ireland	12%	21%	43%	51%	30%
Italy	36%	55%	61%	53%	36%
Lithuania	8%	28%	36%	30%	30%
Luxembourg	4%	14%	34%	29%	30%
Latvia	19%	25%	37%	29%	23%
Malta	16%	41%	65%	58%	38%
Netherlands	13%	20%	26%	25%	19%
Poland	24%	47%	42%	39%	26%
Portugal	24%	45%	48%	37%	38%
Romania	22%	39%	56%	46%	34%
Sweden	12%	32%	24%	16%	21%
Slovenia	25%	35%	38%	11%	13%
Slovakia	30%	33%	55%	50%	31%
UK	12%	36%	42%	7%	36%
Croatia	22%	42%	48%	18%	19%
EU28	18%	37%	44%	30%	31%

Source: European Quality of Life Survey, 2011

Note: red shading indicates greater difficulty in accessing healthcare, green shading indicates less

In order to improve the access to health services, several countries started to develop youth friendly health services which are responsive to the needs of young people and combine targeted services for young people with outreach activities (SE, UK). Outreach activities are especially relevant for NEETs; also young men are often recognised as the most under-served group when it comes to health services. Despite the fact that they are often in need for treatment, they address themselves less often to health services. Youth Health Centres like in SE, offering free of charge services for those

under 20 and linked to youth centres, can be a solution to reach out to those hardest to reach³⁵. Also disseminating relevant information on health matters via Internet can reach out to young people.

Access to health care services	
Universal coverage	UK, CZ, PT, SE, DK, FI, LV
Coverage related to receipt of social benefits (social assistance, unemployment benefit)/registration as job seekers	SK, HU, IE, AT, BE, DE
Access guaranteed through family insurance	CY, AT

5.5 Acquisition of pension rights

One of the potentially more significant issues related to prolonged youth unemployment is the loss of pension contributions with all the consequences this can have on acquiring pension rights as well as the level of pension income. Overall, rights to minimum pension are in most cases protected regardless of the length of unemployment. Member States have different approaches in terms of counting or not years in unemployment for pension insurance and the way periods of unemployment are factored in terms of the acquisition of pension rights. Some countries also have time limits to pension coverage in case of prolonged periods of unemployment.

In some Member States, basic unemployment allowances do not add to an earnings-related pension (SK) and a period of unemployment is not considered as period of pension insurance (SK), but in SK and AT, for example, it is possible to pay a voluntary pension insurance during unemployment.

In other Member States pension contributions are provided by the state if young people are on social benefits (CZ, IE, UK, PT, BE, AT), social benefits are considered as income and thus, compulsory insurable (DE) in order to protect entitlements, or receipt of social benefits confers pension rights (SE). However, in some countries they are conditional upon having previous social insurance record (IE).

In DK, public old-age pension and anticipatory pension do not depend on contributions made, tax paid or labour market attachment as people qualify for the right to social pensions based on the number of years of residence in the Kingdom (Denmark, the Faroe Islands and Greenland) during the qualifying period from the age of 15 to old-age pension age. In NL a similar basic state pension exists, paid under the National Old Age Pensions Act, AOW. The AOW scheme is an insurance scheme which covers everyone who lives in the Netherlands, regardless of nationality. For every year that a person is insured, he or she builds up rights to 2% of the full AOW pension. People who have been insured for the full 50 years preceding their pension age, will get a full AOW pension. A minimum income

³⁵ WHO (2010) Youth-friendly health policies and services in the European Region, p.151

level is guaranteed for every person reaching the pensionable age. In FI the unemployment insurance scheme pays a contribution to the statutory earnings-related pension scheme while a person is on earnings-related benefit. The pension accrues based on the benefit.

In CZ, any person over 18 years is considered to have pension insurance coverage if he or she is registered as a job seeker and receives unemployment benefit. Once the eligibility to unemployment benefits ends, pension insurance coverage lasts for a maximum of three years.

In IE, workers with previous social insurance record may be awarded 'credits' if they claim a social welfare payment because they are out of work, or they are ill or incapacitated, or if they are engaged in certain training or educational courses. Credits are social insurance contributions designed to protect the social insurance entitlements of insured workers who have a previous social insurance record but who are not in a position to make social contributions.

In DE, anyone claiming short-term unemployment insurance benefit (Arbeitslosengeld I) is compulsorily insurable on a regular basis while claiming this benefit. Since 2012, those claiming long-term unemployment benefit (Arbeitslosengeld II) are no longer compulsorily insurable in the statutory pension insurance system, but the time is an unweighted credited period. It does not result in a direct increase in the pension, but can have a positive effect on the assessment of other non-contributory periods.

In BE, the periods during which someone is in a situation of involuntary unemployment and receives a related benefit, is equated to periods of activity for the regulations on pensions for employed persons (= assimilated periods). Pension rights are acquired on the basis of a fictitious salary. In general, the fictitious salary is based on the salary one actually earned during the period preceding the period of unemployment.

Acquisition of pension rights	
No pension contributions during unemployment	SK
Pension contributions provided by the state if on social benefits	CZ, IE, NL, UK, PT, SE, DK, AT, DE, BE
Pension contributions provided by the Unemployment Insurance Scheme while on earnings-related unemployment benefits	FI
Voluntary pension contributions by the individual possible	SK, AT, LV

One important and rather under-researched issue is related to the social long-term consequences of large shares of long-term youth unemployment leading to young people having (significantly) reduced contribution histories and the implications for pensions adequacy and the pension systems overall.

5.6 Conclusions

If periods of education and training increase and transition from education to work becomes increasingly problematic, social protection systems must react to that and foresee targeted approaches for young people in education and training and for unemployed young people. This includes income support either in form of better access to unemployment benefits or to social assistance. Access to income support is also relevant for those NEETs not yet covered, combined with targeted services to re-gain them for education, training or employment.

Arrangements which allow young people to continue full-time education that leads to a higher qualification while receiving social protection payments (such as in IE) can be helpful in order to use the times of unemployment more effectively and to increase employability. Depending on the individual situation of a young person, this could create better long-term opportunities than activation measures which are focussed on short term return to the labour market.

The crisis has delayed the possibilities of young people to start an independent adult life; the experience of long periods of unemployment has scaring effects. This will impact on social developments in different, not yet clearly visible ways. It can have impacts on the participation of young people in society, democratic and civic engagement, in volunteering, in founding families.

As a consequence of the crisis, social protection/ social support of young people in the future would need to encompass a wider range of benefits and services than social support for adults, strengthening access to education and training, supporting young people in engaging in society, but also allowing them to get independent or to maintain independence from parents.

The design of benefit systems for young people is crucial and there is a need to define more in detail what type of benefits and services young people need and what helps to avoid the most negative consequences of (long-term) unemployment. Unemployment benefits are limited in their contribution to the social protection of young people with no or limited periods of contribution. 'Professional integration benefits' (BE) could be an important alternative. Also reaching out to young people is relevant to improve coverage and make sure that young people have access to benefits and services tailored for their needs. More peer learning and research can be useful in this regard in order to identify the policy measures most efficient and effective for supporting young people.

Young people have usually access to general health care services, but especially for the most disadvantaged young people, there is a lack of youth friendly and youth responsive health care services. Models such as Youth Health Centres (SE) can help to better provide adequate services to young people and invest in their health.

High levels of unemployment of young people have long-term consequences leading to lower wages over lifetime, lower contribution to social protection systems (especially if insurance based) and lower pensions in later life. This can also lead to reduced trust of young people in social protection systems overall.