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Subject: 2015 Report of the Social Protection Committee on recent social policy reforms: contribution to the Annual Growth Survey 2016
- Report

Delegations will find attached the full report on the above subject submitted by the Social Protection Committee, with a view to the Council meeting (EPSCO) on 5 October 2015.

The key messages which are drawn from this report are contained in doc. 12079/15.



Review of recent social policy reforms

2015 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 the 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. Each year Member States provide social reporting in the context of the social open method of coordination (OMC) and as indicated in the SPC opinion on the "Reinvigorating the social OMC in the context of the Europe 2020 Strategy²." Building on the instruments of the social OMC, the report focuses on the most recent social policies' reforms over the period 2014-2015 and aims at assessing the main directions of reform efforts in the field of social protection. 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](#)" and the 2014 SPC "[Review of social policy reforms for a fair and competitive Europe](#)." It is based on the social reporting submitted by Member States in 2015³ 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 provide an overview of these reforms while adopting a comprehensive approach to the social protection systems as a whole (social inclusion, health and long-term care and pensions).

The conclusions of the report, which focus on social policy challenges and policy reform priorities for the Union in the short-term, aim at providing the Committee's contribution to the preparatory process leading to the adoption of the 2016 Annual Growth Survey (AGS). 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 Social Europe - Aiming for inclusive growth - Annual report of the [Social Protection Committee](#) on the social situation in the European Union (2014). <http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7744>

² Council document 10405/11

³ The Strategic Social Reporting 2015 can be found at the following link:
<http://ec.europa.eu/social/keyDocuments.jsp?advSearchKey=nsr2015&mode=advancedSubmit&langId=en&policyArea=&type=0&country=0&year=0>

Table 1. Overview of social policy initiatives and reforms for the period 2014-2015

	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	combating discrimination	housing/homelessness	changes in early retirement options	changes to pensionable age	changes to contributory periods and rates	calculation of pensions and indexation	changes to minimum pensions	disability-related pensions	promoting affordability and security of funded and private pension schemes	measures to increase labour market participation of older workers	structural changes in the organization and financing of health care systems	health service delivery (including e-health)	investing in the health care workforce	cost containment and cost-sharing	enhancement of access to services and of patient's rights	organization of long-term care systems	financing and cost-sharing	preventing dependency	service delivery	assuring and monitoring quality	investing in LTC workforce	support to informal carers
BE	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
BG	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
CZ	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DK	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DE	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
EE	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ES	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
FR	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
HR	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
IT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
CY	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
LV	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
LT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
LU	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
HU	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
NL	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
AT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PL	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
RO	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SI	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SK	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
FI	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SE	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
UK	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Source: Members' States reporting;
Note: EL not included as currently under an economic adjustment programme

Table 2. Overview of the 2014 Council country-specific recommendations (CSRs) in the area of social protection and social inclusion (social protection/social inclusion and pensions)

	Social protection/Social Inclusion											Pensions								
	unemployment benefits	social assistance and link with activation	family benefit	support for older people	quality of service provision	poverty reduction	social security spending	housing	targeting	one-stop shops	sustainability	harmonization of statutory retirement age for men and women	increase in effective/statutory retirement age	alignment of retirement age to changes in life expectancy	restriction of access to early retirement	reduction of effective vs. statutory retirement age gap	pension indexation	disability pensions	supplementary pensions	active ageing/employability of older workers
BE	•																			
BG		•	•	•																
CZ																				
DK																				
DE																				
EE	•				•														•	
IE		•																		
ES		•	•																	
FR		•					•													
HR		•																		
IT	•	•	•																	
LV		•																		
LT		•																		
LU		•																		
HU		•																		
MT																				
NL																				
AT																				
PL																				
PT		•																		
RO		•																		
SI		•	•																	
SK		•																		
FI																				
SE																				
UK						•														

Source: http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/2014/index_en.htm

Note: CY and EL not included as recommendations are delivered under the Economic Adjustment Programmes

Table 3. Overview of the 2014 Council country-specific recommendations (CSRs) in the area of social protection and social inclusion (health care and long-term care)

	Health care								Long-term care				
	cost-effectiveness and sustainability	pricing of healthcare services	developing out-patient care	hospital reforms	pharmaceutical spending	quality of health care	accessibility of health care	cost effectiveness and sustainability	improvement of long-term care service	ensuring quality	targeting to those most in need	support to informal/home care	
BE	•												
BG	•	•	•	•									
CZ	•		•										
DK													
DE	•							•					
EE													
IE	•				•								
ES	•				•		•						
FR	•				•								
HR	•			•									
IT								•					
LV	•					•							
LT													
LU								•					
HU													
MT	•												
NL								•	•				
AT	•							•					
PL	•												
PT	•												
RO	•			•									
SI	•											•	
SK	•												
FI	•			•									
SE													
UK													

Source: http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/2014/index_en.htm

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

In 2014 and the first half of 2015, real GDP growth in the EU28 has advanced only moderately, at 0.8% and 1.3% respectively. Despite the weak macroeconomic background, employment has shown a small but consistent growth in the EU since mid-2013, in the large majority of EU Member States, and across the large majority of sectors. Nevertheless, labour market and social conditions remain extremely challenging, marked by 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.

Against 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. Three main types of policy responses to the social challenges emerging in the aftermath of the crisis can be identified: first, fiscal consolidation has led to cuts in budgets resulting in reductions in availability and/or quality of programmes; secondly, a number of Member States moved away from universal social inclusion policies to more targeted and conditional policies that are often less effective in addressing social challenges; thirdly, some Member States have chosen to prioritise passive short-term social protection measures over the introduction of more enabling and active measures.

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

Overview of social inclusion reforms (2014 – 2015)

Area of policy reforms		Member States
Poverty reduction and supporting people's entry into the labour market	Social assistance benefits and minimum income support schemes	BE, CY, CZ, EE, FI, FR, HR, LT, LV, LU, MT, RO, SE, SI
	Support for entry into employment and active labour market policies	BE, BG, DE, DK, ES, IE, LT, LV, MT, NL, PL, SI, RO
	Specific measures targeting groups at higher risk of poverty	AT, BE, EE, FI, HR, IE, LT, NL, RO, SI
Investing in children	Preventing child poverty	BE, BG, CZ, ES, LU, MT, PL, RO, SI
	Supporting employment for people living in households with dependent children	HU, IE, MT, UK
	Enabling access to child care	AT, BE, BG, CZ, DE, EE, FI, FR, HR, IE, MT, PL, RO, UK

Combatting discrimination		BG, FI, HR, IE, NL, RO, SE, SK
Homelessness/housing exclusion		BE, BG, CZ, CY, ES, FI, FR, HR, HU, IE, IT, LU, LV, NL, PL, RO, SI, UK

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

Social assistance reforms aim to provide a minimum income for those in need, which can be supplemented by additional measures for the inclusion of people from vulnerable groups and inactive persons. The design and duration of contributory-based unemployment benefits, minimum income as well as related benefits should ensure an adequate income while at the same time avoiding unemployment or inactivity traps. The coverage of unemployment benefits for the short-term unemployed varies greatly across Member States, ranging from less than 20% to more than 50%. This is due to variations in eligibility criteria and in the average time spent in employment, as well as to differences in the duration of benefits and in take-up rates. While both unemployment benefits and social assistance schemes are increasingly associated with activation measures (job-search support, access to training, individualised support), low coverage undermines the effectiveness of activation in encouraging and supporting actual returns to work.

Most Member States continue to strengthen their policy responses in the aftermath of the economic crisis, in line with National Reform Programmes and the Council recommendations. These measures aim to preserve employment, support activation and promote re-integration in the labour market, and ease labour taxation.

Income support measures

Some Member States increased the amount of income support or maintained it as a universal benefit (BE, EE, HR, SE, RO), others have focused on unemployment benefits and social assistance and their better link to activation through enforcement of conditionalities (BE, FI, FR, RO, MT) and on improved targeting and coverage for social transfers (RO).

In September 2015, BE has increased the minimum benefits (social assistance and social security) by 2% (on top of inflation). The intention of the government is to further gradually increase these benefits to the level of the European poverty threshold, taking into account certain advantages that accompany those benefits and avoiding financial unemployment and inactivity traps. On all levels of government, the possibility of increasingly allocating social rights automatically is actively being examined in order to combat non-take up. A number of reforms of the unemployment benefit system have been introduced, providing financial incentives for the unemployed to take up work. Some measures combine a gradual decrease in the unemployment benefits with targeted interventions to increase the net after-tax pay for low-wage earners. Moreover, job search requirements for the unemployed have been tightened and stricter eligibility criteria and rules have been enforced.

In CY a Guaranteed Minimum Income (GMI) was established with the aim to ensure a socially acceptable minimum standard of living for persons (and families) legally residing in the Republic of

Cyprus whose income and other economic resources are insufficient to meet their basic and special needs. The new GMI will replace the existing public assistance scheme and covers persons/ families that were not eligible for such assistance in the past, e.g. the working poor. The nature of the benefit is differential in that it varies according to the applicant's income and family structure. The following issues were taken into consideration in designing the new GMI programme: the minimum living cost was calculated on the basis of a revised consumption basket and includes basic needs based on a revised consumption basket, a rent allowance or mortgage interest allowance, depending on whether the eligible applicant pays rent or mortgage on a loan for acquiring the family residence, municipal or similar taxes allowance, allowance in case of extraordinary needs.

The **HR** Government adopted in November 2014 an amendment to the Decision on the Amount of Financial Assistance to Unemployed Persons, which increased financial assistance to beneficiaries in the measure Occupational training without commencing employment from HRK 1,600 to HRK 2,400 (around EUR 320, close to the minimum wage), which entered into force on 1st January 2015.

EE adopted legislative changes that implement an annual in-work benefit for low-income workers. This new in-work benefit aims to raise living standards of low-paid workers while encouraging people to take up and declare a full time regular job.

The **FI** Government has adopted several measures to support employment and prevent exclusion. Applying for jobs with short-term employment contracts has been made easier with changes to the guidelines on the application of the Unemployment Security Act as from the start of 2014, with unemployment benefit being paid on application in advance. Furthermore, to improve work incentives, the start of 2014 saw the introduction of a protected share of earned income, to encourage recipients of the Labour Market Subsidy to accept short-term employment.

FR has taken several measures to reform the unemployment benefit system, such as the new unemployment benefit agreed with the social partners which introduces priority incentives and sustainability measures with two main objectives: the sustainability of the system with the decrease of the deficit and the strengthening of incentives to return to employment. This new benefit scheme consists of incentives for people returning to work enabling them to cumulate newly acquired rights with potential remaining rights previously acquired, as well as, review of benefit threshold, reviewed ceiling for the entertainment sector, or introduction of unemployment contribution for people over 65, increased postponed access to unemployment benefits in case of severance pay. To favour the return in the employment and support the purchasing power of modest workers, an allowance of activity ("prime d'activité") will be introduced on January 1, 2016. This allowance will replace both the "allowance for employment" (PPE) and the "RSA activity".

LT continued the Reform of the Cash Social Assistance system which started in 2012. The provision of social benefits has been assigned as an independent municipal function to other 55 municipalities as of 1 January 2014 (before it was a state function). Since 2015, all municipalities provide cash social assistance on newly established common equal terms (they have lost discretion to decide whether to grant compensation/ benefit or not except cases not provided in the Law). Now the municipalities can use the municipal budget funds unused for Cash Social Assistance for funding other social assistance providing additional social support particularly to vulnerable populations, where support by legislation does not exist or is insufficient. In order to promote financial interest of social benefit recipients to find employment and remain in the labour market, municipalities have been provided

with the right to also allocate social benefits in cases when the person (family) income exceeds the state-supported income level enshrined in the Law by 50 percent (previously it was 20 percent).

The **LV** government in 2014 has approved the Concept paper On Setting of the Minimum Income Level. A common and adequate socially and economically justified minimum income level that would serve as a benchmark for the development of support measures and policy for the Latvian population is the first stage of improvement of the social security system and social assistance system. To continue the commenced reform, in 2015, the link between social assistance, state social benefits, minimum pension, and unemployment benefit and the minimum income level will be defined and regulatory enactments and amendments needed to introduce the minimum income level will be identified. It is planned that the system will be introduced in 2017.

The **LU** Government is revising the minimum income scheme, with an emphasis on social activation policies and coordination with active employment. A particular attention will be put on policy coherence in the field of employment and social inclusion. In **MT**, the overall design of the tax and benefit system is also being improved, with the tapering of social assistance benefits over the first three years of employment. Furthermore, the MT government introduced targeted tax incentives and wage subsidies for inactive women above the age of 40, who have been out of the labour market for the past 5 years, to enter the labour market.

The **RO** government is currently drafting a Minimum Social Insertion Income (MSII) law in order to improve the efficiency and effectiveness of social transfers, by better targeting the beneficiaries and reducing the administrative costs. The MSII introduced a benefit formula that gives recipients an incentive to find work by making it a co-responsibility. Moreover, the budget for means-tested programs will be further increased and will be maintained at this level in real terms thereafter. The new consolidated program will become the key anti-poverty program in Romania. This policy initiative will increase both the number of beneficiaries of means-tested programs and the benefit levels that they receive. Moreover, given the increase in funds, the coverage of households in the poorest quintile can be expected to increase from the current level of 60 percent (based on Household Budget Survey data from the National Institute of Statistics as well as administrative data) to about 80 percent, with progressive coverage and larger benefit levels for the poorest. In addition to the MSII programme, the RO Government adopted in 2015 a National Strategy for Social Inclusion and Poverty Reduction for 2015 – 2020 as well as a Strategic Plan. This strategy aims to coordinate and update the set of strategic measures for poverty reduction that have been implemented in Romania so far. Moreover, the Strategy incorporates elements from various sectoral strategies and from particular domains of the Government's social inclusion policy (such as tackling child poverty, reducing discrimination against Roma, and integrating marginalised communities and addressing the regional dimensions of poverty).

SE will implement as of September 2015 a reform of the unemployment insurance scheme that will raise the value of the maximum monthly replacement rate from 14,960 SEK to 20,020 SEK. It should be noted that after 100 days of unemployment, the replacement rate is reduced from 80 to 70 per cent of the previous income and that income from unemployment insurance is more heavily taxed than income from work.

The **SI** government (upon the proposal of the ministry responsible for social affairs) adopted a comprehensive program that includes a mandatory mechanism for debt relief, the introduction of

social card and assistance to evicted families in order to improve the social situation of the most vulnerable families and individuals.

Over the last years many Member States have tightened eligibility conditions for minimum income (commonly related to age, nationality, residence, lack of financial resources and availability for work). Conditionality has generally been increased and availability for work has usually been more tightly enforced. Together with a greater emphasis on activation measures, these reforms contributed to a reduction in long-term unemployment. However, they have not always reduced long-term welfare dependency. Sanctions for lack of compliance with the requirements may lead to reductions in benefit and to the loss of the right to social assistance benefits, adding to the pressure on last-resort welfare schemes.

Active labour market policies (ALMPs)

Inclusion in the labour market through active labour market policies has been a primary focus for many Member States whereby the granting of income support is now largely conditioned to the recipient's active involvement in job searching. Several Member States offer a range of financial and fiscal incentives for employers to hire long-term unemployed, such as wage subsidies, bonuses for hiring long-term unemployed, reductions in social security contributions and/or training cost subsidies.

The **BG** authorities have introduced changes in the existing measures to encourage employers to hire long-term unemployed, through which not only the social insurance contributions but also a part of the remuneration of the hired long-term unemployed persons are subsidised. In this context, a new Programme for Training and Employment of Long-term Unemployed was approved in February 2015, under which 850 long-term unemployed persons will be trained and included in employment. The total amount of the funds provided from the state budget is BGN 3.3 million (approximately EUR 1.7 million). Moreover, subsidised employment measures to encourage employers to hire single parents continued to be implemented in 2015. It should be noted that an Action Plan for the period 2015-2016 for the implementation of the National Strategy for Reducing Poverty and Promoting Social Inclusion 2020 was adopted by the Council of Ministers in August 2015. It puts a strong emphasis on active labour market measures. The Plan also includes concrete measures in the field of education, health, social services and transfers, homelessness, etc.

DE has introduced some ALMPs measures, such as a reform of the performance target system for job centres, in addition to the more extensive reform of active labour market instruments (in force since April 2012) which aims at speeding-up the integration into the labour market.

DK adopted an Active Labour Market / Employment reform in December 2014, which has been implemented since January 2015. The reform will change both the content and the organisation of the Public Employment Services in order to provide better and more individualised support for people who become unemployed. A key function is the 'screening', whereby those who are assessed to be able to find a job independently within six months will have more freedom to do so, while those who are at risk of ending in long-term unemployment should get more support at an earlier stage.

In **ES** the Strategic Plan for Equal Opportunities 2014-2016 was approved by the Government in 2014. It foresees measures to improve the participation of women in the social and economic fields, to foster equal opportunities in the education system, to implement equality policies in other fields and to integrate the principle of equal treatment and opportunities in all government policies. Among actions carried out to reduce wage inequalities between women and men are reinforcement of monitoring and control of compliance with applicable legislation regarding equality between women and men; a self-diagnosis gender pay gap tool that enables companies to identify wage inequalities between women and men, In addition, programs have been developed to improve the employability and self-employment of women in vulnerable situations with personalized pathways and accompanying measures, through collaboration agreements with local authorities; and, social and labour-market integration of women victims of gender violence: agreements have been signed with 34 companies that participate in labour market integration actions, thanks to which around 2.500 contacts with women victims of gender violence have been signed. In addition, a new Employment Activation Program targeted to the long-term unemployed combines active and passive measures providing for an EUR 426 economic support for six months to 400.000 (estimated) long-term unemployed people. A budget of EUR 850 million have been allocated for this program in 2015.

IE has continued to pursue activation policies under the 'Pathways to Work' strategy, first launched in 2012 with further policy measures implemented in 2015. Social welfare and public employment services (PES) have been integrated in one-stop-shops (INTREO), linking benefit entitlements more closely with the activation services. In order to provide additional capacity to the PES, a new employment services model, JobPath was introduced in 2015 to enable PES to engage more systematically with long-term unemployed people Furthermore, an Employer Activation and Youth Employment Charter was introduced in 2014 whereby employers guarantee that at least 50% of candidates considered for employment will be selected from the Live Register of unemployed jobseekers, and the inclusion of a 'Social Clause' in large public works procurement (10% of jobs to be reserved for unemployed jobseekers). A further welfare reform, The Housing Assistance Payment (HAP) was introduced on a pilot basis in 2014 to remove barriers to work and facilitate the take-up of full-time employment.

LV is currently preparing an integrated Programme (with support from EU Structural Funds) for intensive activation of the long-term unemployed, which will provide for a greater involvement of civil society organisations, more customised support, improved assessment of individual barriers to labour market and structured cooperation between PES and social services, in line with the one stop shop principle. A number of amendments to the Law on Social Services and Social Assistance were submitted to the Parliament in February 2015, providing additional stimulus for social assistance recipients to return back to work by introducing a gradual termination of social assistance benefit after 3 months of employment. At the same time, in order to improve the availability of social assistance to families with children, the family benefit will not be taken into account for the income test. Amendments to the Social Services and Social Assistance Law also envisage a separating the system of vocational assessment and the professional rehabilitation service thus ensuring a more effective cooperation between the Social Integration State Agency and the State Employment Agency in integration persons with a disability or health problems in the labour market and providing support that is most suitable to person's needs and skills.

MT has taken measures to further stimulate employment and to limit the extent of inactivity traps. In order to remove disincentives on the labour demand side, as of 2015 maternity leave is no longer paid directly by the employers, but through a specific scheme financed by contributions from all private enterprises in proportion to their number of employees. At the same time, the child allowance for self-employed women has been increased. A number of initiatives have also been undertaken to increase the availability of residential care and community-based services in order to promote independent living and to mitigate the family responsibilities, mainly for women.

NL has also launched several policies to increase labour market participation. Reforms in the labour market, including the modernisation of dismissal law and changes to enhance the activating nature of the Unemployment Benefits Act, aim to improve the functioning of the labour market due to enhanced labour mobility and higher labour participation.

PL adopted an act on employment on promotion of employment and labour market institutions, in force since 27 May 2014, which introduced new measures aimed at vocational activation of women, including an activation benefit for the employers who hire unemployed persons after the break associated with raising a child or with the care of dependent person. Several activation measures such as the teleworking grant for parents returning to work with at least one child under the age of six years or for persons caring for incapacitated adults have been introduced to stimulate the return to labour market of women taking care of dependents. These measures are funded by the labour fund whose budget has been increased to PLN 12.1 billion in 2015.

Measures to promote better inclusion in the labour market of persons with specific needs are particularly important. In the case of the long-term unemployed and of the older workers, prevention against loss of skills and retraining programmes are essential for their integration and the sustainability of pension systems.

In **AT**, an agreement on an additional labour market package for older employees was reached in March 2014. The programme contains wage subsidies, health promoting programmes and enhanced retraining to update skills. A budget of EUR 370 million has been allocated for this initiative up to 2016. Additionally, EUR 600 million have been made available for active labour market measures for the period 2013-2016. Moreover, the Fit2Work counselling infrastructure, with the aim of supporting health and safety at work has been rolled out in all regions and so far 35,000 persons and 500 companies have made use of this offer, which had a budget of some EUR 12.1 million in 2014.

The **HR** government adopted Guidelines for the Development and Implementation of the Active Labour Market Policy 2015-2017. These guidelines aim at encouraging the employment of unemployed persons in an unfavourable position on the labour market (young people, long-term unemployed, and older workers and women), but also job creation by encouraging self-employment, by developing programmes contributing to the activation of persons at risk of social exclusion. The Act on Amendments to the Contributions Act, which was adopted on 25 November 2014 and entered into force on 1 January 2015, stipulates a fiscal benefit by which employers who employ a young person on permanent employment contract are exempt from the payment of mandatory contributions on salary for such young person in the amount of 17.2% for a period of 5 years.

The **NL** government has also introduced a set of measures directed at unemployed and employees working in sectors with a high risk of unemployment. These measures provide for (re)training and in-

service training programmes and apprenticeships, thereby increasing job security and preventing/limiting a rise in unemployment. The recently introduced *Brug-WW* programme aims at facilitating transition from shrinking to growing sectors of the economy by offering possibilities for taking necessary retraining to the unemployed, whilst fully retaining unemployment benefits. In addition, the prospective employer has to guarantee employment for the duration of at least one year.

RO took steps towards strengthening active labour market measures, by providing incentives to employers to create new employment opportunities for persons above 45 years of age and persons who have 5 years until the statutory retirement age. These measures provide incentives to employers who create new employment opportunities for registered unemployed individuals aged 45 years and above and for those who have 5 years until early or statutory retirement age. These incentives are to be disbursed monthly for a period of 12 months and amount to RON 500 (equal to the Reference Social Indicator) for each new employee. Employers receiving the incentive have the obligation to maintain labour relations with the persons employed for at least 18 months.

Another focus is on providing those with health and disability impairments with sufficient income support and on assisting them to become active in the labour market.

In **BE**, certain older disability benefits (that started in 2009 and 2010) were increased by 2% and the catch-up premium for persons with disabilities that have been in work incapacity for at least two years has also increased.

EE has taken a number of steps to ensure the implementation of the work capacity reform package. The reform aims to improve the situation of people with limited work ability both in the labour market and in the society, introducing a qualitative shift from evaluating the incapacity for work to assessing the individual's ability for work. The measures included in the package aim to prevent the loss of ability for work and to motivate people to actively participate in social life.

In **FI**, an amendment to the Disability Benefits Act will come into force on 1 June 2015. The amendment concerns the subsidies for persons with disabilities under 16 years of age, subsidies for persons with disabilities over 16 years of age and care allowance for pensioners. As a result, more than 10,000 newly eligible people over 16 years of age will receive minimum basic benefit by the end of 2020. The Act provides for a more precise definition of the specific costs resulting from the illness, impairments or injuries, which are taken into account when granting disability benefits.

SI has prolonged the measure which enables an exemption of payment of social security contribution for 24 months for an employer in case of permanent employment of young workers (less than 30 years of age). Until the end of 2014 more as 3.000 young people got employed under the mentioned measure.

Access to services

Active labour market policies aimed at increasing employability are essential for providing opportunities for employment. However, these policies are often not sufficiently effective in overcoming non-work related barriers to employment and job seeking activities, e.g. care needs, reskilling, counselling support, transport connections, lack of financial means and income support.

Four main types of enabling services could be effective in removing such obstacles to labour market participation and in reducing the risk of poverty or social exclusion: early childhood education and care, life-long learning, housing, and healthcare. Access to quality social services is essential to providing support for those furthest from the labour market in their reintegration into working life as well as ensuring social participation for those who cannot work.

Providing integrated services tailored to individual needs brings more people into employment and increases the efficiency and effectiveness of spending. Member States have presented forward-looking approaches integrating the three pillars of active inclusion through using integrated services (one-stop shops), targeted services (training package including regarding children), and moving beyond labour activation (through the approach of social activation):

The **CZ** Government amended the Act on Social Services and partially modified some aspects of the system of social services (e.g. quality, financing, planning social services, support to social work). Furthermore, the National Strategy of Social Services Development 2015 has been prepared, setting framework goals and targets for the given period. Moreover, the Social Services Act and the Act on the assistance in Material Need have been both altered so as to include possible grants relating to the social work in public administration, which should help to stabilise the number of social workers in the municipalities and regions, consequently increasing their number and thus increasing the availability of assistance to the those who are in need.

FI adopted an amendment to the Social Welfare Act, which will ensure basic services and reduce the need for corrective measures.

While some Member States already provide integrated services and 'one-stop-shops', others lack policy coordination at the national level, leading to fragmentation and inconsistencies in service provision. Improved coordination between these organisations could lead to more efficient administration and services provision, better monitoring and follow-up while diminishing gaps in coverage.

2.2. Investing in children's welfare and in child care

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.

Important reforms in support of children and families took place over the last years at local, regional and national levels, aiming in particular at facilitating support to parents' access to the labour market, and enhancing preventive approaches through early intervention and increased support to families. Such changes have taken place in a context of increasingly scarce resources, where key interventions have often been affected by budget cuts and/or refocused on the most vulnerable children and families.

Income support measures for families with children were strengthened or expanded in a number of Member States:

After the regionalisation of child benefits in **BE** (6th state reform), the regional government of Flanders plans to introduce a social supplement to the child benefits for children growing up in low-

income families. The income ceiling for this supplement is to vary depending on the composition of the household and will thus depend on the number of people in the household.

In **BG**, a total amount of BGN 568 million (approximately EUR 291.22 million) was allocated in the 2015 budget for payment of all types of family benefits, an increase of BGN 12 million (approximately EUR 6.16 million) compared to the financial resources provided in 2014. It is important to note that in order to improve the legal framework in the field of children and family policy and to improve the efficiency and effectiveness of the family allowances, an act amending and supplementing the Family Allowances Act was adopted by the National Assembly of the Republic of Bulgaria and effective as of July 2015.

CZ adopted a series of changes to the state social support for families with children with effect from 1 January 2015, such as the introduction of the child birth grant also for the second child and the mitigation of eligibility criteria for the child birth grant. Families are entitled to the birth grant provided the family income in the calendar quarter prior to the birth of the child does not exceed 2.7 times the family's living minimum. The birth grant amounts to 13,000 CZK for the first child and 10,000 CZK for the second child.

In **ES** the specific Child Poverty Fund in 2014 amounting EUR 16 million implemented through the regional and local system of social services have been renewed in 2015 amounting EUR 32 million, but enhancing its scope to cover the needs of disadvantaged low income families with children. Income tax burden for families have been generally reduced, in particular for families with ascendant or descendant dependent persons, and lone-parent families with dependent children and low income. A new law on child protection allows large families to retain their targeted benefits until eligibility of the younger son ends, and eliminate poverty risk or situation as a reason for removing parental rights.

In **LU**, the Government is revising family policies (family allowances, parental leave scheme, education allowance) to adapt them to the realities of today's societies. The reforms go alongside with an investment in early childhood education and care (ECEC) and measures to promote multilingualism in child care facilities.

MT introduced this year a child supplement to families who have dependent children under the age of 23 years and whose income is less than EUR 11,900 per annum. The amount of EUR 400 will be paid for every child up to the third child and EUR 200 for the fourth child or more. This measure aims to combat the risk of poverty and social exclusion amongst children. This child supplement is paid on condition that the children register at least 95% of school attendance; undergo regular medical check-ups; and participate in sport and cultural activities, with the aim of improving their education and psychosocial health.

The **PL** authorities continued to provide material support for families with three or more children through the Large Family Card, which was introduced in 2014. Large families receive discounts for cultural events, educational, recreational and transport services from public and private organisations throughout the country.

The **RO** government adopted the National Strategy on the protection and promotion of children rights 2014-2020 and its corresponding Operational Plan. The strategy focuses on the improvement

of children access to quality services, the respect for their rights and the support for the social inclusion of the children in vulnerable situations. Furthermore, the family allowance has been increased by 42 RON for each child in the family, starting with November 2014.

SI has adopted changes regarding the subventions of school meals. By raising a threshold for lunch subsidies from 18% to 36% of average salary per person in family, more children will get the entitlement to subsidized school lunch.

Support for parents' access to the labour market and incentives to work were enhanced in a number of countries, where the tax burden for low wage earners and families with children was decreased:

In **HU**, as of 1 January 2015, the employer's tax allowance concerning parents who raise a small child and work part-time was raised to 100,000 HUF gross salary, as in the case of full time employees. It is expected to encourage the dissemination of part-time employment among parents with child care duties. From 1 January 2015 onwards, parents raising three or more children are entitled to part-time employment for two more years, until children reach the age of 5.

A range of activation measures were introduced in **IE** in 2014/2015 with the aim of increasing the work intensity of jobless households and facilitating labour market participation among households with children. Reforms of the One Parent Family Payment (OFP) continued to be implemented so that by July 2015 the maximum age limit of the youngest child was reduced to seven years for all OFP recipients. The purpose of the reform is to strengthen the links between lone parents and the labour market, thereby reducing the risk of long-term welfare dependency. While the reform has been introduced on an incremental basis since 2013, the biggest impact will be in 2015 when c. 30,000 OFP recipients (with an estimated 50,000 children) will transition from the payment (over 40% of the remaining cohort). The long-term unemployed and lone parents exiting OFP who take up work can benefit from the new Back to Work Family Dividend (BTWFD) which was introduced in 2015. This scheme aims to help families to move from social welfare into employment. It will give financial support to people with children who were getting jobseeker and one-parent family payments and who take up employment, increase their hours of employment or become self-employed. The BTWFD provides support for up to two years after a person moves from social welfare into employment.

The **MT** authorities have introduced in January 2015 an in-work benefit scheme to make employment financially more attractive for low- and medium-income families, where either spouses (or single parents) are in employment and have dependent children.

The **UK** government has announced a number of measures to address affordability of child care. From April 2016, under Universal Credit, in households where both partners are earning enough to pay income tax they will be able to claim 85% of child care costs (up from 70% currently). Furthermore, from 2017, under the 'tax-free child care scheme', eligible families will receive 20% of their yearly child care costs on fees of up to GBP 10,000 per child, which will have a positive gender impact by helping women enter or return to the labour market after having children.

Investment in education, and specifically in early childhood education and care (ECEC) has been sustained in several Member States, thus reflecting a growing awareness of the fundamental role of the pre-school years in shaping children's cognitive and social skills:

In **AT**, additional public funding has been provided in order to improve the educational outcomes in the field of ECEC. However, some planned measures have not been implemented yet, such as the adoption of a national quality framework for ECEC, the introduction of an additional compulsory year in ECEC and of a new transitional phase between early-childhood education and primary school.

FI amended the Basic Education Act in order to make pre-primary education compulsory from the beginning of 2015. The objective of compulsory pre-primary education is to improve the children's learning conditions and to increase educational equality.

In **HR**, a new decision was adopted on 31 October 2014 by which all children are included in a compulsory one-year preschool programme before they start school. The programme includes 592 kindergartens/other legal persons implementing the preschool programme, and 41,590 children.

The **UK** Government has introduced a wide package of support and investment in early education and childcare, which includes funding for 15 hours a week of free child care for around the 40% most disadvantaged 2 years old and all 3 and 4-year olds. In addition the Early Years Pupil Premium programme with a budget of GBP 50 million provides additional support to disadvantaged 3- and 4-year olds. And the Government has announced plans to offer working families with 3- and 4-year olds 30 hours of free childcare a week from September 2017.

Funding for the expansion of child care facilities was increased in some Member States:

AT has announced investments totalling EUR 800 million by the year 2018/2019 for increasing the number and availability of places in all-day schools, as well as for improving the quality of their services.

In **BE**, a second national plan against child poverty (2015-2019) will be drawn up by the end of 2015 in consultation with the Regions and Communities. A child poverty target will be developed. In the Brussels-Capital Region, the authorities have intensified the nursery plan. A budget of 16 million EUR has been committed to new places in child care structures for children aged 0 to 3 years. Priority is given to an increase in the number of places in collective child care structures that are socially available, requiring financial contribution from the parents. The support is concentrated in these areas where the coverage rate of the nurseries is lowest. It aims at guaranteeing access to child care for families in a difficult situation.

In **BG**, under the Social Inclusion Project, a new type of services for children and families are being established in 66 municipalities aiming at: early childhood development, risk prevention in early childhood, better coverage and improvement of the readiness of children for inclusion in the educational system, improvement of the family environment. Currently 24 municipalities have already put into operation the crèches and garden groups under the Project – a total of 1,511 new places in nurseries and kindergartens. As a result of the implementation of the project approximately 9,000 children have access to integrated services for early childhood development.

The **CZ** government adopted in 2014 the Act on Child Group which aims at increasing the availability of private child care facilities. On its basis, any legal subject can provide child care in groups of up to 24 children (of at least 1 year of age). The expenditure on company pre-school facilities has been made tax-deductible, and tax relief has been granted to parents who use the services of child groups. Moreover, the CZ government pledged to increase the capacity of public kindergartens. A new

initiative was announced to establish a governmental fund from which new capacities of public early childhood education and care will be supported: this fund will dispose of CZK 1.5 billion for the period 2014-2021, and CZK 12 billion for the period 2015-2023, planned to be disbursed from EU funds.

In **DE**, the Bundestag has adopted a law on financial relief of *Länder* and municipalities in order to provide further support to the expansion of childcare facilities to back up the newly established right to child care and to improve the quality of services they deliver.

EE promoted a change in regulation allowing municipalities to provide more flexible care services and plans are in the pipeline to create 1,200 additional care places. Furthermore, support will be provided for building / reconstructing care houses with the aim of creating 2,000 additional places.

In **FR** the child care facilities and the accompanying social measure towards the employment for families with children are being strengthened, with priorities given to single-parent families.

In **IE**, eligibility requirements were changed in July 2014 in order to increase the attractiveness and take up of the child care and after-school schemes. The scheme also provides part-time care for children up to the age of 13 - the upper age limit was previously 5 years. A further enhancement to the programme includes an after-school option which enables qualifying parents of primary school children to obtain after-school care at a weekly cost of EUR 15.

MT has taken a number of measures to expand child care facilities and services in order to encourage the participation of women in the labour market. The provision of free childcare services to households in which parents are in employment or pursuing further education was first established in April 2014 and is being continued under the 2015 Budget. According to the data provided by the Maltese authorities, access to child care among the low-to-medium workers has increased significantly. Prior to the start of free child care, women who started work after giving birth accounted for just 34.9% of users. However, since April 2014, this category of mothers accounts for 46.1% of the new entrants.

PL continued to support the program for development of child care facilities for children under the age of 3 (*Maluch* / 'Toddler'). The amount of funding was PLN 101 million in 2014, distributed at local level. The subsidy covered approximately 21 thousand new and existing places at child care institutions for children up to 3 years of age. For 2015, the government has allocated PLN 151 million for this program. Moreover, a statutory obligation was introduced for municipalities to provide a place to participate in pre-school education for each 4-year-old child as of September 2015, and for each 3-year-old child as of September 2017.

The **UK** government has introduced a GBP 2 million scheme, open to anyone who wants to set up a new nursery or child-minding business. Grants of up to GBP 500 are available to help cover the costs of insurance, training, equipment and legal advice. The government estimates the scheme will improve childcare availability by helping to launch up to 6,000 new child care businesses thus helping women with children move back into work.

Further steps were taken to improve the quality of alternative care and support to children growing up out of their family environment: the **BG** authorities will continue to implement the Programme "Child protection policy through the transition from institutional care to alternative care in a family

environment” in 2015 and will increase its funding by over BGN 6 million (approximately EUR 3 million) compared to the 2014 budget. The total amount of the funding allocated to this programme is BGN 16 million (approximately EUR 8.2 million). Deinstitutionalisation of childcare is at a crucial stage and there are specific results from the implementation of the five projects set in the Action Plan under the National Strategy “Vision for deinstitutionalisation of the children of the Republic of Bulgaria”. One of the key projects is “Childhood for All” aimed at the deinstitutionalisation of care for children and young persons with disabilities. The aim of the project is to close the homes for children with disabilities by establishing 149 new centres for family-type accommodation and 36 protected homes in 81 municipalities. Besides residential care, supporting services in the community for children and young people are planned to be established. In parallel with the deinstitutionalisation process, concrete measures for prevention, rehabilitation, foster care and adoption have also been implemented.

The **FI** government adopted several amendments to the Child Welfare Act concerning child protection emergency placement, which will come into force in the beginning of 2016. The requirements for child emergency placement have been tightened. The right of the children and young people in after-care to the housing and livelihood security has been clarified.

2.3. Measures to combat discrimination

Specific measures and projects to foster the social inclusion of persons with disabilities,⁴ from 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 **FI**, the implementation plan for the Immigration Strategy for 2013-2020 and the State Integration programme were adopted in 2014. A Centre of Excellence for Integration under the Ministry of Employment and the Economy was established in 2014. This centre is in charge of supervising and monitoring the integration of migrants, providing support for regional and local actors, the disseminating information, and promoting cooperation and interaction among various stakeholders. Moreover, the FI authorities adjusted the conditions for early access to vocational rehabilitation in 2014 with the aim to prevent retirement on a disability pension. From October 2015 a rehabilitee should be able to receive a partial rehabilitation allowance from the Social Insurance Institution for those days of rehabilitation when a person works only part-time.

HR introduced amendments to the Act on Vocational Rehabilitation and Employment of Persons with Disabilities in December 2014 with the aim of further improving professional rehabilitation and employment of persons with disabilities. These amendments provide for a quota of 3% of persons with disabilities out of the total number of employees for all employers or a substitution quota for employers who conclude a business co-operation agreement with a company or association in which more than half of workers are persons with disabilities. The Act provides for establishment of regional centres for vocational rehabilitation.

⁴ More concrete examples of measures concerning persons with disabilities are listed in the recently published Seventh Disability High Level Group Report on the Implementation of the UN Convention on the Rights of Persons with Disabilities, July 2015: <http://ec.europa.eu/social/main.jsp?catId=1137&langId=en>

In **IE**, the Human Rights and Equality Commission was established as an independent statutory body on 1 November 2014 following the merger of the Human Rights Commission and the Equality Authority. The Commission will support public bodies in placing equality and human rights consideration at the heart of decision making. A significant innovation in the Irish Human Rights and Equality Commission Act 2014 is the introduction of a positive duty on public bodies to have due regard to human rights and equality in their work and conduct their business in a manner consistent with individual human rights. The Commission will assist public bodies to comply with the positive duty, including by producing guidelines and codes of practice.

NL has adopted specific measures targeting people with a more vulnerable position on the labour market: the young, the lower skilled, migrant workers, the second earners, persons with disabilities and the elderly. One of the goals of the new Participation Act introduced by the government is to enhance participation in the labour market of people with disabilities as well as of the lower skilled. This act, which has entered into force as of 1 January 2015, replaces the Work and Social Assistance Act (WWB), the Sheltered Employment Act (WSW) and part of the Invalidity Insurance (Young Disabled Persons) Act (*Wajong*). As of this year, only disabled young persons who are fully and permanently incapacitated to work are eligible to the *Wajong*. Arrangements have been made with employers on the number of jobs to be released in the coming years for people with disabilities. Private employers have pledged to provide 100,000 jobs, with a further 25,000 due to be created in the public sector. These commitments will be effectuated in increasing increments until 2026 (2024 for the government), with the government assessing progress annually. A mobility bonus comparable to that available to older and younger labour market participants will be extended to workers with disabilities who are covered by the Participation Act. Employers hiring workers with disabilities will be eligible for a reduction on the premium of EUR 2,000 for a maximum period of three years.

RO adopted in January 2015 the National Strategy for inclusion of Romanian citizens belonging to the Roma minority for 2014-2020. According to this document, the Romanian citizens belonging to Roma minority, registered to PES, will benefit of measures financed under ESF 2014 – 2020, the Unemployment Insurance Budget and the state budget. According to the Romanian Government's forecasts, approximately 70,000 Romanian citizens belonging to the Roma minority are expected to access active labour market measures until the end of 2016.

In **SK**, access to high quality and inclusive pre-school and school education for marginalised communities including Roma has slightly improved, but the wider participation of Roma in vocational training and higher education is not ensured. The number of teacher assistants for children with special needs, including children from socially disadvantaged environments, has been significantly increased for the school year 2014-2015 and a further increase is budgeted for 2015. Early childhood education and care capacities are being expanded with the support of EU funds, while a proposal for compulsory enrolment in early childhood education and care for children from socially disadvantaged environment was made for Roma Communities, without concrete plans for its implementation at this stage.

In addition to policies fostering the inclusion of ethnic minorities and immigrants, several Member States took measures to combat discrimination against persons with disabilities or belonging to vulnerable groups:

BG adopted an Act amending and supplementing the Protection Against Discrimination Act on March 2015 in order to incorporate the provisions of Directive 2006/54/EC on the protection from discrimination against transgender and burden of proof into national law. The BG authorities have also been implementing several projects aimed at overcoming discrimination on the grounds of disability and on other grounds such as gender, age, etc.

In 2014, the **SE** Government proposed an amendment to the Discrimination Act in order to strengthen the protection for persons with disabilities so that failure to take reasonable measures to increase accessibility may be deemed to constitute discrimination.

2.4. Homelessness and housing exclusion

One of the most dramatic consequences of the recent economic crisis is represented by rising levels of homelessness. Homelessness continued to rise in the EU: according to FEANTSA's evaluation, homelessness levels have only been steadily declining in very few places including FI and UK (Scotland). Budget cuts have reduced the capacity of social protection systems to alleviate and prevent homelessness. The main factors that contributed to the rising number of people in a situation of homelessness are structural (joblessness, poverty or lack of adequate and affordable housing, the mortgage crisis as well as demographic trends such as intra-EU mobility and third-country migration flows), personal (family breakdown, illness, over-indebtedness), institutional (lack of or inadequate support services) or linked to discrimination. Several Member States have identified homelessness as a concern and have adopted national or local strategies to improve policy coordination and implementation and to identify resources but accurate and consistent data on homelessness are still lacking in most Member States.

In **BE**, a cooperation agreement to tackle homelessness was concluded between the federal state, the regions and the communities in May 2014. The "Housing First" pilot project has been extended in five cities until 2016 and expanded to three further cities. In Brussels, the coordination of winter emergency shelter places has been improved by nominating a single coordinator. In Flanders, a new poverty plan has been launched which also addresses homelessness.

BG foresees to address homelessness in the action plan to implement its national poverty strategy, notably through offering integrated inter-sectoral services for the homeless, including begging children and adults.

The **CZ** Government approved in May 2014 a 'Proposal for Specific Steps to Achieve the Objectives of Preventing and Tackling Homelessness until 2020', a strategic document to address homelessness in an integrated way. The first implementation report of this strategy was released in June 2015. Preparatory steps for the "Housing First" scheme were made in mid-2014 with ESF funding.

In **ES**, the National Integral Homeless Strategy 2015-2020 is in its final stages of preparation. It is pending approval by the government in the next months. It has been drafted in collaboration with the autonomous regions, municipalities and NGOs. It proposes a comprehensive framework of action for all public administrations with responsibility in this area and in cooperation with the third sector or social action. It aims at homelessness prevention, awareness-raising and advocacy against discrimination and hate crimes, to ensure access to housing with special emphasis on housing first/housing-led approach, and access to resources to meet basic needs and to achieve social, labour

and personal integration, and with the commitment and the leadership of the public sector in this issue and the reinforcement of the public homelessness care system. The Strategy will strengthen and improve the knowledge of this phenomenon, information exchange and evaluation.

In **FI**, the 2008-2015 strategy to reduce long-term homelessness will be replaced by a new long-term strategy for 2016-2019, with strong focus on the housing first/housing-led approach.

In **FR**, to improve the management of the urgency in the field of hosting and accommodation and set up long lasting solutions, FR enhanced its diagnostic capability. 150 000 new social housing units are planned in 2016-2017, along the financing of first-time home ownership and granting of state-subsidised and regulated loans. A rent guarantee for modest-income household has also been created.

In **HR**, a number of projects were launched in 2014 to develop innovative services for the homeless and to reduce their social exclusion. A consolidated guidance was issued for municipalities and social service providers how to act in the interest of homeless people in emergency winter conditions.

HU continued to invest into homelessness services, temporary shelters and winter crisis programmes. Between 2009 and 2015, several integrated programmes co-financed by the European Social Fund supported the social and labour market integration of street homeless people.

The **IE** Government published an Implementation Plan on the State's Response to Homelessness in May 2014. In December 2014 a '20-point Action Plan to Address Homelessness' was adopted. Actions to address rough sleeping included extending the emergency accommodation capacity. As a result, 271 more homeless beds were put in place in Dublin by the end of 2014.

In **IT**, a new integrated homelessness strategy has been adopted which also foresees the use of the European Social Fund to help the homeless.

In **LU**, a Housing First pilot project started in October 2014 to offer housing solutions for long-term homeless people living in a seriously precarious situation. Two homelessness surveys and homeless counts were made in 2014. They continued to implement the 2013-2020 national homelessness strategy.

In **PL**, the two key national programmes for the homeless – the Programme supporting the rehabilitation of the homeless and the Programme of support for local authorities and public benefit organizations in the construction of social housing, municipal housing, sheltered accommodation, shelters and houses for the homeless - continued.

In the **UK**, in England, considerable investments were made to improve services for single homeless people and to increase bed spaces. A number of 1,600 vulnerable young homeless people were helped through the Fair Chance Fund and a new low rent shared accommodation model is also available for them ("Platform for Life" programme). The Ministerial Working Group on Homelessness published its third report in March 2015 on addressing complex needs. Northern Ireland continued to implement its national homelessness strategy 2012-17 which aims at eliminating long-term homelessness and rough sleeping by 2020 and at efficiently preventing homelessness. The homelessness legislation in Scotland ensures that all unintentionally homeless households have the right to settled accommodation. There is an increased focus on the prevention of homelessness and

the Scottish Government is working very closely with local authorities and their partners to promote this.

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. 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. As a consequence, excess demand for social and public housing is widespread and the quality of the housing stock remains a challenge despite efforts to improve standards. Some countries reacted with measures to protect mortgage holders, strengthen income support and improve the supply of social and public housing. In some cases, targeted measures have been introduced, such as plans for energy efficiency.

In **BE**, the Flemish regional authorities intend to revise the framework decision on social rent. The calculation of rent in social housing will take into account the energy efficiency and renovation of the housing unit and the income of the tenant and regional differentiation will become possible. This will stimulate progression to the private rental and buyers' market. In order to combat energy poverty at the source, the energy and renovation programme ERP 2020 will be further developed. The Walloon government has renewed the agreements that link it to the municipalities in the context of the plan 'Permanent Settlement' (*Plan Habitat permanent*) for the period 2014-2019. The objective is to improve the situation and the quality of life of people that permanently live in a touristic facility.

In **BG**, various measures and schemes for improving access to housing for vulnerable groups under the Operational Programme "Regional Development" 2007-2013 were also implemented during the reporting period. The Scheme "Support for Provision of Modern Social Housing for Vulnerable, Minority, and Indigent Groups of the Population and Other Disadvantaged Groups" aims to provide modern social homes for vulnerable, minority, and indigent groups of the population and other disadvantaged groups; to ensure social inclusion, spatial integration and equal access to adequate housing conditions for people in disadvantaged and vulnerable situation.

CY has recently introduced a scheme to support vulnerable households that are facing economic hardship and are unable to fulfil their mortgage obligations. This scheme protects the primary residence of these households by subsidising their mortgage interest payments. The housing allowance (rent or mortgage interest) is determined on the basis of the number of members of a family and the geographical district in which the family resides, as well as the rent prices which were calculated in cooperation with the Royal Institute of Land Surveyors and were endorsed from the Department of Lands and Surveys. The amount of the allowance for mortgage interest cannot exceed the amount which is calculated for GMI purposes, taking into account the parameters mentioned above.

In **CZ**, several changes related to the housing benefits became effective as from 1 January 2015. The new legislation aims to prevent payments of the supplement for housing (from the system of social assistance) for substandard accommodation premises, financed to the excessive benefit of their operators, and sets housing quality standards to be assessed for the eligibility to this benefit. A new definition of the threshold income for entitlement to housing benefits has been introduced, while the limitation on the eligibility term for the housing allowance has been cancelled. The legislation also determines the maximum rent amounts according to the location and standardised housing

costs (according to the Act on State Social Support). By the end of September 2015, a legislative intent on a Concept of Social Housing in the Czech Republic 2015–2025 is to be submitted to the government, while a legislative proposal is expected in the second quarter of 2016. The social housing system will consist of the social services, the state housing allowance and the use of social or affordable housing. The Act will also stipulate priority target groups, which will be provided social or affordable housing in an expedited procedure.

In **FI**, a new Act governing the general housing allowance entered into force on 1 January 2015. The Act simplified the definition of the maximum housing expenditure that must be taken into account for the basis of total rent when granting the allowance. Personal responsibility resulting from income is determined by a formula and in addition to income, the number of children and adult members affect the amount of allowance. The Act governing the general housing allowance includes earned-income deduction in the amount of EUR 300 for the earned income and entrepreneurial income.

In **HU**, as from 1 July 2015, the social policy support, which used to be available to families with two or more children for building or buying a new home, has also become available to families having only one child, and can also be used for buying a used home or expanding the existing home.

IE adopted the Housing (Miscellaneous Provisions) Act 2014, which provides for the Housing Assistance Payment (HAP) scheme. The first phase of the HAP statutory pilot commenced in September 2014 in one local authority with a further rollout to six other local authorities; including a specific focus on accommodating homeless households in Dublin. Consideration is currently being given to the sequencing of local authorities to commence the HAP on an incremental basis in 2015. The HAP scheme is being designed to bring all of the social housing services provided by the State together under the local authority system; with local authorities being responsible for all households with an established housing need. The scheme will also provide for a better integrated and more streamlined service for households, facilitate better regulation of the private rented sector, provide certainty for landlords as regards their rental income, improve standards of accommodation and provide greater consistency in the application of social housing policies in Ireland. Furthermore, a Social Housing Strategy 2020 was published in November 2014 which sets out clear, measureable actions and targets to increase the supply of social housing, reform delivery arrangements and meet the housing needs of all households on the housing list. A target of a total provision of over 110,000 social housing units is provided for in the Strategy. The Strategy will address the needs of the 90,000 households on the housing waiting list in full, with flexibility to meet potential future demand.

In **LV**, a state guarantee of housing loans for families with children was introduced in August 2014 (capped at 20% of the loan or up to EUR 20,000 for a family with 3 children); 78 guarantees were issued by 31 March 2015. Moreover, the LV authorities passed amendments to the Housing support act in June 2014, lowering the eligibility threshold for insolvency protection and obliging local governments to pay housing allowance for orphans.

In **NL**, measures have been taken (planned effective date 1 January 2016) to prevent the allocation of expensive rental homes with rents above “the capping limit” (aftoppingsgrens) to people whose income is too low to pay for them. The draft Public Housing (Approved Organizations) Decree and the recently revised Housing Act (on which the Decree is based) reintroduce the suitability test during the allocation of rental homes to people who are eligible for housing benefit. The new standard means that housing associations must allocate to at least 95% of the candidates entitled by law to

housing benefit, homes with rents below or equal to the “capping limit”. As a result of this new standard, these tenants pay rents that are affordable considering their income and the budget of the housings benefit can be controlled.. In addition to this, business cases on prevention and early detection of debts were set up in 2014 to encourage municipalities to develop their own approach to prevention and early detection of debt. One such business case is ‘*Vroeg Eropaf*’ (Rapid Response) in Amsterdam, which targets the prevention of evictions. It is estimated that 80% of evictions are caused by rent arrears.

In **PL**, the Council of Ministers adopted on 9 June 2015 a bill (prepared by the Minister of Infrastructure and Development) amending the *Act on certain forms of support for housing construction*. Its aim was to reactivate social housing construction, carried out so far by social housing associations and housing cooperatives. Beneficiaries are people whose income is too high to allow them to qualify for a council flat, yet insufficient to satisfy their housing needs on the housing market. Refundable funding provided by Bank Gospodarstwa Krajowego, in the form of preferential loans and guarantees for the purchase of bonds is expected to be an instrument of social support for social rental housing. Within 10 years, it is planned to finance the construction of 30,000 new social rental apartments. The amount of funding from the state budget is expected to total approximately PLN 750 million, while the amount of credit is estimated at PLN 4.5 billion over the 10-year period. The amended act is to enter into force in the third or fourth quarter of 2015.

In **RO**, the recently adopted National Strategy for social inclusion and reducing poverty for 2015-2020 has a separate chapter on housing, which envisages increasing accessibility and improving housing quality, especially for vulnerable people, developing the social housing system, ensuring emergency aid and the homelessness prevention capacity as early as possible.

SI intends to adopt by the autumn of 2015 a Draft “National Housing Programme 2015-2025” providing for an increase in the housing stock aimed at the most vulnerable population groups. The expected positive consequences of the new regulation include: easier access to their first home for young people and young families, construction of young people’s housing communities, higher availability of adequate housing for the elderly and the construction of 800 additional housing units for the most socially excluded, to be awarded on a temporary basis to those who have become or are at risk of becoming homeless. Related to the evicted families special pilot project will be carried out in the period of 2015 to 2017. The aim of pilot is to prepare concrete legislative proposal to improve situation of evicted families.

In **UK**, the Homes and Communities Agency and Greater London Authority announced in July 2014 grant allocations totalling GBP 1.3 billion to deliver almost 62,000 new affordable homes through the 2015-2018 Affordable Homes Programme. Through the Localism Act 2011 and other changes, the Government has given local authorities and social landlords greater flexibility to make the best use of the existing social stock, in a way which best meets the needs of their local area In March 2015 the Government introduced a ‘Right to Move’ for existing social tenants to increase their mobility for work-related reasons.

2.5. Conclusions

Adequate income support, including unemployment benefits and social assistance, linked to inclusive labour market measures, activation measures and access to quality services in an integrated

approach, are part of a comprehensive policy response to ensuring adequate livelihoods and preventing and reducing the level and depth of poverty. Policies aiming at fighting poverty and tackling housing exclusion and homelessness require integrated strategies combining financial support to individuals, effective regulation and quality social services, including housing, employment, health care and welfare services.

The role of social transfers such as unemployment benefits and minimum income schemes as well as disability pensions, family and child allowances is highly relevant. Policy responses should take the form of a systemic approach to cash and in-kind benefits (i.e. services) provided by the social protection system, taking into account their interaction with other policies and institutions, such as fiscal incentives/disincentives to work and labour market institutions (public employment services, minimum wage).

Efforts to address severe poverty and reduce the poverty gap should also comprise simplifying services and benefits and their administration, reducing administrative burdens and increasing take-up. This could be achieved through for instance setting up one-stop-shops and improving targeting through progressive universalism. In addition to the upgrade of educational and qualification opportunities, the expansion of quality child care, 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.

3. Recent reforms to achieve adequate and sustainable pensions

The necessity of adjusting entitlement rules, the level of benefits and retirement practices to reflect the challenges of population ageing and the economic crisis have made pensions one of the most reform-intense policy areas in EU Member States in recent years. In 2014 a total of 17 Member States received country-specific recommendations in the area of pensions, with the majority of the recommendations being a follow-up from the previous year. In 2015 this was the case for 13 Member States. Most reforms have changed the rules for future benefits with important changes related to increases in pensionable age and aligning pensionable age with changes in life expectancy. But in a number of Member States the need for strong fiscal consolidation efforts continues to have important implications for pension in payment and current retirement rules.

Overall fewer Member States have introduced changes and reforms to their pension systems during the reporting period (mid 2014-mid 2015) compared to previous year (mid 2013 – mid 2014). The pension reforms undertaken over the period 2014-2015 combine different actions which can be grouped around the following six policy levers: a) early retirement rules; b) pensionable age; c) contributory periods; d) level of pension benefits and pension indexation; e) supplementary pensions, f) improving employment opportunities for older workers. The main driver behind reforms is improving the sustainability of pension systems with some Member States applying specific attention to the adequacy of pensions. While putting public finances on a sustainable path is a top economic priority, there is an increasing recognition that unless adequacy concerns are also addressed for future pensioners, including by enabling and encouraging people to work longer, there may be reductions in future replacement rates which could increase pensioners' poverty levels to

worrying levels in some Member States, with an important impact on social cohesion, political acceptability and inclusive growth.

3.1 Access to early retirement options

Changes in early retirement options 2014-2015	
tightening	BE, LU, PL
improved access	PT, FR
preserved access for specific categories	BG, HR

Few Member States have introduced changes to the early retirement options in the reporting period.

BE has raised the minimum age from 62 in 2016 to 62,5 in 2017 and 63 in 2018 with relative increase in the career length, going from 40 to 42 years by 2019. **LU** is reviewing its pre-pension system, notably through the elimination of the “pre-retirement solidarity.” **PL** is phasing out its early retirement options in the Farmers’ Social Security Fund (KRUS) by 2017. In the context of the implementation of a comprehensive pension reform, in the new draft Law on Social Insurance Pensions **LT** has put forward the following amendments concerning access to early retirement: restrict the granting of early old-age pension to 3 years before the pensionable age. **PT** reintroduced early retirement for employed workers as of age 60 with at least 40 year insurance record, and established a transitional regime for 2015 granting the possibility for beneficiaries aged less than 60 years to access early retirement pension.

Only two countries have introduced changes preserving early retirement options for specific categories of workers. **BG** has decided to retain the 2014 retirement age for persons who have worked in arduous and dangerous conditions and refrain from increasing it further. The expected financial effect of the retention of this provision to the end of 2015 is an increase in the costs for new pensions of approximately EUR 10.93 million. Similarly, **HR** in the new Pension Insurance Act provides for the possibility for early retirement for the long-term insured (over 60 years of age and having completed 41 years of insurance). Further to that, in view of the unfavourable economic conditions and the unemployment problem, the Act introduced access to early old pension resulting from bankruptcy. **FR** has lowered the permanent disability rate required for early retirement from 80% to 50%. This rate applies to the insured people of all social security schemes. Moreover, all the people who have a 50% disability rate will obtain a full rate pension at the pensionable age.

In addition, **FR** has increased the conditions of access to the progressive retirement which is now accessible from the age of 60. Progressive retirement allows insured people to continue their part-time work while they start to receive a fraction of their pension.

3.2 Pensionable age

Changes to the pensionable age, 2014-2015	
increase	BE, BG, NL, UK

aligning to life expectancy	PT
lowering for particular categories	DE (individuals with particularly long insurance record)

Most Member States have already put in place mechanisms for gradual increase in the pensionable age as a part of an on-going trend to improve pension sustainability through later retirement and longer working lives and thus also contributing to pension adequacy. In those cases where the increases are automatic over a medium to long-term time period, they do not lead to legislative changes in the reporting year but to actual changes in pensionable age.

Table 4. Pensionable ages in the EU

	2009		2013		2020		After 2020	
	Men	Women	Men	Women	Men	Women	Men	Women
BE	65		65		65		67 (in 2030)	
BG	63	60	63y8m	60y8m	64y3m	61y6m	65	
CZ	62	56y8m-60y8m (1)	62y6m	57y8m-61y8m (1)	63y10m	60y6m-63y10m (2)	67+ (in 2044) (3)	
DK	65		65		66		67 (in 2022)+ (4)	
DE	65		65y2m		65y9m		65y10m-67 (in 2029)	
EE	63	61	63	61	63 (in 2016)		65 (in 2026)	
IE	65		66		66		67 (in 2021); 68 (in 2028)	
EL	65	60	67	62	67		67+ (5)	
ES	65		65-65y1m (6)		65-65y10m (6)		65-67 (in 2027) (6)	
FR	60-65 (6)		61y2m		62-67 (6)			
HR	65	60	65	60y9m	65	62y6m (7)	65 (in 2030), 67 (in 2031-2038)	
IT	65y4m	60y4m	66y3m	63y9m (18)	67y		67+ (5)	
CY	65		65		65+ (8)			
LV	62		62		63y9m		65 (in 2025) (9)	
LT	62y6m	60	62y10m	60y8m	64	63	65 (in 2026) (10)	
LU	65		65		65		65	
HU	62		62		64y6m		65 (in 2022)	
MT	61	60	62		63		65 (in 2026)	
NL	65		65y1m		66y8m		67+ (in 2021) (11)	
AT	65	60	65	60	65	60	65 (in 2024-2033)	
PL	65	60	65y1m (12)	60y1m	66y10m-67	61y10m-62	67 (in 2020)	67 (in 2040)
PT	65		65		66+ (13)			
RO	63y4m	58y4m	64y8m	59y8m	65 (in 2015)	61	65	63 (in 2030)
SI	63	61	65	63y6m (17)	65			
SK	62	55y3m-59y3m (1)	62	57y6m-61y6m (1)	62+ (14)			
FI	63-68 (15)		63-68 (15)		63-68 (15)		63-68 (15)	
SE	61-67 (15)		61-67 (15)		61-67 (15)			
UK	65	60	65	61y3m-61y8m	66		67+ (from 2028) (16)	

Notes:

- (1) Depending on the number of children raised.
 - (2) Depending on the number of children raised. The pensionable age for women is increased by 4 months each year (6 months from 2018) until it equals that of men. After that, the increase will also be 2 months per year.
 - (3) Increased by 2 months annually until further amendments.
 - (4) Adjusted to life expectancy gains every 5 years, starting 2030.
 - (5) Linked to life expectancy.
 - (6) If qualifying period completed - and if not completed.
 - (7) The pensionable age for women is being gradually increased by 3 months per calendar year from 1 November 2010 onwards, to reach 65 in 2030. After that, the increase will also be 3 months per year for men and women, reaching 67 in 2038.
 - (8) Adjusted to life expectancy gains as of 2024.
 - (9) The pensionable age is gradually increased by 3 months per year.
 - (10) From 2012 onwards, the pensionable age is annually increasing by 4 months for women and by 2 months for men until it reaches 65 for both women and men in 2026.
 - (11) Adjusted to life expectancy gains every year, starting 2024.
 - (12) Since 1 January 2013 the pensionable age gradually increases by 1 month per three months.
 - (13) After 2015, the pensionable age will vary according to the average life expectancy at the age of 65.
 - (14) Adjusted to life expectancy gains as of 2017.
 - (15) Flexible retirement age linked to benefit level. Upper age limit is not statutory.
 - (16) To be adjusted after a formal Government review every 5 years.
 - (17) It holds true only for women in the period 2013-2015; later 65 years (ZPIZ-2 27/1). Provided that his/her pensionable age is at least 15 years.
 - (18) For female private employees, the SPA is temporarily lower (62 years and 3 months in 2013). After 2020 SPA is linked to life expectancy.
- y – years; m – months*

In the reporting period, **BE** has adopted an increase of the pensionable age from 65 to 66 by 2025 and 67 by 2030. After 2030, the intention is to implement a system in which age and career conditions are automatically linked to the evolution of life expectancy. With the Pensions Act 2014, the **UK** will start increasing the state pensionable age for men and women as of December 2018 from 65 to reach 66 by October 2020, and 67 between 2026 and 2028. In 2015, the legislated increase of the pensionable age in **NL** was accelerated so that it will reach 67 in 2021 instead of 2023, before being linked to the development of life expectancy. After 2015 in **PT**, the current pensionable age of 66 will be linked to the evolution of life expectancy at the age of 65. Thus, as of December 2014, taking into account the recent evolution in life expectancy, the normal age for access to old-age pension will increase by two months in 2016, rising to 66 years and 2 months.

BG has adopted a comprehensive pension reform in July 2015, which includes the increase of the pensionable age to 65 years for men by 2029 and for women by 2037.

On the basis of a time-limited special regulation, **DE** has since 1 July 2014 lowered the pensionable age for individuals insured for particularly long time (45 years of mandatory contribution payments). If born before 1953, such individuals can receive their retirement pension at 63 without any pension deductions.

While no legislative regulation regarding the pensionable age has been adopted by the **CZ** government for the period 2014-2015, the Expert Committee on Pension Reform has recommended

that a regular method for determining the pensionable age is put in place. The aim is to ensure that the pensionable age for different generations corresponds to developments in life expectancy⁵.

3.3 Changes to the duration of contributory periods and contribution rates

Changes to the duration of contributory periods and contribution rates, 2014-2015	
Increase in contributory periods	BG (with exception for workers in arduous jobs, military, policemen and teachers)
decrease in contribution rates	DE

Together with increases in the pensionable age increases in the contributory periods for pensions is a policy measure used by a number of Member States to signal to workers that in order to have access to a pension without an actuarial reduction they must work longer and meet the requirements for a full employment and contribution history.

As of 1 January 2015 **BG** adopted legal provisions to increase the contributory period required for acquiring the right to a full pension by 4 months for workers in the conditions of third-category labour, i.e. non-arduous jobs. As a result, men and women acquire the right to a pension if they have a contributory period of 38 and 35 years, respectively. However, for servicemen working under special laws (military, policemen, etc.), workers in arduous jobs and for teachers, the contributory requirements from 2014 were retained with no upward changes, leading to an increase in the costs for newly granted pensions of about BGN 18.5 million in 2015. In the context of its pension system reform, **LT** is gradually increasing the contribution requirements for a public pension from 30 to 35 years.

In view of the continuing favourable financial development in the pension insurance system, **DE** lowered the contribution rate in the general pension insurance system to 18.7% on 1 January 2015. Compared with 2011 when the rate stood at 19.9%, the contribution rate has been reduced for the third time and is currently at the lowest level since 1995.

In **FR**, apprentices can validate as many trimesters as they have apprentice trimesters. This measure entered into force retroactively for the apprentice periods from the 1st of January 2014. Moreover, students can from now on validate up to two trimesters with a reduced contribution.

⁵ The control parameter is to be set as a percentage share of the average life expectancy at the retirement age threshold to the sum of the average life expectancy and the retirement age threshold. Should the value of the control parameter for some of the generations lie beyond the margins of 24-26%, the government shall be obliged to propose an adjustment to the retirement age.

3.4 Calculation of pensions and pension indexation

Changes to the indexation of pensions, 2014-2015	
minimum indexation guarantee	PL, UK
return to full indexation	CZ
freeze	PT ⁶
new indexation mechanisms	HR, LV
Changes in calculation of benefits and other measures, 2014-2015	
combining pensions and income from work	BE
changes in state pension calculation	DE, UK
supplementary measures for women	ES

In 2015 **CZ** has renewed the yearly indexation mechanism, increasing pensions by 100% of the CPI growth and one third of the increase in real wages, thus ending short the period of reduced indexation valid from 2013 to 2015.

PL introduced in 2015 a single change of the currently applicable indexation rules, which guarantees that in 2015 the increase in benefits would not be less than PLN 36. In the case of farmers under the Farmers' Social Security Fund, all benefits were increased by the same amount. The 2014 **UK** Pensions Act provides for the new state pension to be uprated at least in line with earnings.

In the context of the 2015 State Budget, **PT** maintained a suspension of the indexation of pensions, including a freeze of the nominal value of regular invalidity and old age pensions, other pensions, allowances and supplements assigned by the social security system, as well as of retirement, disability and other pensions, allowances and supplements granted by the General Retirement Fund. However, an exceptional update of 1% of the minimum pension was introduced, similar to the practice in the past 3 years. In the context of the freeze on indexation, pensions, grants and other cash benefits paid to the same individual will in 2015 be subject to an extraordinary solidarity contribution. The aim is to involve pensioners with higher pension income in the fiscal consolidation effort. Still, compared to 2014, the solidarity contribution was reduced.

As of 1 January 2015, **HR** introduced a new model for pension indexation, which changes the way developments in salaries and consumer prices are taken into account. Here after pensions will be uprated by applying the ratio 70:30, 50:50 and 30:70 in the share of the rate of changes of consumer prices and gross salary. From 2015, **LV** links its indexation base to the average social insurance contribution wage of the previous calendar year, and the pensions or their part that do not exceed 50% of the average social insurance contribution of the previous year in the state will be indexed. **LT** is in the process of implementing a comprehensive pension reform. The draft Law on State Social

⁶ With the exception of minimum pensions

Insurance Pensions provides for the establishment of an indexation mechanism based on the average changes in the wages fund for the past 3 years, current year and 3 forecasted years (7 years in total).

Few Member States have implemented measures related to the calculation of pension benefits and combining pensions with income from work. As of 1 January 2015, in **BE** it is possible for pensioners who have reached 65 years of age or who have a 45 year career to combine pension with unlimited income from work. In addition, the pension bonus has been abolished in all pension schemes for people who before 31.12.2014 did not meet the age or career length criteria for access to an early retirement pension. As of April 2016 the new **UK** State Pension system will base the calculation of state pension on the length of an individual's National Insurance record. Transitional arrangements are in place to recognize individuals' National Insurance records accrued pre-April 2016. As of 1 July 2014, in **DE** mothers or fathers of children born before 1992 receive an additional earning point per child in the old age security system. In **ES**, the Spanish Government approved on May 14, 2015, the Comprehensive Plan for Family Support 2015-2017. With regard to maternity support and the acknowledgment of the role of women who decide to have children, the Plan includes a supplementary payment to contributory pensions for women that have given birth to two or more children. This retirement supplement, to be applied from January 1, 2016, will be of 5% for women who have had two children; 10% for those who have had three; and of 15%, for those who have had four or more. Therefore, the more children a woman has had, the higher the pension to be granted by the Social Security system.

3.5 Changes to minimum pensions

Changes to minimum pensions, 2014-2015	
Increase (or equivalent measures)	BE, BG, SK, MT, RO
tightening of criteria	BE
establishing minimum pension	SK

The few Member States, which have reported changes to the minimum pension, have aimed at increasing the benefit level while at the same time tightening access criteria and encouraging prolongation of the working career.

BE has raised minimum pensions by 2% on 1 September 2015. One of the criteria for calculating the minimum pension has been tightened (increase in the minimum number of days worked before the year is taken into account for calculating the minimum pension) and remaining differences between self-employed and salaried workers will be eliminated by 1 August 2016 (increase in minimum pension for some self-employed). As of 1 July 2014 **BG** increased the minimum amount of the old-age pension from 150 BG to 154,50 BGN (an increase of approximately 2.40 euro). As of 1 January 2015, pensioners in **MT** whose pension does not exceed the minimum wage will not be taxed and the cost of living adjustment is now tax-exempt for pensioners.

As of 1 January 2015 **RO** increased the amount of the minimum pension from 350 RON to 400 RON (an increase of approximately 11 euro).

In **SK** as of July 2015 people with 30 or more qualifying years of pension insurance will be entitled to a minimum pension. The minimum pension is calculated in reference to the subsistence level and the number of years of pension contribution, with the aim of motivating the insured to prolong their working career. According to calculation of the Ministry of Finance, the minimum pension is expected to increase the net income of approximately 80,000 pensioners by EUR 31 on average per month.

3.6 Disability-related pensions

Disability-related pensions, 2014-2015	
tightening of access criteria	BG, HR
increase/ Improvements (or equivalent measures)	DE

The overall trend in the reporting period is of tightening the access to disability pensions.

The **BG** government introduced more stringent criteria and procedures for allocation of invalidity pensions as of 1 January 2015. This is expected to reduce the costs of new invalidity pensions paid by the state budget with approximately EUR 3.75 million (BGN 7.3 million) in 2015, approximately EUR 10.63 million (BGN 20.7 million) in 2016 and approximately EUR 17.55 million (BGN 34.2 million) in 2017. **HR** introduced measures to reduce the number of disability pensions (from 25% in 2008 to 6.7% in 2014) and the cost of the expertise procedure as of 1 January 2015. 1 January 2013 **DK** implemented a reform of the disability pension, which restricts access to disability pensions for persons below 40 years of age and introduces new measures to help people to enter a life of education and employment rather than being awarded a permanent disability pension. The reform includes the establishment in municipalities of interdisciplinary rehabilitation teams, which are to ensure that individual, interdisciplinary rehabilitation programmes are offered to citizens at risk of ending up as disability pensioners. Current results show a steady movement away from passive income support towards more active efforts thanks to a flexi-job scheme and the interdisciplinary rehabilitation programmes.

DE introduced two measures which provide greater security to people with reduced earning capacity who are eligible to disability-related pensions. Firstly, the non-contributory supplementary period is extended from age 60 to 62 (i.e. the contributory period is prolonged by two years as if they had continued working until the age of 62 at their average previous income). Secondly, the last four years of the contribution history before being eligible to disability-related pensions are not to be counted if they reduce the individual pension entitlement.

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

Implemented reforms 2014-2015	
Improved access and better security	BG, IE, UK, MT

Some Member States have implemented policy reforms to facilitate the use of funded and private pension schemes through improvements in the access and security.

As of 1 January 2015 **BG** introduced the possibility for insured people born after 31.12.1959 to choose whether to be insured only in the Pension Fund of the State Public Insurance (I pillar) or to be insured in both the Pension Fund and a universal pension fund (statutory funded II pillar).

The **IE** government announced in January 2015 a series of measures aimed at tackling Ireland's low rate of workplace pension coverage, improving consumer confidence in the system and ensuring greater efficiency and oversight of pension schemes. As part of this process, the Government confirmed its intention to proceed with work to develop a roadmap and timeline for the introduction of a new, universal, supplementary workplace retirement saving scheme, with an aim to progressively achieving universal pension coverage with a particular focus on lower-paid workers. A Universal Retirement Saving Group has been established to prepare this roadmap for consideration by Government. In addition, the office of the pensions regulator has been restructured and provides for two distinct entities: 1) the Pensions Authority which retains the key regulatory role in safeguarding the benefits of pension scheme members and the provision of information on occupational pensions and 2) a separate Pensions Council to give consumers greater input into pension policy and advise the line Minister on matters of relevance to pensions, with a particular focus on policies to support the sustainability and adequacy of pension provision.

The 2014 **UK** Pensions Act contains a number of provisions to further strengthen workplace pension provision: i) a framework for automatic transfers for defined contribution arrangements; ii) restricting scheme charges and improved scheme governance and administration requirements; iii) giving the Pensions Regulator 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. Legislative changes in the Taxation of Pensions Act 2014 and the Pensions Schemes Act 2015 came into force on 6 April 2015 to give people freedom and choice in how and when they access pension savings and support them through guidance. The 2015 Pensions Schemes Act also provides a framework for new forms of pension saving, such as Shared Risk schemes.

The **LU** government has announced plans to expand the coverage of supplementary pensions through a revision of the current legislation.

The **MT** government is implementing a multi-tier strategy with the state Pay As You Go (PAYG) and the voluntary third pillar pensions which aim to address poverty relief, insurance and smoothing objectives. Following the entry into force of the Retirement Pensions Act on 1 January 2015, fiscal incentives were introduced with the aim of sustaining the policy objective of diversifying retirement income through the take up of voluntary third pillar pensions. Furthermore, the Ministry of Finance is studying the possibility of home equity release.

Upon recommendation of the Expert Committee on Pension Reform, the **CZ** government will terminate the funded pension savings scheme (pillar II), while respecting the pension rights of the participants, in order to prevent further redirection of pension insurance contributions to private accounts in the pension fund. The objective is to stop the reduction in the volume of funds collected through pension insurance contributions for pension pillar I. Compared to pillar II, the pillar III, which shall remain in existence, has achieved substantially greater popularity and the Expert Committee

has made recommendations for amendments to the legislation, which shall make the Supplementary Pension Savings scheme (pillar III) more attractive.

3.8 Measures to increase labour market participation of older workers

An important part of ensuring sustainable and adequate pension in the future, in view of the ageing population and the increases in retirement age, is related to guaranteeing adequate employment opportunities for older workers. This requires efforts related to retraining, life-long learning, improving working conditions to fit the needs of elderly workers, providing reasonable accommodation in the workplace in case of disability, among others. A recent OECD-EC workshop on delivering longer working lives and higher retirement ages confirmed that if Member States are to succeed in their efforts to change retirement patterns employment and social policies need to become much more mutually supportive and well-linked up. Only a few Member States have reported on specific programmes and policy packages with such objectives.

As part of its national employment policy in favour of seniors **LU** has introduced a bill on a package of measures in relation to ageing policy, which is currently in the legislative process. The bill provides for an obligation for employers with more than 150 employees to develop an age management plan which must cover at least three of the following: recruitment of older workers, anticipation of changing careers, improving working conditions, access to lifelong learning or the transmission of knowledge and skills. Financial incentives are provided. Further to that, programs on increasing the activation of jobseekers have also been developed (e.g. “fit4job-Restart my career”).

LT has developed an Action Plan for the Implementation of the Strategy of National Demographic Policy for the Welfare of Families 2014-2015 and an Action Plan of the Programme for Increasing Employability 2014-2020, which aim at contributing to increasing the employability of older workers. Amendments to the Law on Support for Employment which took effect as of 1 September 2014 aimed at encouraging employers to put in place measures to support the acquisition of professional skills to retain older employees (50 years or older) in the cases where they train newly hired young people (up to 29 years of age).

RO has recently adopted a National Strategy for Active Aging and Promoting Elderly’s Rights for 2015-2020 and a corresponding Strategic Plan encouraging an promoting active aging in good health conditions and maintaining an active working life for as long as possible.

3.9 Conclusions

Reforming pension systems has consistently been an important element of the structural reforms agenda for a number of Member States since the start of the Strategic Social Reporting within the Social OMC and the European Semester. Increase in retirement age has been a priority for all Member States. Aligning it with life expectancy is in the process of being analysed or planned for by a number of countries in view of future measures but is not considered by all Member States as a solution for raising the retirement age. Increasingly significant efforts have been focused by some Member States on limiting early retirement options, among others through reviewing access to disability pensions and reforming work incapacity schemes in order to facilitate labour market participation and the accumulation of pension rights. The area of indexation is addressed by some countries, with specific challenges related to elderly poverty and average pension levels, as a tool to contribute to pension adequacy. Other Member States focus on increases to minimum pension as a

way to strengthen the social protection to those most in need. A few Member States are stepping up efforts to develop supplementary pension schemes. Few are underpinning their pension reforms through initiatives in the labour market aimed at improving the employability of older workers.

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

Over the last 18 months, many Member States undertook health policy reforms to improve the accessibility, quality and sustainability of their health systems. The economic slowdown in some Member States adds an additional challenge to the sustainability and efficiency of their health care systems.

The Social Protection Committee carried out a multilateral surveillance of the implementation of the Council recommendations on health policy in March 2015. In addition to the conclusions of the surveillance undertaken within the framework of the European Semester, this chapter presents an overview of the latest health policy developments reported by Member States in their National Social Reports and National Reform Programmes. As Member States have different starting positions and face different economic and health challenges, their reform efforts and concrete measures differ to reflect country-specific circumstances.

The aim of this chapter is to provide a comprehensive strategic overview of reforms in the field of health care. Member States are responsible for the definition of their health policies as well as for the organisation and delivery of health services. The EU promotes cooperation among Member States in this area through the Open Method of Coordination, focusing in particular on access, quality and sustainability, and through the relevant guidelines adopted by Council as part of the broad economic and employment guidelines. In its Communication of 2014 on "Effective, accessible and resilient health systems", the Commission highlighted the importance of effective, accessible and resilient health systems.

Overview of policy reforms in the field of health care (2014-2015)

Areas of policy reforms		Member States
Structural changes in the organisation and financing of the health care systems	Policy changes	AT, BG, CY, CZ, DE, ES, FI, FR, HR, HU, IE, LT, LU, LV, MT, NL, PL, PT, RO, SE, SI, SK, UK
	Services delivery	AT, BE, BG, CZ, CY, DE, HR, IE, LT, PL, SE, UK
Health service delivery (including e-Health)	e-Health	AT, BG, CY, CZ, HR, HU, IE, LT, LV, MT, PL, RO, SI, UK
	Pay increase	CZ
Investing in the health		

Health care systems	care workforce	Professional development and better working conditions	BE, CZ, DE, ES, HR, HU, IE, LV, PL, SE, UK
	Cost containment and cost-sharing	Cap on health expenditure growth	AT, BE, FR, PT, UK
		Optimising pharmaceuticals spending	BG, DE, ES, FR, HR, HU, IE, LU, MT, PT, RO, SI, UK
		Cost-sharing	BE, CZ, ES, HR, SE, UK
	Enhancement of access to services and of patient's rights	Access to services	CZ, ES, FI, HU, IE, LT, LV, RO, UK
		Patients' rights	BE, HU, IE, PL, PT, SE, UK

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

Several Member States are undertaking structural reforms aimed at improving the organisation of health care delivery and financing in order to ensure a more efficient and effective utilisation of the available financial and human resources. In many cases, this reorientation has been reflected in a move towards a greater centralisation of both financing and delivery of health care services, an increase in outpatient care, strengthened ambulatory services and a renewed focus on primary care. Several Member States have introduced activity-based financing of hospital services. These are usually based on diagnosis-related groups (DRGs), which attempt to establish a comparable structure of hospital costs. In addition, there is greater use of prospective budgeting for hospitals. Some Member States introduced mechanisms for the measurement of hospital efficiency, hospital benchmarking and ranking.

In **AT**, the 2013 health care reform defined a ceiling for the expenditure path, which should generate a total of EUR 3.4 billion in cost reduction effects by 2016. According to the most recent monitoring report, the cumulative cost reduction effect for provincial governments and statutory health insurance providers amounts to approximately EUR 2.955 billion for the years 2012, 2013 and 2014. As a result, expenditure remained below the agreed cap during that period. In June 2014, the Federal Commission for Health System Governance (*Bundes-Zielsteuerungskommission*) decided to expand multidisciplinary primary care in Austria. Starting in 2015, multi-profession group practices will be piloted in Austria. By the end of 2016, a coverage level of 1% of the population is planned in each federal province. In the medium term, this measure will provide relief for Austria's more costly hospital clinics and serve to expand acute care in private practices.

In **BG**, an amendment to the Health Insurance Act adopted by the Council of Ministers in January 2015 provides for: restructuring of the main package of health services through the launch of a basic

and a supplementary package of health activities; better control on the quality of the medical care; patients' participation in the control process; and centralised negotiation of the prices for medicinal products. Moreover, in order to enable the implementation of the basic policies of the National Health Strategy 2014-2020, the BG government has defined concepts that contain a detailed description of the strategic objectives and priorities, specific actions to achieve them and expected results: the Concept for Restructuring of the Hospital Care System aims at developing the structures for emergency diagnosis and treatment, and at modernising the health infrastructure for long-term treatment; a Concept for the Development of the Emergency Care aims at developing an integrated emergency medical care that will ensure equal access of the citizens to emergency medical care; a Concept "Goals for Health 2020" (adopted by the Council of Ministers on 18.02.2015) defines the long-term priorities of the country in the health care area.

The **CY** government published in December 2014 a draft Bill on the establishment of a National Health System (NHS) to be fully in place by mid-2016. However, according to the last updated MOU the NHS kick-off date was determined for 2017. In parallel, the Ministry of Health in cooperation with the Health Insurance Organisation and the Ministry of Finance are working to prepare the introduction of co-payments within the framework of NHS as well as they are preparing a paper on contingency measures, just in case additional revenue to finance the NHS is needed after the kick-off of the system.

In **CZ**, with a view to reforming the hospital sector, the project Diagnosis-related groups (DRG) Restart was started in January 2015, with the aim of addressing shortcomings in the current hospital funding scheme. Since that the network of 45 reference hospitals was established, methodology for cost per patient assessment was developed, the Manual for appropriate coding of diagnosis was prepared and the development of the new system for coding of procedures has started.

In **DE**, an Act to Strengthen Medical Care in the Statutory Health Insurance System (*Gesetz zur Stärkung der Versorgung in der gesetzlichen Krankenversicherung, GKV-VS*) entered into force in July 2015. The Act aims at improving access to health care services with more flexible, cross-sectoral access and a broader range of services and benefits, along with the creation of a dedicated fund for increasing support for innovations and health services research. The creation of a dedicated fund for innovations and health care services research may lead to the improvement of quality for inpatient and outpatient care. Furthermore, the Federal Government has set up a Federal/*Länder* task force which has been developing the foundations for a hospital reform. A draft law was discussed in Parliament in July 2015. The Hospital Reform, which should come into force beginning of 2016, focuses on examining and evaluating performance, which will lead to the reduction of surplus capacities, the consolidation of hospital sites and the conversion of hospitals into local health care facilities, helping to improve the cost-effectiveness of public spending on health care and long-term care.

The **ES** Government has adopted the Royal Legislative Decree 1/2015, approving the revised text of the law on guarantees and rational use of medicines and medical devices. The text aims to harmonize and clarify the amendments to the Law 29/2006 that have been made to improve the quality and safety performance of the national health system, ensure sustainability, among others.

The **FI** government is considering measures to foster the integration of social and health care services and to expand their coverage while strengthening the governmental guidance at the national level. For this purpose, in 2014 the FI authorities granted EUR 13 million for development projects managed by local authorities. Moreover, a significant consolidation of the hospital network is currently under way, resulting in increased quality and efficiency of emergency services.

The **FR** government has set up a comprehensive national health strategy, which aims at enhancing the efficiency of the system by rationalising and pooling procurement, developing the system of out-patient care, optimising treatment pathways and reducing unnecessary and redundant treatments, both in and out of health care establishments.

In **HR**, the Parliament adopted the National Plan of Development of Clinical Hospital Centres, Clinical Hospitals, Clinics and General Hospitals 2015-2016. The goals of the National Plan are to improve the accessibility of hospital health care, upgrade the quality and efficiency of providing hospital services, boost efficiency, and rationalise the costs of operation of hospital institutions. In 2015, a new model of contracting hospital and specialist-consultation care was introduced through individual diagnostic-therapy groups and diagnostic-therapy procedures.

In **HU**, the "Healthy Hungary 2014-2020" public health strategy has been completed and approved by the Government. It outlines several sectoral management objectives aiming at enhancing the efficiency and sustainability of the health care sector. The strategy sets the strengthening of primary care as an additional target. The financing system has also been changed: from 1 January 2015, the service providers operating family doctor services with a regional service obligation are now entitled to a utility charge subsidy of HUF 130,000 a month per service. Furthermore, the rules for determining the amount of the cash benefits payable through the health insurance were revised so as to take into account the most recent income taken into account for the calculation of the benefits.

In **IE**, the White Paper on Universal Health Insurance (UHI) was published in April 2014. The Department of Health, in conjunction with the Economic and Social Research Institute and other state agencies, is undertaking a major costing exercise to examine the cost implications of a change to a multi-payer UHI model as proposed in the White Paper. The resulting analysis will include a review of evidence of the effects on health care spending of alternative systems of financing and of changes in financing methods and entitlements. It will also estimate the cost of UHI for individuals, households and the Exchequer. Initial results from this exercise are expected in the near future, following which the Minister for Health will revert to Government with a roadmap on the next steps to UHI. In addition, since May 2015, the Irish private health insurance market has been underpinned by the principle of lifetime community rating through the introduction of late-entry loadings for those who join over the age of 35. The purpose of this initiative is to encourage people to purchase private health insurance at a younger age so as to keep the health insurance market sustainable by spreading the costs of older, less healthy people across the market. In January 2015, the IE Minister for Health published a list of priorities for the period 2015-2017, which provide a clear direction for the development of health services and health policy as well as identifying a targeted plan against which progress can be measured. During 2014, the implementation of the *Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2025* focused on cross governmental work in order to address the determinants of health across a range of issues, such as integrating health and

well-being into education and promoting the 'healthy workplaces' agenda. In addition, the National Rare Disease Plan was published in 2014 with a view to the establishment of a rare disease office within the Health Service Executive. Reforming pension systems has consistently been an important element of the structural reforms agenda for a number of Member States since the start of the European Semester with a particular focus on key infrastructural changes such as the establishment and development of Hospital Groups and Community Healthcare Organisations and the development of patient centred integrated models of care. Significant changes are being made to the way public hospitals are funded through the implementation of an Activity Based Funding (ABF) model. Full roll-out of ABF is a multi-year project and a phased approach to implementation is being taken in order to ensure operational stability in hospitals. An ABF Programme Implementation Plan for 2015 – 2017, setting out the key steps for implementation, was published in May 2015. A restructuring project, as outlined in Future Health, is being scoped in the context of the development of policy on a healthcare commissioning framework and roll-out of ABF. The revised road-map for delivering Universal Health Insurance will also inform this process.

In **LT**, the Plan for the Development of Health System and Consolidation of Hospital Network until 2025 was approved in 2014. It will be implemented in stages, drawing up specific action implementation plans for each stage.

In **LU**, the new hospital plan 2015 aims at a structural reform of the hospital sector by improving its quality, efficiency, long-term financing and transparency. For instance, it is planned to create national centres of competence providing highly-specialised care. This means that not all services will continue to be offered everywhere, potentially leading to economies of scale and a higher quality of service. Out-patient surgery is planned to be strengthened in order to reduce hospitalisation periods

The **LV** government adopted in October 2014 the Public Health Strategy for 2014-2020, which provides guidelines in priority areas with regard to access, quality and efficiency of health care services, assessment of the location and expertise of service provider, availability of human resources and technologies, quality assurance for health care services, cross-sectoral cooperation and integration of services in particular for groups at risk of poverty or social exclusion. Furthermore, some important measures have been adopted in 2015. The implementation of Diagnosis-related Groups (DRGs) project and higher focus on health promotion will help achieve better cost-effectiveness, while the reduction of co-payments aim at improving accessibility.

MT took a number of relevant measures with the view to improve the governance of its health care system, further promote healthy life-styles and disease prevention and strengthen primary health care. Thus, the MT government adopted a new National Health Systems Strategy covering 2014-2020, based on 3 pillars: improving governance; health promotion and disease prevention; and strengthening of primary care. A Health System Performance Assessment framework has been set up to monitor the progress achieved in these areas with a periodic assessment. The launch of an investment programme for public primary health care aims at achieving a cost-effective and sustainable use of available resources. The MT government also adopted the Communicable Disease Strategy and the Food and Nutrition Policy and Action Plan 2015-2020, aiming at improving the health and well-being of citizens.

In **NL**, the Minister of Health announced a measure in February 2015 that will enable insured persons to have a greater influence over their insurance companies. Moreover measures were announced that will stimulate transparency. These measures are meant to push for more insight into the quality of health care (provision). Insured persons will be able to make better informed choices. One of these measures is the possibility for health insurance companies to give discounts to insured persons on the mandatory deductibles in case they use contracted health care providers.

PL adopted an amendment to the Act on health care service introducing tools targeted on the improvement of cost effectiveness of allocation of public resources such as: health care needs maps, plans of financing health care services, opinions on the desirability of the investment's plans. A "Policy paper on health protection for 2014–2020. National strategic framework" was elaborated, combining goals, strategic directions, health care provision and public health priorities. The Government is currently working on an amendment to the act on health care information system. Legislative works on the project of the Act on public health are being conducted and a new edition of the National Health Program is being elaborated. A project to improve the quality of healthcare system management in terms of rights and obligations arising from cross-border healthcare is currently being implemented from March 2014 to September 2015. Actions undertaken are focused primarily on improving information policy conducted by the National Health Fund in relation to patients and providers of medical services.

In **PT**, the new statutory law of the Health Regulatory Authority (ERS) was published in August 2014, giving ERS new powers (Law Decree 126/2014). ERS has now exclusive jurisdiction for assessment and monitoring of all complaints by users of all health services and is responsible for the supervision of licensing of private health care providers. These changes strengthen regulation in areas that directly contribute to safeguarding the rights of health care users and to the quality and safety of services.

The **RO** government adopted the National Health Strategy 2014-2020 at the end of 2014. The strategy aims at improving public health and health care with a focus on improving the health of women and children, reducing morbidity and mortality from non-communicable diseases, as well as ensuring equitable access - especially for vulnerable groups - to health care. Another aim is to reduce the excessive use of hospitalisation by increasing the funds allocated for outpatient care and primary health care.

The **SE** Government is working on the implementation of its National Cancer Strategy. One of the main reforms in this Strategy is the development of regional cancer centres (RCC) for the purpose of achieving higher quality care, improved patient outcomes and a more efficient use of healthcare resources. There are now six RCCs in operation serving 20 county councils.

The **SI** government plans to adopt a Resolution on National Health Care Plan (2015-2025) by the end 2015, which will focus on improving public health care, while ensuring the financial sustainability of compulsory health insurance with a more solidarity-based distribution of the burden among insured persons and retaining existing rights as much as possible. The Plan will also aim at redefining the management, operation and supervision of public health-care institutions and increasing the responsibility of directors and boards.

The **SK** government is currently implementing a project to shift primary care delivery to an integrated care model in order to achieve better results in patient management, a significantly lower number of redundant referrals to outpatient specialists and hospitals, while providing better access for patients to health care services. The SK government has also taken measures to rationalise hospital care through the introduction of a financial management system in the hospital sector, based on regular monitoring and evaluation of economic and quality indicators.

In **UK** (England), the GBP 5.3 billion Better Care Fund offers significant financial incentives for the integration of health and social care. The programme will drive better integration between health and social care, and is designed to allow more care to be delivered in the community, keeping people out of acute settings where possible and improving patient experience while making better use of the available resources.

4.2. Health services delivery

In order to improve the delivery of health care services, several Member States (AT, BG, CZ, DE, HR, IE, PL, SE, UK) introduced policies aiming at optimising the use of treatments and the prescription patterns.

In **AT** one topic concerning health service delivery is the strengthening of the primary health care. Therefore in June 2014, the Federal Commission for Health System Governance (Bundes-Zielsteuerungskommission) decided to expand multidisciplinary primary care in Austria. Starting in 2015, multi-profession group practices will be piloted in Austria. By the end of 2016, a coverage level of 1% of the population is planned in each federal province. The start und the continuation of the roll-out of ELGA (electronic health record) and the implementation of pilots of telephone- and web-based initial contact and advice services in three provinces ("Bundesländer") are further topics of the implementation of the health care reform."

In **BG**, several amendments of the legislative acts of the NHIF have been made (National Framework Contract 2015) and new clinical care pathways for children and pregnant women have been introduced. In order to optimize the health services access for rare diseases, the Healthcare Act was also amended. In addition, a Committee on rare diseases will nominate the centres of expertise that offer quality health care services for patients with rare diseases.

In **CZ**, a project of streamlining the database of reports on the performance of medical facilities is under preparation. The aim is to simplify reporting on the part of the providers and to refine the database. The Ministry of Health also approved the Action Plan for Ensuring the Quality and Safety of Health care Services. The plan aims to optimize conditions for quality evaluation and setting safety objectives, to assess effectively and eliminate unwanted occurrences and to develop the related awareness of the public and of health professionals.

In **DE**, the Federal Government created the "Alliance for People with Dementia" in order to improve the quality of life of dementia patients. The aim of the Alliance is to set up a network at federal level, which will bring together responsible parties to deliver lasting improvement to the situation of people affected by dementia and raise public awareness of dementia.

The **IE** Government is promoting the construction of Primary Care Centres. In April 2015, the EIB approved a project to build 14 new Primary Care Centres through PPP projects, which will be

financed under the European Fund for Strategic Investment (EFSI) initiative established to support investment across Europe. Services at 14 centres will include GPs, community nursing, dental, occupational therapy, physiotherapy, social work, speech & language, home help, mental health, counselling and nutrition. Further to these 14 centres, the Irish Government is developing another 20 centres using non-PPP financing.

The **LT** Minister of Health approved National Electronic Health System Development Program for the period of 2015-2025. Patients' needs oriented electronic health records aims to assure lifelong and effective provision of healthcare services.

The **PL** government carries out several programmes aimed at improving the availability of health services, which include a number of measures such as the purchase of medicinal products and medical devices, specialized treatment and disease prevention services, oncology, cardiology and transplantation equipment, renovation and construction works in transplantation centres, tissue and cell banks and diagnostic laboratories operating within the transplantation medicine system. Expenditure on the implementation of the above measures aimed at improving the availability of services amounted to PLN 783.6 million and was comparable to the expenditure incurred in 2013. The amount of 2015 allocation was comparable to the 2014 allocation.

In **SE**, there are currently a number of reforms at national level supporting the development of service delivery, and health promotion and disease prevention. For example, one major strategy targets chronic disease management and includes efforts to develop and improve primary care's role in addressing chronic disease patients. Also, this strategy reinforces the focus on and the importance of health promotion and disease prevention. Due to Sweden's decentralised health system, the State has supported many projects that facilitate the exchange of patient information between different care providers as well as between the healthcare system and the patient.

In **UK** (England), the National Health Service in England announced a GBP 1 billion fund over four years for primary and community care infrastructure in order to improve premises across primary care and other community services. This will support the development of more integrated health and care services. A total of GBP 50 million has also been invested to help 1,100 general practitioners develop new ways of improving access. Another GBP 100 million will be invested into the scheme next year.

Moreover, many Member States (BG, CZ, HR, HU, MT, PL, RO, SI, UK) developed ICT and e-Health 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.

In **BG**, the integration and connectivity of health care services is pursued through the establishment of a national health information system providing public access through an electronic identifier. The future unified information system of health care will have as main components the electronic health record, electronic prescription, electronic referral and a web portal. Moreover, a Roadmap on e-Health has been published. The main preparatory activities have been started in order to build up the electronic health record (e-Health record), electronic patient record, electronic prescription (e-Prescription) and electronic delivery of drugs (e-Pharma).

In **CY**, the following actions have been completed in the area of e-health in 2014: implementation of Integrated Health Information System (IHIS) at new Health Centers, implementation of the Picture archiving and Communication System (PACS) in all of the hospitals, installation of Software for the order and the receipt of the results through a Web Application of specialized and expensive blood test examinations.

In **CZ**, the e-Health Strategy under preparation will focus mainly on strengthening the role of the patients, improving the data infrastructure of the system to measure the effectiveness of health care services and to provide other functions, improving the accessibility and quality of health care and harmonising and providing interoperability for health information sharing. The strategy should be completed by April 2016, while the set of measures should be implemented in 2016–2020. **HR** has also made steps towards developing the e-Health infrastructure and improving the function, safety and interoperability of eHealth services. The National e-Appointment List and e-Appointment Project was upgraded throughout 2014. At the end of 2014, the project e-Newborn was launched. For the purposes of the National Health Programmes of Early Detection of Breast, Colonorectal and Cervical Cancer, a special IT project was developed. After a very successful national implementation of e-Prescription (with more than 55 million electronic prescriptions issued annually), mechanisms for cross-border use of services that the Croatian Institute for Health Insurance provides to its insured persons were successfully developed.

In **HU**, the implementation of the comprehensive sectoral electronic system (Electronic Health Service Space) for developing sectoral, institutional and electronic services and data publication (electronic prescription, eReferral, iRegister) is in progress. The eDoki web-based team work was already completed in the period under review, and the system designs of the comprehensive primary care system and the sectoral human resources monitoring system are also expected to be prepared.

In **LV** legislation was adopted and measures were taken to expand the available range of e-health solutions aimed at commencing operation of a electronic health record system and e-health portal from 2016. The public will have access to the e-health portal ensuring an opportunity to patients access their health data stored in the electronic health record system, to register with a family physician, to submit an application for the receipt of the European health insurance card, as well as access to e-prescription and sick-list services will be ensured.

The **MT** authorities also adopted a series of measures to foster investment in ICT systems and to develop a comprehensive national e-Health infrastructure and integrated portfolio of eHealth systems, with a view to ensuring a cost-effective and sustainable use of available resources.

The **PL** authorities also took measures in the area of e-Health services such as the *Electronic Platform for Collection, Analysis and Sharing of Digital Resources on Medical Events - P1 Project* and a draft act amending the Act on the information system in health care.

The **RO** government has also made significant steps in its use of ICT services in the health care sector, by introducing the National Health Card to 14 million beneficiaries and by making its use mandatory in health care settings from September 2015. In addition, since May 2014 the electronic filing system is functional and accessible, comprising over 4 million electronic files submitted by physicians and hospitals across the country.

The **SI** e-Health system will be implemented by the end of 2015 in all healthcare facilities. It will enable continuous monitoring of waiting lists on a national level, based on real and accurate data. This will enable the implementation of measures for shortening a waiting list as soon as the number of waiting patients for a certain service starts to increase. A possibility for e-Booking of medical services will be implemented nationally in the second half of the year. The Telestroke solution (i.e. a system that enables a remote consultation and examination of the patient with a suspected brain stroke through a video conference system) is in full use; over 500 consultations from the regional hospitals to the central centre with a full time available neurologist have been made since September 2014.

In **UK** (England), the launch of the MyNHS website in September 2014 will help drive improvement across the health and care system by encouraging organisations to compare their performance in different areas and look to see where they can improve their systems to deliver safe, effective, high quality care. Comparable information on hospitals, social care, public health, mental health hospitals, and consultant surgeons is now available online. A greater focus was also put in some Member States (BE, DE, HR, LV, PL, UK) on health promotion and disease prevention:

The **BE** authorities are currently running two campaigns for health promotion and disease prevention, in such areas as the responsible use of antibiotics and the adapted use of medical imaging techniques.

In **DE**, the Federal Government adopted the draft of an Act to Strengthen Health Promotion and Prevention (*Gesetz zur Stärkung der Gesundheitsförderung und der Prävention*). The Act is expected to enter into force in the second half of 2015. A particular aim of the Act is to strengthen individual-directed and environment-directed prevention and health promotion in all domains of life, particularly in childcare facilities, schools, businesses or nursing homes. To ensure an integrated, holistic approach, all social security institutions will be included with the participation of private health insurance and private compulsory long-term care insurance.

The **HR** government adopted the Strategic Plan to Reduce Table Salt Intake in the Republic of Croatia 2014 – 2019, the National Programme for Rare Diseases 2015-2020 and the Strategic Plan for Promoting and Protection of Oral Health 2015-2017 were adopted. There are preparations under way for adopting the Action Plan for Preventing and Controlling Chronic Diseases 2015-2020.

The network of **LV** national healthy municipalities was expanded to provide municipalities with methodological support for public health promotion issues at local level and to increase the local government employees' education for public health and health promotion. Government approved amendments to the dietary rules at schools, which includes additional quality requirements for food products on the menu, as well as to determine the permitted range of food products which will be allowed to distribute in the school cafeteria, snack and beverage vending machines. Alcohol abuse restriction policy was implemented, for example increased excise taxes on alcoholic beverages. Starting with January 1, 2015 the vaccination against rotavirus infection state pays 100% (previously - 50%).

In **PL**, intervention campaigns were carried out in 2014 to promote healthy lifestyles: events linked to the World No Tobacco Day or the World Obesity. Informational and educational activities were

conducted, as well as media campaigns in the field of cancer prevention. Funds allocated to the above tasks in 2014 amounted to PLN 9.8 million.

The **UK** has introduced legislation to end smoking in private vehicles carrying children, which is to come into force on 1 October 2015. The Parliament has also voted to bring in standardised packaging for tobacco products.

4.3. Investing in the health care workforce

A particular issue of concern for several Member States is represented by the availability of skilled health care workers, particularly physicians and specialists. The ageing of health workforce coupled with challenges to recruit or to retain health workers due to demanding working conditions and relatively low pay in some health care occupations are leading in many countries to workforce shortages in the health care sector. This poses significant challenges to the delivery of health care services as well as to the efficiency and effectiveness of the health care sector. To counteract this, some Member States (BE, CZ, DE, ES, HR, IE, LV, PL, SE) adopted measures to facilitate the training and upskilling of health care professionals and to offer wage increases and support (HU) in order to increase the appeal of the health care sector.

The **BE** authorities are currently pursuing measures to further improve the attractiveness of the nursing profession, while at the same time encouraging the nursing personnel to further improve their skills. New measures concern home care nursing personnel and the nursing staff in home and local (community) care centres and psychiatric care.

In **BG** significant improvement of the conditions for specialisation in health care has been made by development of new by-law on acquirement of a specialty in the health care system. This legislative document provides for more free regulation for concluding a contract for specialisation; for making sure that graduates will receive salaries by the medical establishments where they specialise; and as well as for an opportunity the payment of the fee for theoretical and practical training to be covered by other sources, including European projects or programmes.

The **CZ** Ministry of Health also prepared measures to simplify the system of postgraduate education in the field of health care, which should be submitted to the Government in June 2015. The aim of these legislative changes is to reduce the number of attestation subjects, limit the scope of the work required for certification and introduce attestation centres at regional hospitals. These measures are expected to increase the efficiency of the process of the postgraduate education in this area. Furthermore, from 1 January 2015 salaries of health workers have been increased by 5% through the so-called reimbursement decree.

In **DE**, the Hospital Reform will also include a programme to fund the recruitment of nurses totalling EUR 660 million over the next three years.

The **ES** Government approved in March 2015 the Royal Decree 184/2015, establishing the homogeneous catalogue of equivalency of the professional categories in the statutory staff of health

services, in an attempt to ensure the mobility of professionals across the NHS. Royal Decree 639/2015 regulating accreditation diploma, is aimed to strengthen the value of life-long training as an efficient issue of professional acknowledge in order to strengthen capacity and competence of the professionals in a given functional field.

In **HR**, the National Plan for the Development of Human Resources in Health Care is in its final stage; the goal is to ensure the optimal number of human resources for the implementation of all health care measures. In addition to this, the National Programme for the Protection of Health and Work Safety of Employees in the Activity of Health Care for the Period 2015-2020 was adopted.

After a successful launch of the Resident Support Programme, a supplementary financing programme provided to resident doctors, for the period 2011-2013, **HU** is continuing it with a launch of a new call in January 2015. The participants of the programme commit, after obtaining their special qualification, to work as a specialist in a publicly financed institution in Hungary for the term the scholarship is paid and that they will not accept gratuities.

The **IE** Department of Health is developing a national integrated strategic framework for health workforce planning on a cross-sectoral basis, while the Health Service Executive will begin the deployment of an operational model for workforce planning and development. In the context of integrated models of care, *Future Health* will provide the overarching context for discipline-specific strategic workforce planning and development in the future which is intended to support the stability and sustainability of the health workforce in Ireland.

In **LV**, a new policy planning document for health workforce (2016-2020) is under elaboration. This document will focus on professional training for health care workers and on strategic planning of the supply and demand for workforce in the health care sector with the aim of achieving cost-effectiveness and ensuring the fiscal sustainability of the health care sector.

In **PL**, several training programmes for medical personnel involved in the implementation of services in the area of oncology, transplantation and treatment of haemophilia, optimizing the use of blood and blood components in treatment were organised in 2014, for which the government allocated PLN 1 million. In 2015, the allocation earmarked for the implementation of specialized training for health professionals in the framework of the above programmes amounted to nearly PLN 5 million. From 2012 until the end of June 2015, "Nationwide training in the health care system as well as communication skills, cooperation and building relationships with patients for young doctors" was implemented. Training is addressed to doctors under 35 years of age; thus far, 2,312 people have participated in training. The amount of allocation for project implementation totalled PLN 8.1 million. The number of resident doctors will increase from 12,000 to 18,500 in 2015. It is anticipated that total funding for residencies in 2015 will amount to approximately PLN 703 million.

In **SE**, the number of places in the education and training programmes has increased. Moreover, an ongoing inquiry will conduct an analysis of how healthcare professionals can use their resources more efficiently and propose measures that can be taken at national, regional and local level to ensure that healthcare professionals use their time, knowledge and commitment in the best possible way in order to increase healthcare efficiency.

In **SK**, to secure sufficient number of GPs in the future, there is ongoing program of education and specialization in general practice. Graduated doctors' and their mentors' salary expenses are covered by EU funds.

4.4. Cost-containment and cost-sharing

For all Member States, the development of their health care policies continues to take place in a context marked by economic slowdown and the need to control public expenditures with a view to ensure fiscal sustainability and debt reduction. It is therefore crucial to achieve sustained expenditure control through efficiency savings and greater effectiveness.

Some Member States (BE, FR, LV, PT) tried to achieve this by capping the health care expenditure, while others (DE, ES, HR, HU, IE, RO) introduced measures to increase the efficiency and effectiveness of health care providers and to ensure the sustainability of the sector.

In **BE**, the budgetary envelope for the health insurance in 2015 has been fixed at 23.8 billion EUR. From 2015 until 2018, the so called budgetary growth norm (allowed real increase in health insurance expenditure) is fixed at 1.5%. In this framework, the subsidy for the basic hospital services in 2015 was fixed at 8.1 billion EUR. Further steps were taken to improve access to care by increasing the insurance coverage for a number of categories, such as patients with rare diseases facing high medical costs.

In **DE**, the Act to Further Develop the Financial Structure and Quality of the Statutory Health Insurance System (*Gesetz zur Weiterentwicklung der Finanzstruktur und der Qualität in der gesetzlichen Krankenversicherung, GKV-FQWG*) which entered into force on 1 January 2015 puts the finances of the statutory health insurance system (SHI) on a viable basis and strengthens competition in terms of price and quality in the interests of the members. With the reduction of the general contribution rate from 15.5% to 14.6% and the introduction of the possibility for health funds to levy individual, income-based additional contributions, the autonomy of the health insurance funds with regard to contributions has been increased. In future, different additional contribution rates will send important pricing signals as the funds compete for members. In order to remain attractive for members and avoid members changing providers, the health insurance funds can limit the amount of the additional contribution rate by making efficient use of resources. The employer's share of the general contribution rate remains fixed at 7.3%.

The **ES** Government has approved the Organic Law 6/2015 on budgetary stability and financial sustainability. This law includes a set of measures on transparency and sustainability of health spending. Moreover, it mandates the Government Commission for Economic Affairs to propose a set of measures to help improve the sustainability and efficiency of pharmaceutical and health spending that may be adopted by the Autonomous Communities. Moreover, the law has created an instrument to support the sustainability of the pharmaceutical and health expenditure of the autonomous communities.

In **FR**, public health budgets have been kept under control in the last few years thanks to improved monitoring, with public expenditure on health planned to be below the target set in the initial finance law for the fifth consecutive year in 2014. The national health insurance expenditure target

will see its rate of growth capped at 2% on average over the 2015-2017 period, representing an overall savings effort of EUR 10 billion over three years.

The **HR** government included two new items in the budget of the Croatian Health Insurance Institute for 2014 amounting to HRK 3.2 billion, thus continuing the process of rehabilitation of the health system that began in 2013. The additional budget was spent on settling obligations of medical institutions and of the Croatian Health Insurance Institute. Departure of the Croatian Health Insurance Institute from the treasury in 2015 will enable greater freedom and flexibility in the operation of the Croatian Health Insurance Institute and more complete use of funds planned for the medical protection of insured persons.

In **HU**, in July 2014, a budget of 14 billion HUF was used, inter alia, to pay a part of the overdue accounts payable and public debts of the healthcare service providers and provide one-off compensation for the increased operating costs of patient transport and rescue. In March 2015, the name of the Institute for Quality and Organisational Development of Healthcare and Medicine changed to the State Health Service Centre. 60.0 billion HUF was available for managing the financial problems of the central budgetary organisations, including the healthcare sector.

In **IE**, the Health Service Executive (Financial Matters) Act 2014 provides for the Health Service Executive to be funded from January 2015 through the Vote of the Minister for Health. The budget allocation for 2015 provides for an increase of EUR 564 million on the 2014 allocation.

In order to increase access to medicines for patients and facilitating the entry of cheaper medicines to the **LV** market, the government has adopted a regulation that supports parallel distribution of medicinal products. The **PT** government has also introduced mechanisms to cap the public expenditure on medicines, such as a claw-back tax.

The **RO** authorities are also implementing a project for calculating the actual cost of hospital services and the development of cost benchmarks so as to ensure efficient management of financial resources in hospitals. Moreover, the project Good Governance in the Health Care System aims at reducing the use of informal payments and preventing corruption in health care settings.

Several Member States (BE, CZ, ES, HR, SE) adopted measures that include the reduction of both pharmaceutical and medical supplies expenditure as well as the introduction of co-payments for services and drugs:

In order to improve the transparency of the reimbursement system and the final cost to the patient, **BE** introduced since January 2015 a system of fixed patient co-payments for consultations of medical specialists, fixing the co-payment to 3 EUR for the beneficiaries of preferential reimbursement (vulnerable groups) and 12 EUR for the rest of the population. In any case, the co-payment for the preferential groups cannot exceed 15% of the consultation fee. Furthermore, from April 2015 a new system of provision and billing of (oral) drugs in nursing homes is in place to avoid waste. The billing will be done on a units' basis and no longer by package (full boxes). Pharmacists will get a special fee of 3 EUR per patient and per week for administering this system.

In **CZ**, several changes have been implemented in order to improve financing of the health system and cost sharing: increase in payments for the state insured; reduction of annual limits on operating costs of health insurance companies; establishment of a commission to assess deployment of costly medical devices (>5 mil. CZK); central purchasing of interchangeable commodities for hospitals directly managed by the Ministry of Health; reduction in the reserve funds of health insurance companies; and the change in redistribution of premiums collected by health insurance companies. As from 1 January 2015 VAT on medicines was reduced, with an anticipated negative impact on the revenue side of the state budget. The positive impact of the measure consists in reallocating the reduced costs of medicines in the category of medicines fully and partially paid by health insurance companies. From 1 January 2015 also the regulatory fees were virtually cancelled, with an indirect impact on the public health insurance budget resulting from the compensation of lost fee income to health care providers.

The **ES** government adopted a Decree that regulates the system of reference prices for medicines for human use included in the portfolio of medicines to be reimbursed by the National Health System. It also regulates the system of clustering of homogenous medicines as a mechanism to extend the principles of the reference prices system. In December 2014, the ES Ministry of Health, Social Services and Equality updated the maximum contribution amount for above-the-counter drugs considered to have a reduced contribution in the treatment of serious illness or chronic conditions as well as the maximum monthly contribution for pensioners and their beneficiaries in outpatient pharmaceutical services. Moreover, updating the homogeneous clustering of medicines system every three months led to estimated savings in 2014 of over EUR 435 million in 2014.

In **HR**, the value added tax for all medicinal products was lowered from 25% to 5% in late 2014.

In **SE**, the current Government is shortly due to implement a new reform targeting children's medication expenses. There are indications that children in families with limited financial resources may experience delayed access to pharmaceuticals. As of 2016, pharmaceuticals will be free of charge for children and young people below 18 years of age. The reform is intended to contribute to more equitable access to pharmaceuticals, regardless of the financial situation of the family.

The centralisation of the procurement system has been undertaken as an effective measure for reducing both the cost of drugs and of medical supplies (in BG, ES, FR, IE, MT, PT, RO, SI). Increasing the use of generic drugs has also been employed in some Member States (FR, IE, LU, PT) as a way to reduce expenditure for pharmaceuticals.

In **BG**, legislative amendments to the Health Insurance Act were made in January 2015. The changes aim to create mechanisms for assessing the quality of pharmaceutical therapies and for centralising price negotiations for pharmaceutical products in order to reduce the expenditures of the NHIF. Introduction of mechanisms of Health Technology Assessment is planned.

The **ES** Ministry of Health has also centralised the procurement of pharmaceutical products. For instance, in May 2015, it has reached a framework agreement for the joint procurement of vaccines for seasonal influenza for the 2015-2016 season. The Ministry of Health, Social Services and Equality estimates that this purchase will result in savings of over EUR 5.1 million.

The **FR** authorities made efforts to contain the growth of health care expenditure through an increased use of generic drugs and improved price-setting mechanisms, including increased control on prescriptions patterns of physicians.

In **IE**, following the enactment of the Health (Pricing and Supply of Medical Goods) Act 2013, generic substitution and reference pricing continued to be introduced during 2014 which delivered almost EUR 50 million in savings.

In **LU**, a plan for substitution of medication by generic medicines started in October 2014. A list has been defined specifying certain original medicines whose patents have expired and their potential substitutes (generics). It will become the pharmacist's duty to inform the patient that an expensive original drug prescribed by the doctor could be substituted by a cheaper generic drug. The national health insurance will reimburse only the cheaper price of the generic.

In **MT**, the adoption and implementation of comprehensive reforms with respect to medicines and medical devices procurement and distribution processes have led to minimal stock holding and hence efficiency gains by circa EUR 5 Million in 2014 to date. Further, the fast-track procurement approach has facilitated the procurement cycle of medicines to one week and the aging of out of stock items to less than 10 days. In addition, this procurement approach has been instrumental in acquiring efficiency gains by achieving savings of over Euro 700,000 in acquisition costs.

PT introduced a centralised system for purchasing medical products and services, as well as a 60% target for the use of generics. As a result of these measures, the total public expenditure on health care is expected to have a further reduction of EUR 107.6 million in 2015, supported by savings in medicines, supplies and external services.

The **RO** authorities have also made progress in establishing centralised procurement procedures through framework contracts for the supply of some medicines. This generated savings totalling RON 47 million to the health budget.

The **SI** government is currently implementing a transparent and uniform system of public procurement in the health-care sector. A pilot project of common public procurement for medicines in hospitals will expand in 2015 in order to include most drugs. In order to rationalise public expenditure in the health care sector, common public procurement for the majority of medicines, some medical devices and some medical equipment will in the coming years gradually become obligatory for all public hospitals.

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

As a consequence of the prolonged economic crisis and sluggish recovery, it has become increasingly challenging to achieve sustained expenditure control through efficiency savings and greater effectiveness while at the same time improving the equity of access to health care services. Difficulties in accessing health care 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.

Therefore, several Member States (CZ, ES, FI, IE, RO) took measures to improve access to health care for people in a vulnerable situation.

In **CZ**, the three important Action Plans to Improve Accessibility and Quality of Health care, After-Care, Long-Term Care and Home Care, Strategy for the reform of the psychiatric care beside other action plans were approved as a part of the National Strategy Health 2020 by the Government in August 2015. A strategy for the reform of the psychiatric care aims at facilitating the transition from institutional to community services for specific diagnoses. The approved strategy is being implemented, with funding a new type of health care and testing at the first pilot centres. The psychiatric care reform brings a new community feature to the health care system, the so-called Mental Health Centres as a new pillar of the care for the mentally ill in addition to current in- and outpatient facilities.

In **CY**, the Guaranteed Minimum Income and in general the Social Benefits (Emergency Needs and Care Needs) Decree of 2014 incorporated the Scheme for the Subsidisation of Care Services, which covers social care needs **ES** approved in March 2015 the National Strategic Plan for addressing Hepatitis C aiming at ensuring access to innovative medicines. Spain has been one of the first countries in the European Union to incorporate these treatments. The number of people affected by Hepatitis C treated in the first half of this year is 18,134 but a total number of 51,900 patients are expected to be treated according to the plan.

The **FI** Ministry of Social Affairs and Health set up a working group for reforming the legislation on disability for the period 3 May 2013 – 31 March 2015. The working group's task was to coordinate the current Disability Services Act and the Act on Special Care for People with Intellectual Disabilities to produce a new special law to ensure the equal services for different disability groups, in line with the UN Convention on the Rights of Persons with Disabilities and the Government Resolution on Housing and Services for the Persons with Intellectual Disabilities.

In **IE**, the Health (General Practitioner Service) Act 2014, which provides the legal framework for the extension of general practitioner care free at the point of service to all children aged under six years, was enacted in July 2014. This service became operational on 1st July 2015. Also, the Health (GP Services) Act 2015, which provides the legal framework for the extension of general practitioner care free at the point of service to all persons aged 70 years and older was enacted on 26th June 2015 and became operational on 5th August 2015. Although free GP care for all will not be delivered by 2016, as initially planned, an additional 320,000 people will be covered by the end of 2015. The government envisages this agreement as “a major step forward in improving access, quality and affordability of health care in Ireland. It also marks the most tangible step forward so far along the road to universal health care.”

The **RO** authorities implemented 18 programmes for prevention and curative health of women and children as well as measures to ensure access to medicines for low-income pensioners. Furthermore, in order to increase the access of persons belonging to remote and isolated communities to health care, seven pilot projects for the development of community centres were set up in cooperation with seven local authorities by the end of June 2015. The project "Improving the health of the Roma population by enhancing Roma health mediators network" selected 45 communities in 6 counties in which teams of community mediators and nurses will offer social and health care services to members of the local Roma communities.

Several Member States (BE, HU, IE, LV, PL, PT, SE, UK) have also made efforts to improve the transparency of procedures and the availability of information, as well as to enhance the patients' rights and choice of health care providers and to reduce the waiting time for health care services.

In order to improve transparency of out-of-pocket payments, from July 2014 hospitals in **BE** are required to better inform patients, prior to admission by making information available on the hospital's website and by offering a contact person who can provide the patient with more personalized information about the costs associated with the hospitalization.

In **HU**, the waiting list programme aims to reduce the time spent by patients on the waiting list to less than two years and to prioritise high-risk surgical interventions within a professionally acceptable time limit. The budget is 1 billion HUF, which the NHIF transferred as an advance to the 25 institutions involved in December 2014. The source approved for financing surgical operations provides a financial coverage for the care of more than 1,500 patients, and an additional source of 5 billion HUF is provided in 2015 to reduce waiting lists. Access to medicine supply has improved as a result of the inclusion of new active substances in the social insurance subsidy scheme. The implementation of the public health-focused primary care model programme is in progress (2012-2016). It includes the complex screening and lifestyle consulting of 50,000 people, including 10,000 Roma persons. Focusing on the healthy life start and supporting the successful school starting of children aged 0 to 7, including, in particular, those in need of special support, the implementation of the early childhood programme continues and will be completed in the fourth quarter of 2015. The operation of the Health Promotion Offices, which were established integrated in the care system to support the preventive capacities of the healthcare system, is ongoing. From September 2014, grade 7 girls in the schools receive vaccination against the human papilloma virus (ratio of applicants for the vaccination: 80%). As regards the children born after 30 June 2014, the vaccination against pneumococcal diseases is integrated into the compulsory vaccination scheme. The large bowel screening programme of women and men in the age range from 50 to 70, based on testing the faecal blood, was extended to other counties, and the programme designed to extend cervical screening by the district nurses was also launched with the output requirements added to the primary training of district nurses. The Ministerial Decree on the nutrition-health standards concerning public catering entered into force on 1 January 2015, and shall be applied from 1 September 2015. The recommendations till now are replaced by binding legislation, which is designed to provide healthy catering with the energy and nutrient content necessary for the proper physical, psychic and mental development of the children. The developments planned during the 2007-2013 programming period and implemented in the period under review improved the access to care since they focused mainly on the rural areas that are mostly less-favoured, as well as on more efficient forms of care.

The **IE** Minister for Health has set a target that by mid-2015, persons will not have to wait more than 18 months for in-patient and day case treatment or an out-patient appointment. The Health Service Executive is working on an implementation plan to achieve this target and has committed, in its Service Plan 2015, to the publication of waiting lists at consultant and specialty level. Waiting list performance will be assessed within the revised accountability framework which is published as part of the Service Plan.

The **LT** government is improving the access to health care with respect to unmet need for medical care due to waiting times due to action set up on the programme of the sixteenth government of the Republic of Lithuania for 2012–2016.

The **LV** government managed to increase the health budget for 2015 compared to 2014 for about 31.19 million EUR and has approved 30.6 million EUR increase each year till 2017. Additional funding to the health budget of 2015 allowed reducing patient co-payments.

In **PL**, the "Safe Hospital – Safe Patient" project has been implemented since June 2013 and is expected to be completed in November 2015. Its aim is to improve the quality of hospital management and the number of accredited hospitals. The amount of funds amounted to the programme totalled PLN 8 million. Furthermore, the Programme for reducing social inequalities in terms of health aims has supported the development of 23 pilot projects in the field of public health in local communities. The total allocation for this programme in the period 2014-2016 amounts to PLN 79.1 million.

In **PT**, since January 2015, NHS users can access the online platform "Portal do Utente". Several types of services are available, including access to clinical data, prescriptions, blood tests and imaging, and immunization records; patients can even request user charge exemptions or an outpatient consultation. Access to the portal is granted using the National ID card after an initial visit to a Primary Care Centre.

In January 2015, a new patient act was introduced in **SE**, reinforcing a number of issues related to patients' rights to information, second opinion, etc. Furthermore, the act significantly improves possibilities for patients to choose primary care health providers and open specialist care providers.

The **UK** Government has put in place the first waiting times standards in mental health in England. The new five-year plan for mental health "Achieving Better Access to Mental Health Services by 2020" sets out the actions that will be carried out in order to achieve better access and waiting times in mental health services. In what concerns the access to health care services provided by the NHS, the UK government has taken measures from April 2015 that require non-EEA nationals applying to reside in the UK between 6 months and 5 years to pay a health surcharge alongside their visa application. Surcharge payers will receive NHS care in the same way as a permanent resident as long as their leave to remain is still valid. They will only pay charges that a resident would also be expected to pay, such as dentistry and prescription charges in England.

4.6. Conclusions

In the last 18 months, important health care reforms have been implemented in most Member States. Some Member States have enacted new legislation or amended existing legislation in order to enhance the effectiveness of their health care systems, while others opted for improving the existing mechanisms of their health care systems. A wide range of structural reforms have been implemented in many Member States, including a restructuring of primary and secondary care, greater care coordination, more intensive and interoperable use of ICT and e-Health solutions, a shift in the pharmaceutical policies toward price regulation and generic substitution, as well as the introduction of financial and non-financial incentives for both providers and users of health care services.

Spending on health care and the provision of services represent a large share of public expenditure. Health-related expenditure is the second biggest component of social protection expenditure in public budgets: total health care expenditure accounts for roughly 10% of GDP (almost four fifths of it coming from public sources), and close to 15% of public budget is spent on healthcare.

Furthermore, the ratio of total health expenditure to gross domestic product has increased over time, although in several Member States it registered a decline after 2010. Expenditure projections indicate a further growth in the future due to the emerging challenges of population ageing, technology development and rise in chronic diseases and co-morbidities.

Although cost-saving measures offer potential efficiency gains, and therefore appear effective in the short-term as expenditure declines, cutting spending in the present does not necessarily guarantee decreased future costs. Further, the efficiency gains of such measures on health expenditure growth will be more tangible if structural reforms reviewing both the financing of the system and its effectiveness in improving health outcomes are also undertaken.

A rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination across different levels and services of the health care systems is necessary. Good coordination of care can reduce the need for hospital stays, the unnecessary use of emergency care and the duplication of procedures. This can be achieved by reconfiguring provider structures to include multi-disciplinary teams in care practices, improving the use of ICT and e-Health tools, including electronic health records or software that allow the exchange of information among health care providers, introducing incentives for coordination to care providers and addressing administrative barriers. By ensuring a coherent care path, coordination can be of great importance to the most disadvantaged groups, who often lack continuous follow-up in terms of preventive or early care and end up relying on late or emergency care instead. Care coordination is particularly pertinent in the context of ageing and the attendant multi-morbidity and chronic diseases, which result in greater use of many different types of both medical and support care at the same time.

Ensuring accessible, quality and sustainable health systems may require strengthening of health promotion and disease prevention in all relevant policy sectors, while improving integrated health care, enhancing primary health care, early diagnosis, optimising use of specialists and hospital care and securing an appropriate and skilled health workforce.

Investing in preventive and early intervention measures may also consider holistic policies that combine health and social action, while tackling social gradients in unhealthy lifestyles and devoting special attention to citizens particularly at risk.

5. Recent reforms to achieve adequate social protection for long-term care needs

Dependency on long-term care is a significant health-related economic and social risk for individuals and their families. A lack of social protection (through benefits in cash or the provision of services) against the risk of dependency thus exposes many Europeans to an increased risk of poverty and social exclusion, and their number could grow as Europe's population ages. The lack of formal long-term care arrangements, for the elderly, but also for children, chronically ill adults and disabled, also

negatively impacts on labour market participation of informal carers, who are disproportionately women.

At present, there are big differences between Member States regarding the level of social protection for long-term care needs and in the way long-term care is provided. In recent years some Member States have developed comprehensive long-term care policies while others are working in the context of action plans and targeted programmes.⁷

Over the last 18 months many Member States have taken measures to reform the provision of long-term care with the aim of increasing accessibility, quality and sustainability. 7 Member States received Council country-specific recommendations in this area in 2014. The reforms implemented combine one or more of the following policy developments:

- Organisation of long-term care systems
- Financing and cost-sharing
- Preventing dependency
- Service delivery
- Assuring and monitoring quality
- Investing in the long-term care workforce
- Support to informal carers

Overview of policy reforms in the field of long-term care (2014-2015)

Areas of policy reforms		Member States
Long-term care systems	Organization of long-term care systems	BE, CY, CZ, LU, LV, NL, PL, SE, SI, RO, UK
	Financing and cost-sharing	AT, BE, BG, HU, DE, LU, RO
	Preventing dependency	AT, BG, ES, IE, RO
	Service delivery	DE, HR, IE, RO
	Assuring and monitoring quality	AT, IE, MT, RO
	Investing in LTC workforce	HU, RO, SE
	Support to informal carers	AT, BE, CZ, DE, FI, RO

⁷ The recently published Seventh Disability High Level Group Report on the Implementation of the UN Convention on the Rights of Persons with Disabilities (July 2015) contains concrete examples of measures concerning persons with disabilities that are listed in the Member States country fiches on people with disabilities in the Europe 2020 strategy <http://ec.europa.eu/social/main.jsp?catId=1137&langId=en>

5.1 Organization of long-term care systems

In **BE** after an important transfer of competencies from the federal level to the level of the federated entities (6th state reform), two protocols aimed at better matching care provision with existing needs have been agreed between the federal government and the governments of the federated entities. The first protocol promotes intensified mutual information between the personnel of the recognized services for home help and the health professionals working in people's homes. The second protocol concerns the health care policy that should be implemented with regards to the chronically ill. It also reinforces the need to cooperate between the actors.

In **CY**, the Guaranteed Minimum Income and the Social Benefits in General (Emergency Needs and Care Needs) Decree of 2015 incorporated the Scheme for the Subsidisation of Care Services, which covers cash benefits for home care, residential care, day-care, respite care, child care and incontinence pads. Beneficiaries of this Scheme are persons and/or members of the family unit who can be benefited from the social care services according to the relevant legislation of the Guaranteed Minimum Income.

CZ is at the beginning of the reform of social-health care, its financing and coordination. In 2014 was set up an Interdepartmental committee for social health and connected issues, which was tasked to prepare the draft legislative proposal for the aforementioned reform. In **LV**, in 2015, the development of the de-institutionalisation plan, which was launched in the previous year, is continued. It is expected that starting from 2016, long-term social care and social rehabilitation service institutions (hereinafter — Care institutions) will be able to welcome only adults with severe mental disorders. It is also planned that limitations of placing clients in Care institutions will force local governments to develop the range of social services in their territories so that the persons who are not eligible, as well as those who are already in a care institution but wish to establish independent living could receive the support and social services that are needed for such independent living. The deinstitutionalization is also one of the policy targets and main directions under the EU structural funds - the identification of specific needs of clients living in social care institutions and development of services and support infrastructure in the municipalities appropriate to the needs of individuals starting life in the community, closure of the affiliates of the state social care centres and training of specialists to provide new services is foreseen.

The **LU** government is preparing a reform of the nursing care insurance with the objective of providing help and care in adequate amounts to persons requiring assistance from a third person, while ensuring the financial viability of the programme. The planned reform would potentially improve the cost-efficiency ratio of the nursing care insurance system. A consultative debate was held on the issue in Parliament in July 2014. Initial exchange discussions also took place at the end of 2014 with stakeholders.

NL has totally revised its long-term care system. A new Long-term Care Act came into force on 1 January 2015, guaranteeing the rights of the most vulnerable clients in need of institutional care. As from 2015 parts of outpatient care and the supervised and secure housing of the Dutch mental healthcare clients will be governed by a new Social Support Act (Wmo 2015). Home care by nurses and parts of the long-term mental healthcare have been transferred from the Exceptional Medical Expenses Act to the Health Care Insurance Act as from 2015. **PL**, similarly to the trends observed in other Member States, is focusing on deinstitutionalization of care for dependent persons, including

elderly, through the development of alternative forms of care in the context of the Operational Programmes under the EU Structural Funds.

RO through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of establishing a unified LTC system, by integrating all LTC benefits and services in a unified system with its own identity, management and organisational structures.

The **SE** government has set aside an incentive grant of over SEK 1 billion (EUR 106 776 005) in 2015 to support municipalities and county councils in their efforts to improve the quality of health and social care for elderly people. The incentive grant intends to increase the number of health and social care staff and to improve the social content in the daily life of the elderly. The incentive grant also aims at improving the safety and security of the elderly.

In **SI**, an important political consensus was achieved in 2014 on the clear connection between the planned reform of long-term care and the health care reform. A working group was established comprising representatives of competent ministries, services providers and users of services, which in collaboration with social partners will prepare legislation which primarily focuses on establishing sustainable financing for long-term care and ensuring quality integrated services in the local environment as well as strengthening the role of the user in the selection and planning of the most appropriate services.

In the **UK**, in the 2014 Care Act, England set out the legislative framework for the most far-reaching programme of reform in adult social care undertaken in the past 65 years. The first phase of implementation in 2015 will see reforms related to establishing a new statutory "wellbeing principle" which sets out the outcomes that should underpin care and support, a national minimum eligibility threshold for care and support, a new duty to prevent, delay or reduce needs for care and support, a duty to promote the local care market with a particular focus on ensuring diversity, quality and sustainability of provision, an expanded duty to assess the needs of carers and to provide support on the same basis as rights for users of services, enshrining rights to personal budgets to support choice and control, and creating a universal system of deferred payment agreements to ensure people do not have to sell their home during their lifetime to pay for care. The Public Bodies (Joint Working) Scotland Act 2014 provides the legislative framework for integration of health and social care services in Scotland. It requires local integration of adult health and social care services with the objective of improving the quality and consistency of care, providing seamless, joined care that enables people to stay in their homes (or another homely setting), and ensuring that resources are used effectively and efficiently to deliver services that meet the needs of the growing population of people with long-term care needs. In a similar vein, Wales also adopted in 2014 its Social Services and Well-being Act which also aims at greater integration between health and social care with a stronger focus on preventive services.

5.2 Financing and cost-sharing

AT has implemented targeted changes in the hours of care required each month in order to qualify for a care allowance as a way to improve the cost effectiveness and sustainability in long-term care services. Previously, more than 60 hours of care per month were required in order to qualify for a Level 1 care allowance (EUR 154.20 per month), and more than 85 hours per month were required in order to receive a Level 2 care allowance (EUR 284.30). In January 2015, the Level 1 requirement was

raised to more than 65 hours per month and the Level 2 requirements increased to more than 95 hours per month. This measure has reduced access to care allowances. This reduction in costs is expected to total approximately EUR 19 million in 2015, EUR 57 million in 2016, EUR 95 million in 2017 and EUR 133 million in 2018. The extension of the care provision fund from 2016 to 2018 also brought about progress in improving the cost effectiveness and sustainability of long-term care. Between 2011 and 2018, a total of EUR 2.035 billion will be transferred for this purpose. Two-thirds of that amount is to be provided by the federal government, while the remaining third will be covered by provincial and municipal governments. The extension of the fund to include the years 2017 and 2018 will be included in a legal amendment by 2016.

Given the important health cost for chronic patients, the **BE** government has introduced the possibility for patients to pay only the out-of-pocket part of the fee. Further to that, 'care trajectories' are being developed as a way to support patients' interest in care coordination. Out-of-pocket payments are reduced or abolished in case patients fulfil the conditions linked to the trajectories. In the 2015, the diabetes care trajectory will be extended.

BG has increased in 2014-2015 the funding for elderly people and people with disabilities by 2,3% to BGN 115405757 (approximately EUR 59170627).

In 2015 **HU** clarifies the mandatory nursing activities to be provided by home caregivers, limiting state subsidy only to those activities. The eligibility limit has also changed and claims can be put forward if one lives with a need for nursing that necessitates the work of skilled and professional social caregivers.

IT has increased the Fund for non-self-sufficient people at the highest level (400 million euro) in its Stability Law 2015 and has made it structural (even though at a lower level – 250 million euro). In the past, it was necessary to find financial means for the Fund every year.

The **DE** Federal Government will increase the benefits under social long-term care insurance by around 20% (% billion) in this legislative term by two Acts to Strengthen Long-term Care. This is considered to be the biggest increase in benefits in this field since the introduction of long-term care insurance in 1995.

In **LU**, the law dated 19 December 2014 on the budget for income and expenses of the State for the 2015 financial year called for a freeze of monetary values at the 2014 level. In combination with the other health insurance measures, the expected gain from the various budget measures under the Zukunftspakt programme represent 3.5% of expenditures for services in kind in 2018.

RO through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of establishing an LTC fund. Moreover, the Strategy aims at promoting an adequate and equitable financing, by creating a mechanism for equitable allocation / distribution of state budget transfers to local budgets for LTC programs for elderly implementation, calculated on the basis of the number of 65+ inhabitants of each county or city.

5.3 Preventing dependency

Within the reporting period, **AT** is developing a dementia strategy as part of the government's work programme for 2013-2018, which is to include recommendations for awareness raising, support and prevention measures, early diagnosis as well as training and support for relatives providing care.

BG is focusing on developing community social services with a preventive character and closing institutional care. It should be noted that concrete steps to reforming the long-term care system for elderly and people with disabilities have been recently undertaken or planned – an established interdepartmental working group to develop a special Social Services Act to improve planning, management, financing, quality and effectiveness of social services; developed draft Act amending and supplementing the Social Assistance Act; developed analysis of the conditions in the specialized institutions for elderly people and people with disabilities. An Action Plan for the implementation of the National Strategy for Long-term Care will be developed on the basis of the analysis of the specialized institutions. **ES** Royal Decree 291/2015 of 17 April, amends Royal Decree 1051/2013 of 27 December, by which the performance of the System for Autonomy and Care for Dependency is regulated according it is established in Law 39/2006 of 14 December on the promotion of Personal autonomy and Care for people in situations of dependency. This Royal Decree introduces the regulation of service to promote personal autonomy for those with grade II and III of dependency, which aims to develop and maintain personal capacity to control, face and make decisions about how to live according to the rules and own preferences, facilitating the implementation of the basic activities of daily life and achieving a better quality of life and personal autonomy, as the service was regulated only for I the degree of dependence.

IE established a Healthy and Positive Ageing Initiative in the context of the National Positive Ageing Strategy, which will run in the period October 2014-December 2017. The Initiative will monitor changes in older people's health and wellbeing linked to the goals and objectives of the Strategy through the development of positive ageing indicators to be published regularly. Further to that, the Irish National Dementia Strategy was published in December 2014 to increase awareness, ensure early diagnosis and intervention, and develop enhanced community based services.

RO through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of analyzing and improving the multidisciplinary evaluation procedures in order to better identify particular needs and capabilities/ resources of elderly for delivering personalized services. It also envisages the prioritization of rehabilitation programs to prevent dependency.

5.4 Service delivery

Through the First Act to Strengthen Long-Term Care, which entered into force on 1 January 2015, **DE** aims at strengthening care at home by expanding the framework of possibilities to claim respite care and short-time care and making this framework more flexible, and by fully granting day care and night care in addition to out-patient benefits in cash and in kind. In addition, low threshold assistance services are complemented by respite services and are available to all those in need of care and not only to insured parties with a considerably limited ability to cope in everyday life. Furthermore, the maximum amounts for measures to improve the individual's living environment and for the use of certain nursing aids have been increased significantly. The framework for the complementary care of people suffering from dementia in care facilities by additional care staff is improved and the service

is extended to everyone requiring care. In future, care facilities can hire more care staff so that the carer-to-patient ratio for this service is improved from 1:24 to 1:20 (one carer to 20 residents).

HR is implementing its Strategic Plan of Palliative Care Development currently through pilot projects related to mobile primary level health care and out-of-hospital palliative care.

Transfer from institutional care to community-based care and development of the new services in community is seen as a priority in many Member States. 11 countries (BG, CZ, EE, EL, ES, HR, IT, CY, HU, LV, SI, FI) mentioned de-institutionalisation as a high priority in the Seventh Disability High Level Group Report on the Implementation of the UN Convention on the Rights of Persons with Disabilities (July 2015).

IE is using a person-centred planning process to address the needs of people with disabilities transitioning from congregated residential settings. Adult day services for people with disabilities are being reconfigured, based on a model of individualised and person-centred support.

RO through a recent Government Ordinance has opened the market of social services delivery to economic operators (companies, SMEs etc). Moreover, through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of transition to care in the community.

5.5 Assuring and monitoring quality

In the context of its comprehensive long-term care reform, in 2014 **AT** implemented some further developments to the quality assurance measures for home-based care: before the reform, caregivers were not able to request house calls to receive advising at home; relatives providing care on an informal basis or the persons requiring care themselves can now request such a house call free of charge if desired. Relatives who provide care can now also request a meeting with a psychologist in cases where they mention psychological burdens during a house call. This measure is preventive in nature.

In **IE** all nursing homes are registered with and inspected by the Health Information and Quality Authority. The Health Act 2007 Regulations (Care and Welfare of Residents in Designated Centres for Older People) came into effect in July 2014 and the Registration of Designated Centres Regulations came into operation on 1 March 2015. The government has committed to the development of national standards for home care services, which will be subject to a Health Information and Quality Authority inspection.

The **MT** government is planning to ensure better quality of service delivery through the finalisation of the National Minimum Standards for Care Homes for Older Persons and further establishing the Standard Operating Procedures (SOPs), Policies and Care Protocols to enable benchmarking of standards. Quality is then ensured by carrying out various Internal Audits of Homes for the Elderly by the Audit and Management Team. It is also planned to set-up Residents' Associations in all Government Homes as well as to publish and implement a Home Residents' Charter of Rights.

RO through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of establishing a department for LTC responsible for coordinating, planning and solving LTC related issues at all levels. The department will function at Ministry of Labour, Family, Social Protection and Elderly's level, in collaboration with the Ministry of Health. Moreover, RO has revised

and improved the legal framework regarding the accreditation of social services providers and licensing of social services based on quality standards.

5.6 Investing in the long-term care workforce

In 2014 **HU** introduced a sectoral top-up allowance for workers in the social field.

RO through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of developing HR plans for improving the recruitment, training and maintaining the personnel in social assistance system, including by providing different working arrangements and bonuses etc. Moreover, it aims to set up one or more programs for social management and LTC services management and facilities to prepare future directors, social assistants and case managers.

The **SE** government intends to set aside SEK 1 billion in 2015 for an initiative to increase staffing levels in elderly care aimed to improve security and the level of quality for the individual. Increased staffing levels can create opportunities for staff to spend more time with individuals, but can also allow more time for staff to develop their professional activities together. Higher staffing levels can also be expected to improve the work environment and thereby increase the attractiveness of elderly care professions.

5.7 Support to informal carers

AT implemented a care leave benefit in cash on January 1, 2014 which supports the caring and nursing family member taking care leave or part-time care leave or family hospice leave or part-time family hospice leave which helps family members to better coordinate work and care. A close family member may draw care leave benefits for one to three months during care leave or part-time care leave, depending on the period of leave agreed with the employer. During care leave or part-time care leave, care leave benefits may be claimed for up to six months for each family member in need of care (provided that at least two close family members take care leave/part-time care leave). **AT** also published a (second) study on so called 'young carers' in November 2014. In December 2012 the results of a first study, which was financed by the Federal Ministry of Labour, Social Affairs and Consumer Protection, were published. This study, which was executed by the Institute for Nursing Science, shows for the first time figures about how many care-giving children exist in Austria and on the other hand also shows the way and frequency of assistance by these children. According to this study there are 42.700 care-giving children and adolescents between the age of 5 and 18 in Austria. On the basis of this first study the social ministry ordered the Institute for Nursing Science to develop a concept of support for children and adolescents as care-giving relatives in this second study.

BE has recognized informal carers legally through legislation in 2014 as a way to improve the reconciliation of private life for persons giving informal care and their valorisation in society.

In **CZ**, a project of the Fund for Further Education is being implemented, which should produce a draft legislative solution targeted at a greater support to informal carers. The project should be completed in July 2015 and its results will be assessed subsequently. The issue of support to informal carers is also addressed by the above mentioned Action Plan for Ensuring the Quality and Safety of Health care Services.

DE has adopted the Act for the Better Reconciliation of Family, Care and Work Commitments (*Gesetz zur besseren Vereinbarkeit von Familie, Pflege und Beruf*) which entered into force on 1 January 2015. As a result of this Act, the legal regulations of the Caregiver Leave Act (*Pflegezeitgesetz*) and the Family Caregiver Leave Act (*Familienpflegezeitgesetz*) have become more closely aligned and have been developed further. The Caregiver Leave Act gives employees the possibility of being released from work - either entirely or in part - for a period of up to six months⁸. Since 1 January 2015, workers have been entitled to family care-giver leave, i.e. partial release from work for up to 24 months with a minimum working week of 15 hours, for the care of a close relative requiring care in a home environment⁹. Under the provisions of both Acts, the total length of time individuals are entitled to leave is 24 months. For the time they are released from work under the Caregiver Leave Act, and partially released from work under the Family Caregiver Leave Act, employees are entitled to financial support in the form of an interest-free loan so they can better safeguard their livelihood during the time they have less or no income. The entitlement to support in the form of an interest-free loan also applies to employees at smaller businesses (but no legal claim against employers with fewer than 15 employees) where the time off work was agreed on a voluntary basis. The loan is paid out in monthly instalments and generally covers half the net salary missing as a result of the reduction in work time. Apart from the care of a close relative in a home environment, employees are also entitled to be released from work (fully or partially) for up to six months or for up to 24 months (partially) to care for an underage close relative who is in need of care, wherein the care environment can be both the individual's own home and a facility outside the home and can change at any time. Furthermore, employees are also entitled to be released from work fully or partially for up to three months to provide support to a close relative in the last phase of his/her life. Since 1 January 2015, employees who are temporarily unable to work for care reasons for a period of up to ten workdays can receive a care's grant allowance as an income replacement benefit. This allowance is limited to ten working days. The amount of income replacement benefit is calculated along the same lines as the rules for child sickness benefit and is paid by the nursing insurance fund or the insurance company of the close relative requiring care.

The **FI** National Development Plan on Informal Care Support was completed in 2014. The need for support for family members will also be taken into account in the provisions of the new Social Welfare Act that comes into force in April 2015. The preparation of the legislative reform on informal care has been initiated at the Ministry of Social Affairs and Health at the beginning 2015. The new Government will decide on the implementation of the law reform.

RO through the National Strategy for Active Aging and Promoting Elderly's Rights 2015-2020 sets the basis of developing supporting mechanisms for informal carers (family members), including professional training, preferential access to temporary subsidized care (e.g. 10 days/year treatment in special resorts) for informal carers and their cared elderly, together or separately.

⁸ This entitlement does not apply to workers at businesses with 15 or fewer workers in general.

⁹ This does not apply to workers at businesses with 25 or fewer workers in general, wherein workers in vocational training are not counted.

5.8 Conclusions

In the last 18 months, most Member States have implemented reforms in the area of long-term care. Some Member States have implemented or are planning to adopt new legislation, while others launched new measures within the existing legislative framework.

Several Member States are in the process of adopting or implementing major reforms with the aim of ensuring a more efficient use of existing resources. Reform measures focus on further developing home care services and strengthening care integration.

Long-term care financing arrangements have been modified in a number of Member States. While some decided to increase public funding and to reduce private cost-sharing, others lowered existing eligibility thresholds for public support or introduced other measures for cost-containment.

A limited number of Member States have reported measures for preventing dependency which were mostly related to better prevention and early diagnosis of dementia. National governments put a stronger emphasis on improving service delivery by making care more patient-centred, by promoting the transfer from institutional care to community-based care, by developing and assuring new quality standards and by increasing staff levels.

Some Member States improved the support provided to informal carers through new strategies, better opportunities for reconciling work and care responsibilities and through legal recognition of informal carers.